

# State Innovation Models Test Round 2: Healthier Washington

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Sustainability Plan Part 2  
Strategic Roadmap for Sustaining Healthier  
Washington SIM Investments

Submitted: December 31, 2018

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Appendix 1: Healthier Washington SIM Driver Diagram for Award Year 4

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## Executive Summary

This document represents a status update and sustainability discussion of Washington’s State Innovation Model (SIM) investments, through September 2018. This document assumes a base level of knowledge of the SIM investment in Washington. Background can also be found in the companion piece to this document, our Sustainability Report Part 1.

Please note that this document describes SIM investment sustainability from the state’s perspective, with a section on health system partner reflections on SIM and thoughts on sustainability. Additional information about SIM impact, stakeholder engagement activities, and spending information will be available in the final four-year SIM report, to be released in mid-year 2019.

### Sustainability snapshot: SIM components

While we think of this work holistically, it can still be helpful to visualize the sustainability strategy of each program, in order to have an idea of whether elements were meant to be one-time investments, have found continued funding or resources, or will be embedded in state agency operations. The table below provides a brief overview of high-level plans for the continuation of our main SIM programs. Additional information on each program area can be found in the body of this document.

<b>Component / Driver</b>	<b>Plan for sustainability</b>
Accountable Communities of Health (ACH)	Accountable Communities of Health will continue, supported by funding from the Medicaid Transformation (1115 Waiver) through 2021. Individual ACHs are also seeking additional funding and creating use-cases for their own sustainability.
Plan for Improving Population Health (P4IPH)	The Population Health Planning Guide is complete and available on the web. Our P4IPH initiative has been embedded into the functions of the ACHs.
Practice Transformation Support Hub: Connector function	The Department of Health will continue to oversee connector services.
Practice Transformation Support Hub: Practice coaching, facilitation, and training	Coaching, facilitation, and training for practices will become a community asset after the SIM period.
Practice Transformation Support Hub: Hub Resource Portal	The Department of Health will continue to manage the Hub Resource Portal.
Shared decision making	The Health Care Authority will continue to certify decision aids as an agency process. Spread and

	scale efforts will continue, led by the Bree Collaborative.
Workforce/Community Health Workers	Workforce development will remain a function of the state, in partnership with the Washington State Workforce Board. ACHs also have a required commitment to workforce development.
Model 1: Fully integrated managed care	Legislation and funding is in place to continue integrated managed care in 2020 until all regions are integrated.
Model 2: Encounter to Value: Alternative Payment Methodology (APM) 4	Pending evaluation results, this model will continue, owned and supported by the Health Care Authority.
Model 2: Encounter to Value: Rural Multi-Payer model	This model is currently in development, seeking additional funding from CMMI through an all-payer demonstration.
Model 3: Accountable Care Program	The UMP Plus Program will continue, as agency business of the Health Care Authority. A similar benefit offering for school employees may be implemented in 2020 (negotiations are underway).
Model 4: Greater Washington Multi-payer	Components are being considered for agency contracts and new models. Decisions will be made with the help of final deliverables and sustainability plans for the networks, due in early 2019.
Performance measurement	The Performance Measures Coordinating Committee will continue to convene, supported by HCA. The Washington State Common Measure Set will continue to exist and evolve.
Health information technology/health information exchange (HIT/HIE)	Our interagency HIT/HIE investments will continue through support from state agency funds, HITECH funds, and Medicaid waiver support.
Data and analytics	Medicaid Transformation funds will continue to support the ARM team, in creating data products to support Accountable Communities of Health, as well as evaluation efforts for SIM and Medicaid Transformation.

## Introduction

The Healthier Washington State Innovation Models (SIM) program has been a major catalyst for health systems transformation in Washington State. Over the last four years, we have sought to operationalize three major strategies in pursuit of the quadruple aim of better care, better health, lower cost, and satisfied providers:

1. Pay for value instead of volume
2. Integrate physical and behavioral health to care for the whole person
3. Strengthen links between health systems and communities through a collaborative, regional approach

Through this investment, most of which has been distributed from the state to external entities doing the work, we have achieved myriad successes, encountered and successfully mitigated several challenges, forged new relationships, and partnered to bring together disparate systems and processes.

In Washington, we consider the SIM investment foundational funding, a way to move work forward and provide the resources to accelerate efforts that were already in motion. Now that this foundational funding mechanism is coming to a close, the sustainability of a dynamic and continually transforming health system is paramount to our continued pursuit of the quadruple aim. The Healthier Washington work has been a true multi-sector effort, with the participation and hard work of community partners, providers, tribal governments, local governments, state agencies, our state legislature, people and their families, and many others. We look forward to both reflecting on the past and looking to the future of this work.

During the SIM period, Washington took on several bodies of work that advance the foundational elements of Healthier Washington. These include cross-agency responses to the opioid epidemic, rural system transformation, hepatitis C treatment efforts, community transformation, and behavioral health integration. Washington has also entered into a Section 1115 waiver agreement with the Centers for Medicare & Medicaid Services (CMS). While not a SIM investment, the Healthier Washington Medicaid Transformation project (Medicaid Transformation) was designed to build upon foundational elements of SIM work, most notably the Accountable Community of Health infrastructure, and serves as a direct continuation of these efforts and an accelerator of future transformation. Medicaid Transformation is important to highlight as a near-term sustainability strategy, both in terms of adding resources for innovative programs as well as supporting the continuation of health transformation work statewide. Medicaid Transformation was designed to augment and enhance what was started by SIM, and will remain a catalyst for continued innovation until the projected 1115 Demonstration end date of December 31, 2021. Sustainability planning for Medicaid Transformation has already begun. (Additional detail on preliminary Medicaid Transformation sustainability and how it links to the work begun by SIM is discussed later in this document).

## How to use this document

This document is a strategic roadmap of SIM investments, providing both a status update within the SIM period and a look to the future of the work post-SIM for our major investment areas. The term “strategic roadmap” was chosen to illustrate that while this document is not a work plan, it outlines our plans to continue implementation of health systems transformation once SIM funding concludes on January 31, 2019. The document addresses distinct approaches for each project and program, as well as holistic strategies for the continuation of this work as a

public-private collaborative committed to transformation. For introductory information on Washington’s SIM program, including background on all initiatives, please refer to the companion document, our [Sustainability Plan Part 1](#), released on May 30, 2018. Please also note that references in this document to primary and secondary drivers are required reconciliations of our original driver diagram, as can be referenced in Appendix 1.

## Washington’s approach to sustainability

In Washington, we consider sustainability in the context of our health system rather than its component parts. For that reason, we have developed a Sustainability Framework to guide us in thinking beyond the SIM investment and into the future, to help us consider each program and investment as it relates to the whole. The Sustainability Framework considers the levers for sustaining transformed relationships, between people, institutions, funding sources, and governments, in order to ensure a holistic approach to sustainability. Using the primary driver of paying for value, the sustainability framework also highlights four critical business processes: capacity and infrastructure, strategic partnerships, inclusion and equity, and communication and storytelling.

### Healthier Washington’s Sustainability Framework



## Sustainability Strategy Workgroup

A critical piece of sustainability in Washington State rests within our ability to come together as a cohesive team across the Health Care Authority, Department of Health, and Department of Social and Health Services. To this end, we chartered a Sustainability Strategy Workgroup in 2018 to contribute ideas and build relationships in service to sustainability of viable innovations. The work group met initially in April 2018 and is scheduled to continue meeting monthly through the end of the SIM grant period. While collaboration has always been a critical part of Healthier Washington design, all of the agencies at the table are aware of the uncharted nature of health systems transformation, and are committed to continually exploring creative ways to collaborate and partner. Members were selected by agency executives, with inter-departmental and inter-agency representation in mind, and these members are generally management level, with vast knowledge of both the design and implementation of policies and programs that improve the health of Washingtonians. The workgroup is not a decision-making body, instead serving to cultivate evolved relationships and awareness of our unique

contributions to health system transformation sustainability, and create recommendations for high-level leadership.

While the work of the Sustainability Strategy Workgroup is preliminary, group members have highlighted several case studies to illustrate models of this enhanced collaboration, in order to inform and align with what will be necessary post-SIM. These case studies are presented in call-out boxes throughout this document, and meant to be examples of how we can work in partnership with statewide and community entities moving forward.

## Sustainability in practice: partner engagement in sustainability planning



To support Washington's sustainability planning efforts, the nonpartisan and objective research organization (NORC) at the University of Chicago technical assistance team facilitated a meeting on September 10, 2018, with key community partners and state agency staff from the Health Care Authority, the Department of Health, and the Department of Social and Health Services. This convening, "The Future of Healthier Washington: Co-Developing Continued Roles for Statewide and Community Partners," was a reflective discussion focused on the roles and strategic partnerships necessary to ensure enduring transformation of Washington's community health and wellness system.

A foundational principle of the Healthier Washington sustainability framework is that change needs to occur at a systems level rather than at a programmatic one. Moreover, the achievement and sustainment of a healthier Washington is fundamentally about shifting the way partners work together within a system, rather than in individual silos, to improve the health of the population.

### Main takeaways

- General support from all community partners is needed to advance the objectives of Healthier Washington. Similarly, there was the consensus that meaningful change will be effected in partnership rather than by actors working in their silos.
- There was a strong desire for common definitions and standardization. Specifically mentioned were "value" and "performance," and a call was made to collectively define what value means for specific components of Washington's transformation efforts, such as in the integration of physical and behavioral health. There was also a call for alignment around measures.
- There was the desire for strong leadership from state agencies around standardization, particularly as it relates to Accountable Communities of Health (ACHs). While participants agreed that ACHs are hubs for innovation, there was a call to distill innovations into standard policies and recommendations, and that this distillation is the state's role to lead. For example, stakeholders indicated that while the state encourages ACHs to promote health equity, there is ambiguity as to what constitutes health equity and the ways in which ACHs should address it.

### How partners and state agencies can continue to support each other in furthering transformation efforts

- Continue to bring payers and purchasers to the table.
- Keep working to define value.
- Move forward on health equity.
- Encourage standardization among ACHs.
- Continue to make connections across providers to achieve meaningful behavioral health integration.

*For additional information about this convening, please see the full NORC memo in Appendix 2.*

## Community empowerment and accountability

### Primary driver: Accountable Communities of Health

Accountable Communities of Health (ACH) are a structural backbone to health system transformation in Washington State. These entities embody the infrastructure for our collaborative and regional approach, and allow for a convening table that goes beyond the traditional health care system. Through the SIM investment, ACHs were conceptualized, defined, and developed across all regions of the state. SIM investments and state support enabled Washington to formalize regional collaboration through ACHs to reinforce and build upon partnerships that were already in place. During the SIM period, ACHs formed and became legal entities, built relationships with traditional and non-traditional health and wellness system partners, and partnered with the state to develop projects and plans for addressing the health concerns and opportunities in their region.

Midway into SIM, ACHs became heavily involved in Medicaid Transformation (the state's Section 1115 waiver), as the waiver relies on ACHs to serve as lead entities for implementing regional projects, delivering incentive dollars to providers, and partnering with the state to develop statewide structures and processes. All of this was intentional, making strategic use of these collaborative, community-based entities that evolved under SIM. Because ACHs are not revenue-producing entities and are not projected to become service providers, continued funding is required to support ACHs across the state in the near-term. This funding can be earned through Medicaid Transformation and will support ACHs in advancing health transformation through the waiver period, scheduled to end in 2021, with performance incentives scheduled into 2023.

### Sustainability analysis: ACHs

ACHs are legally self-governing entities, currently relying on funding through Medicaid Transformation for near-term sustainability, though other funding sources have been secured in several ACHs through philanthropic support, grants, and local braided funding strategies. The state does not direct or "own" the ACHs, though there is a close relationship that relies on the foundation of shared goals. Once SIM concludes, this partnership will not change.

Our long-term sustainability plan for ACHs will take place later in the Medicaid Transformation period, since near-term support from Medicaid Transformation allows for additional time. In addition, Medicaid Transformation has been designed to focus on implementation of regional project portfolios and community engagement activities, so that evaluation and monitoring activities can measure value-add and inform longer-term sustainability.

While the near-term financial sustainability of the ACHs is secured by their role in Medicaid Transformation, there is still a need to evolve the policy-defined role of ACHs beyond the Medicaid Transformation period. ACHs were supported and developed under Healthier Washington because they were considered a missing part of the system, a convener and facilitator in the advancement of a value-based, integrated health system linked to community supports. Acknowledging this, the state sees an ongoing role for ACHs as community-based entities serving as a neutral convener of multiple sectors to continue to link health care and community organizations to advance the health of the population. We will rely on evaluation findings from SIM and the Independent External Evaluator (IEE) of the Medicaid Transformation project to help inform the continued role of the ACH. We will have SIM results in early 2019 and expect IEE reports in 2020 and 2021.

Healthier Washington worked through initial sustainability planning in early 2018 to inform next steps. This process showed that current sustainability questions are not financial, which, in turn, impacts the phasing and timing of sustainability mechanisms. Despite this, it was recognized that early planning is important. The following strategies were identified:

- **Support for ACHs and managed care organizations (MCOs) to develop local/regional sustainability plans in partnership.** This strategy is a clear opportunity to support ACH activities that have established value both for those partnering with the ACH and to the ACH region itself. ACHs are likely to develop their own sustainability plans or strategies, although the strategy below recognizes the unique role the state can play to further define core ACH functions, levers, signals, or funding mechanisms.
- **Identify ongoing funding sources to sustain ACHs.** This strategy focuses on the direct value provided to the state, state agencies, or statewide organizations. State-level funding could be pursued several ways, and this lever requires state agencies and organizations to identify the alignment between ACHs and population health and purchasing strategies pursued by the state. One example of this could be Washington State's value-based payment (VBP) strategy: This strategy will continue to rely on collaboration and shared accountability for health and wellness, requiring active coordination across sectors and communities.
- **Provide state support through technical assistance or infrastructure.** This strategic area includes indirect resources and support, to be aligned with direct financial support. If the ACHs are sustained financially, we would continue to offer state support through technical assistance and infrastructure. Examples of potential support areas include Health information technology (HIT)/health information exchange (HIE), VBP, data and analytics, and practice transformation. Types of support and technical assistance include the provision of guidance, convening support, access to subject matter expertise, and access to state dashboards or information systems, as appropriate.

It is important to recognize that Medicaid Transformation implementation and activities significantly inform the evolving value proposition and long-term role of ACHs. Many ACHs are also actively discussing their regional vision for long-term value and sustainability. This will continue to be a conversation between state partners and ACHs.

Although there is no immediate need for additional funding to support ACH work, many of these value propositions and roles must be explored in the near-term, as they directly relate to roles and structures that are being developed at the local level through transformation activities. In addition, state agencies, MCOs and other statewide organizations may be assuming that ACHs will continue in the long term and need to engage now to capitalize on opportunities for ongoing collaboration. To move this conversation forward in 2019, we have outlined several essential functions that ACHs may be uniquely positioned to provide. It is important to acknowledge these require additional discussion with ACHs and partners. Essential ongoing functions of ACHs may include:

- Formally convene community members and partners, including health plans, to identify shared goals, strategies, roles, and resources.
- Facilitate engagement and outreach to community members, including Medicaid beneficiaries, with a formal feedback loop.
- Coordinate regional HIT/HIE, data and analytics, and strategic planning.

- Create regional braided funding models that support collaborative efforts to improve population health.

In addition to the functions outlined above, HCA mapped out existing state support levers, along with a starter set of potential future levers. Note that several of the potential future levers listed below will require ongoing development and discussion. Potential future levers for the state to employ may include:

- Commit to developing state funding strategies to support the essential ACH role, assuming a shared value proposition is developed.
- Support public-private statewide braided funding strategies.
- Clearly define purchasing contract language and the intent of ACH partnership, including areas where ACHs can support or lead in VBP.
- Align MCO functions and funding to leverage ACH core functions, such as community engagement, regional alignment, and strategic planning.
- Facilitate and develop state-supported grant applications.

State partners will continue to engage ACHs in this conversation in order to identify roles, gaps, and critical policy levers. Sustainability planning is a joint effort between state agencies, organizations like provider associations, health systems, MCOs, and ACHs and their traditional and non-traditional health system partners. Ongoing engagement and sustainability planning will include the continued analysis of available levers, potential funding opportunities, and evaluation results.

#### Reconciliation of secondary drivers: ACHs<sup>1</sup>

<b>Secondary driver</b>	<b>Status</b>
Define vision, build foundation for ACHs to collaborate in region.	Complete.
Develop and strengthen regional partnerships so that collaboration can lead to complementary and collective health improvement activities.	Complete in the context of the SIM period. Work is ongoing.
Participate in broader Healthier Washington activities, including delivery system transformation.	Complete in the context of the SIM period. Work is ongoing.
HIT secondary drivers:  (1) Buildout of the Healthier Washington regional dashboards to include additional measures based on prioritization. Analytic support and coaching for ACHs (support could be provided by the Center for Community Health and Evaluation [CCHE], Analytics, Interoperability	Complete in the context of the SIM period. Work is ongoing.

<sup>1</sup> The SIM Driver Diagram is a visual representation of levers to advance SIM work. Primary drivers are addressed in the narrative of this document. In this table, secondary driver progress is reconciled based on current status. The driver diagram is in Appendix 1.

and Measurement [AIM] and/or regionally, e.g., local health jurisdictions).

(2) Support to develop strategic connections between the dashboard and evidence-informed strategies to address identified population health issues.

(3) Department of Health (DOH) and Research and Data Analysis (RDA) data supports – increase in support for data extracts (FTEs).

(4) Washington Health Alliance Community Checkup Report – maintenance and enhancement.

(5) Addition of Public Employee Benefit (PEB) data – for evaluation and dashboard enhancement.

## Population health

### Primary driver: Plan for Improving Population Health

The Washington State Plan for Improving Population Health (P4IPH) was implemented to guide how state and local communities can best implement population health improvement strategies. This work started with an intensive community engagement process, and outcomes included a guide for implementing population health approaches, as well as a work plan for hard-wiring these approaches at the community level. Informed by national and local experts, the completed [Population Health Planning Guide](#) outlines a structured process that provides access to standard population health approaches while allowing flexibility for unique needs and resources of local communities. The P4IPH represents an avenue for ensuring the Healthier Washington initiative addresses prevention, health equity and social determinants of health. Providing a standardized process and individualized interventions, the guide allows diverse communities to take any health priority and implement strategies that:

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

### Sustainability analysis: P4IPH

Since the first iteration of the guide was completed and housed on the Practice Transformation Support Hub's Resource Portal ([www.waportal.org](http://www.waportal.org)) in the fall of 2016, a work plan focused on hardwiring these activities in ACH regions was developed and is currently being implemented. Separate efforts to address health equity, using the tenets put forward in the guide, are being developed and implemented by state agency staff in partnership with the ACHs.

Because Washington's approach to developing a P4IPH was a one-time process of community engagement to create a tool for the public, the work of this part of SIM is complete and is considered a one-time investment. The guide is public and housed on the web, and the plans for

hard-wiring population health activities at the community level have been embedded into the work of ACHs.

The Population Health Planning Guide is maintained by the Department of Health (DOH) and housed on the Portal. Population health is central to public health’s work and DOH regularly updates the guide with evidence-based best practices for new and evolving health issues. They’ve also made additional assistance available to public health, ACHs, and other partners in using the guide as an effective tool in addressing local population health planning issues. DOH will continue to maintain and improve the guide, adding new resources and planning aids for users on a regular schedule each year. The guide is available to the public at <https://waportal.org/population-health-planning-guide>.

### Reconciliation of original secondary drivers: P4IPH<sup>1</sup>

<b>Secondary driver</b>	<b>Status</b>
Develop and strengthen regional partnerships so collaboration leads to complementary and collective health improvement activities.	Complete.
HIT secondary driver: P4IPH website migration to University of Washington, addition of well-child tools. New interfaces. New analytics. Additions to Providence CORE data dashboard.	Complete for the SIM period. Work is ongoing.

## Practice transformation

### Primary driver: Practice Transformation Support Hub

The Healthier Washington initiative supports transformation of the health delivery system through investment in knowledge, training, and tools, that effectively coordinate care, promote clinical-community linkages, and transition to value-based care.

The Hub was implemented to coordinate and provide resources or connections to resources and tools that would better enable small to medium-sized primary care or behavioral health practices to make progress on the following clinical transformation goals:

- Stimulate and accelerate the uptake of integrated behavioral health (mental health and substance use disorder) and primary care.
- Accelerate provider readiness to engage in VBP arrangements.
- Improve population health management by strengthening clinical practice operational capacity and alignment with community-based services for whole-person care.

These goals have been accomplished through a variety of strategies and a nimble, provider-centric approach. Most notably, we deployed a statewide coach and connector network, through which skilled individuals serve providers as coaches and advisors, helping them to implement practice transformation assessments and providing individualized action plans for transformation. These coach/connectors activate clinicians to integrate new service delivery models with expanded care teams, in order to increase quality of care, reduce costs, improve

health outcomes, and enhance provider satisfaction.

Coach/connectors focused on smaller clinics and behavioral health agencies. In addition, we built the Washington State-specific Practice Transformation Support Hub Resource Portal, an online platform to support providers. This resource was put in place to advance strategic practice improvement, support geographic linkages to nearby providers and community-based resources, and offer curated resources relevant to Healthier Washington priorities, including whole person care and evidence-based practices.

The Hub also provided training and tools to improve data management capacity in clinics, in order to strengthen the use of data-driven decision-making, support contract negotiations, and achieve better coordination of care. Providers were also supported in connecting more formally with each other, as well as sources of technical assistance, training, and problem resolution supports. The Hub acted as a resource in raising issues and barriers encountered by individual practices to state agencies, for awareness and issue resolution at the policy level. These activities supported robust and effective linkages among clinical practices, state agencies, and community partners to improve whole-person care through strategies and approaches tailored to individual providers and practices.

## Sustainability in practice: collaborative care codes

Medicare and Medicaid currently pay for services provided to patients participating in a collaborative care program or receiving other behavioral health services.

This program debuted in Washington on January 1, 2018 as a new payment mechanism for many provider types.

A new code, 99492 (formerly G0502), reimburses behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating provider. The challenge: getting providers to use these new codes. What new connections and collaborations must be made to encourage use of the new code?

In response to that question, the Practice Transformation Support Hub planned and facilitated a work group to discuss possible solutions and roles. Attendees included the University of Washington AIMS Center, Qualis Health, Department of Health subject matter experts, and Health Care Authority staff. The multi-disciplined group created a plan for an enhanced approach.

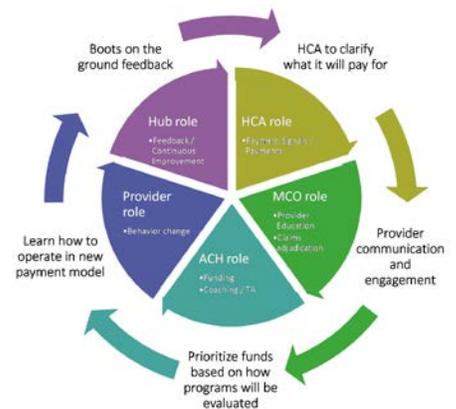
Essentially, the participants each identified their best/highest contribution to achieving the stated outcomes.

- The Hub offered to facilitate communication with providers and Accountable Communities of Health about the option to use the codes, and report barriers on the uptake of the codes.
- HCA provided additional educational materials about use of the Medicaid codes.
- MCOs contributed their access to provider education and claims adjudication communication.
- ACHs discussed providing funding to spread the word and provide additional technical assistance.
- Providers acknowledged their role to learn to operate in this new model.

The group identified key success factors for sustainability of the new codes:

- Continue to design payment models by looking at our goals within a system of care and not in isolation, and map outcomes back to the primary drivers.
- Continually clarify roles.
- Add clarity to definitions and documentation.
- Acknowledge, prioritize, and address gaps.
- Maintain the right connections and partnerships
- Commit to collaboration and shared language.
- Ensure feedback is gathered and applied to future efforts.

The sustainability of the new collaborative care codes will rely on new collaborations, new conversations and improvements in communications and clarity.



## Sustainability analysis: the Hub

The Hub, as currently funded and supported by SIM resources, provided an initial investment to help support providers in taking the first steps toward transformed practices with integrated care and VBP. The Hub also planned to assess the needs of providers for support during the test grant. The Hub consisted of integrated components that included the practice coaching, facilitation and training program, and a Regional Health Connector Network provided through contracts with Qualis Health and the Portal developed in partnership with University of Washington Primary Care Health Innovation Lab. All of this work was connected to Healthier Washington through leadership from DOH, where collaboration was fostered across agencies, associations, and ACHs.

Because health systems transformation is still very much in progress, practice transformation support is still necessary to support practices and providers. Practice coaching and facilitation, along with resource sharing and bidirectional communication with the state will continue, and there is funding through Medicaid Transformation that ACHs can leverage to fund these services. The Portal has secured bridge funding from the Department of Health state fund budget and is aiming to become financially self-sustaining through continued resources provided by DOH. The need to coordinate practice transformation across the state and connect coaches and programs is under discussion as part of Medicaid Transformation, and will transition away from SIM funding. While coaching in individual clinics will become a community asset, with the responsibility for funding and sustainability shifting away from the state, the coordination of policy issues, shared tools, resources, and training will be an evolving function, guided and supported by the state. There may also be an ongoing role for the Practice Transformation Consortium, a group that meets to align and coordinate practice transformation resources and efforts in Washington State. DOH will contribute resources to fund a practice transformation liaison, to align public health resources with Medicaid Transformation.

This approach to sustainability and transition away from SIM funding for practice transformation assumes that the Hub (as a set of integrated coaching, training, and connecting functions) will continue in a different framework, with new resources and relationships across organizations. Clinician coaching will become the responsibility of ACHs and statewide provider organizations, with support from state agencies. The Portal can continue to host and deploy resources while also remaining an interactive platform for practice transformation. The state will continue to monitor practice transformation and respond to needs in clinical settings around HIT/HIE, workforce, payment issues, or questions regarding best practices. Some of these formal feedback loops have been established (e.g., workforce development), and others are still in process. The state has the capacity to respond to needs of guidance, technical assistance, and ongoing design and implementation of policy mechanisms to support needs and gaps. DOH will work to support a smooth transition of Hub components to local communities, and respond to areas where statewide coordination is appropriate. We will also continue to facilitate the Practice Transformation Consortium to align SIM and P-TCPI<sup>2</sup> resources and consider options to expand the group to include new community partners and ACHs working on practice transformation. The Hub has engaged state agency staff, the American Indian Health

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<sup>2</sup> The Pediatric Transforming Clinical Practice Initiative (P-TCPI) is a unique partnership among the Washington Chapter of the American Academy of Pediatrics, Molina Healthcare, and the Washington State Department of Health. The initiative advances child health priorities in statewide transformation efforts and helps providers prepare for the new payment paradigm while leveraging the patient-centered medical home model to improve the health of children.

Commission, provider associations, and MCOs in conversations about the sustainability of practice transformation in Washington.

The experience of the Hub as part of Healthier Washington yielded valuable lessons. Based on Qualis Health leadership experience and comparison of the Hub to previous practice transformation engagements, we learned that the flexibility of coaching engagements with practices, while experimental, led to high levels of engagement, easier recruitment, and higher retention rates for practices than Qualis Health had experienced in other initiatives. We learned that connecting coaches to each other and other practice transformation initiatives allowed a rich sharing of expertise across regions: each coach/connector was assigned a region, but could call on other coaches to bring in stronger expertise in various areas such as HIT/HIE, behavioral health, care coordination, or other topical areas. We learned that the high engagement and response of behavioral health agencies in Hub provided activities and coaching points to a higher level of need among that community of providers. We learned that the connection of a practice transformation program to Healthier Washington, executive sponsors, ACHs, provider associations, tribes, and MCOs was a successful model. The individual coaches on the ground were better informed to support providers and also could voice provider concerns to state agency officials in a coordinated way. Resources were allocated based on emerging needs ensuring the Hub met providers and practices where they were.

Several challenges were addressed by the Hub team over the SIM period. The Hub faced workforce challenges in finding locally based coaches to serve some of the ACHs. We mitigated this limitation by sharing coaches across the state. The timing of the Hub required us to approach providers for coaching before the full business case for transformation was clear, which also presented a challenge. Communications strategies helped provide clarity to encourage providers to get started as the VBP landscape and contracts evolved.

The Hub has successfully broadened awareness of practice transformation support in various forms, whether it be through self-help resources on the Portal or direct hands-on coaching from Qualis Health. ACHs are increasingly better prepared to take on the role of ensuring practice transformation resources remain available in their regions without interruption for providers. The statewide coordination of practice transformation has left a strong foundation for provider support across the state. ACHs can turn to state agency staff, members of the Practice Transformation Consortium, aligned staff at the MCOs, or state associations, and will be connected to support. Whether or not the structures and relationships continue as created under the Hub, the opportunities for maintaining momentum and strong alignment of resources initiated by the Hub will remain available to the state.

### Reconciliation of original secondary drivers: the Hub<sup>1</sup>

<b>Secondary driver</b>	<b>Status</b>
Understand the practice transformation training and technical assistance needs of providers to inform Hub services.	Complete.
Make tools and resources available online, informed by needs of providers.	Complete for the SIM period. Work is ongoing.
Refer and provide training, technical assistance, and facilitation services.	Complete for the SIM period. Work is ongoing.

Develop regional health connector role and establish linkage between practice community and public health.	Complete. Work will continue in the community through ACHs.
HIT secondary driver: Connect HIT with practice transformation. Coaching will involve technical assistance in optimizing use of electronic health records, use of shared decision making, and data analytics use in the clinic.	Complete. Coaches included these topics in action plans where clinics chose them. Work is ongoing.

### Primary driver: shared decision making

Shared decision making is one of many innovative areas in health care that Washington State is leading. In 2007, Washington became the first state to pass legislation around shared decision making, when the Blue Ribbon Commission bill (Chapter 259) enacted a shared decision making pilot. The legislation also provided that if a provider uses a “certified decision aid” as part of the informed consent process, there is a presumption that informed consent has been given and obtained. In 2012, state legislation granted the Health Care Authority’s chief medical officer the authority to certify patient decision aids. The certification criteria are guided by the work of the International Patient Decision Aid Standards (IPDAS) Collaborative, addressing content, development process, and effectiveness.

Certification plays a significant role in ensuring the quality of decision aids used by consumers, providers, and payers. Washington State’s leadership in creating the decision aid certification process provides a model that other states and organizations can adopt.

### Sustainability analysis: shared decision making

There are three main projects within shared decision making:

1. Establishing a process for the state to review and certify patient decision aids
2. Using contract methods to require the use of certified patient decision aids in interactions with clients
3. Training providers on the effective use of these tools in clinical settings

These functions will continue in the program operations of the Health Care Authority, living within the Clinical Quality and Care Transformation (CQCT) division. The only process that requires continued funding is certification of decision aids, and the current sustainability strategy is to begin a fee-based model where developers pay for review of decision aids submitted for certification. This model provides value to all involved parties: developers benefit from having their decision aids certified, ensuring likelihood of being purchased by providers for use across the nation. Purchasers benefit from having a repository of certified decision aids to choose from when requiring the use of these aids in contracts. Providers benefit because using a certified decision aid adds additional malpractice protection and helps to ensure people and their families can make thoughtful and informed decisions about their care. HCA will support contracting and provider training.

SIM sustainability processes described above are currently being designed and implemented by SIM staff, agency CQCT staff, and our longtime contractor for this work. We are confident that the current fee-based model in development will be self-sustaining.

It is our goal to spread shared decision making and the use of certified patient decision aids across Washington through the development and implementation of a “Shared Decision Making Roadmap.”

In July 2018, the Dr. Robert Bree Collaborative<sup>3</sup> chose shared decision making as a priority topic area for state focus, a notable nod toward the viability of this work, and an important lever to use for spread and scale. Leveraging the input of a group of community thought leaders, as well as the National Quality Forum (NQF) SDM Playbook, an initial approach and guidelines have been developed that will be transitioned in 2019 to a Bree Collaborative workgroup to fully develop an implementation roadmap.

The value in having the Bree Collaborative focus on shared decision making is that efforts that began under Healthier Washington will successfully transition to community partners. The completed roadmap, which will include outcome measures, will be presented to key stakeholders later in 2019 for buy-in and commitment to kick off the implementation process. We are also partnering with Coverys, a malpractice insurer in Washington State, to apply for funding through their foundation for an implementation project focused on a specific topic area, such as end of life care.

Much discussion has centered around the sustainability of this work stream. Several elements that support the next stage of work have been put in place:

- Foundational legislation that requires the development of a fee structure for future revenue
- Strong community support from partners who have been successfully implementing shared decision making in Washington for several years
- Opportunities for financial support from foundations
- A designated operational team within the state

In addition, having providers from health systems talk about the value of shared decision making is much more impactful than anything the state can do, so we will continue to leverage the valuable partnerships established during SIM.

#### Reconciliation of original secondary drivers: shared decision making<sup>1</sup>

<b>Secondary driver</b>	<b>Status</b>
Provide training and practice coaching opportunities on shared decision making implementation.	Complete.
Promote and spread the integration of shared decision making and use of certified patient decision aids in clinical practice.	Complete.
Develop a multi-state Shared Decision Making Innovation Network.	Not complete. Because NQF has led a national effort to develop an SDM Playbook, we have instead focused

<sup>3</sup> In 2011, the Washington State Legislature established the Dr. Robert Bree Collaborative so that public and private health care stakeholders would have the opportunity to identify specific ways to improve health care quality, outcomes, and affordability in Washington State. Each year, members identify health care services with high variation in the way that care is delivered, that are frequently used but do not lead to better care or patient health, or that have patient safety issues. For most topics, the Collaborative forms an expert workgroup to develop evidence-based recommendations.

	resources on certification of PDAs, provider training, and spread and scale of shared decision making.
HIT secondary driver: Help providers automate shared decision making in their EHR.	Not complete. . Work is ongoing, using the lever of VBP contracts.

### Primary driver: workforce

Our SIM investments in health workforce activities were centered on Community Health Worker policy recommendations and the [Health Workforce Sentinel Network](#), a body dedicated to the collection and analysis of data between health system employers and health education institutions.

The Sentinel Network is a collaboration between the state’s Workforce Board and the University of Washington Center for Health Workforce Studies, with startup funding from SIM. The Sentinel Network links the health care sector with partners in education and training, policymakers, and workforce planners to collectively identify and respond to new and changing demand for health care workers, skills, and roles. The Sentinel Network is an online tool that helps capture key recruitment and retention issues by facility type, profession, and geographic area. The data and reporting tools simplify access to timely workforce data that can be used by educators, policy makers, planners, and industries in their workforce planning activities.

The Community Health Worker Task Force was created to develop recommendations to align the Community Health Worker workforce with the Healthier Washington initiative. Over a period of five months, members were tasked with making recommendations that would support the integration of Community Health Workers into our health and health care system. In December 2015, the task force concluded its work, releasing a [final report](#) in February 2016, which contains recommendations, overarching guidelines and strategies, a Community Health Worker definition, roles, skills, and attributes, training and education, and finance and sustainability considerations.

### Sustainability analysis: workforce

Medicaid Transformation is a key sustainability mechanism for state action for workforce development, including appropriate and effective use of Community Health Workers. The Medicaid Transformation Project Toolkit incorporated key points from the final Community Health Worker Task Force report to guide ACH projects in Medicaid Transformation’s Domain 1 workforce activities focusing on coordinating ACH and state planning and implementation, including the role of Community Health Workers in team-based care and care coordination. For this reason, there is an ongoing role for the Health Care Authority to coordinate with ACHs and key state and community-based partners, including DOH, to support alignment and coordination of workforce activities that support the success of ACH project implementation, an activity that will largely take place in 2019 and beyond.

The Health Workforce Council (HWC), as a program of the Washington State Workforce Training and Education Board, exists as the state’s coordinating entity for health workforce activities. The HWC develops a strategic plan and priorities for action and holds at least biannual meetings to set and monitor progress on state health workforce policy priorities. For sustainability purposes, tapping into this existing resource will create a better communication pipeline and opportunities for coordination between ACHs and the state, and will allow for one

point of contact for ACHs to have an ongoing conversation and engagement about these issues. This will be the extent of the state role when it comes to more traditional workforce activities. HCA staff have been assigned to perform this liaison role between the HWC and the state, and membership will also be expanded to at least one ACH representative. This activity leverages agency human resource capacity and will not require additional funding.

HCA, ACHs, and the HWC will still need to develop a structure to guide decision making, communication, and engagement in shared activities supporting common HWC and ACH cross-regional and statewide projects or interests. An HCA staff member will provide staffing and support to this new partnership by supporting communication and coordination to manage the ACH-HWC shared project goals and structure. HCA anticipates that the ACHs and the HWC will identify a structure for participation that actively engages the input and needs of all ACHs. ACHs will coordinate to identify shared ACH and HWC priorities and goals. We anticipate this work may evolve to support broader ACH involvement in identifying and planning for 2019 legislative and HWC goals. These shared goals will drive statewide or cross-regional ACH workforce development planning activities. The ACH-HWC coordination will begin by focusing on a single HWC and ACH priority project to address behavioral health licensing and scope of practice. Additional projects may be identified and deployed in 2019.

HCA, ACHs, and HWC will define roles, responsibilities, and ownership of planning and implementation during 2018. Overall, the ACHs identify their workforce priorities and plans. These plans and priorities will be communicated and coordinated with the HWC and its statewide priorities. The HWC coordinates priority setting and planning and implementation of these priorities through its HWC members. As members of HWC, the ACH representative will identify priorities and partner with HWC and its members to align work plans and implementation. DOH and HCA provide staffing resources to support coordination between the ACHs and the HWC.

We consider our approach to workforce development to have several strengths, including efficient, aligned use of statewide expertise and resources to prioritize and optimize the ability to coordinate timely, critical workforce priorities at local and statewide levels. This includes assessing and addressing behavioral health licensing and scope of practice issues impacting integration of physical and behavioral health, and access to team-based, whole person care. Other strengths include clear, consistent communication and action on statewide priority workforce activities requiring state leverage or resources, clear alignment and voice for ACHs in statewide workforce development, and the development of new partnerships and integration for local and statewide planning activities. We also recognize that there is still more to do, including a continued need to communicate resources and tools clearly, and continue to build relationships to aid in ongoing development and implementation of workforce strategies.

### Reconciliation of original secondary drivers: workforce<sup>1</sup>

<b>Secondary driver</b>	<b>Status</b>
Engage community health workers.	Complete.
Survey the health care industry and make targeted investments to address identified workforce needs.	Complete. Work is also ongoing.
HIT secondary driver: Support for Sentinel Network to administer survey and provide results.	Complete. Sentinel Network is capable of these tasks without assistance.

## Payment redesign

### Primary driver: Payment Model 1: integrated managed care

Integrated managed care is an integral part of Washington's move to fully integrated physical and behavioral health services for Medicaid clients. Legislation requires all regions in Washington to be fully integrated by 2020, so this work will extend beyond the SIM period and will be primarily led by our Medicaid program at HCA. The initial SIM investment catalyzed activities that would eventually change the way the core Medicaid business is delivered in Washington, and this transformation will be sustained within the program and funded by the state and federal dollars that fund the Medicaid program now. A 1915b waiver amendment is currently in process to make the required changes for operations once all regions have transitioned.

### Sustainability analysis: integrated managed care

After SIM concludes, these activities are owned in partnership between the Medicaid program and the policy division at HCA. This work has always been a partnership between these two divisions, as well as the Division of Behavioral Health and Recovery (DBHR), formerly at DSHS, and now housed within HCA. Because regions will continue to transition after SIM concludes, this continued partnership between divisions will still be necessary to support the last round of transitioning regions. While there have been many lessons learned from the early and mid-adopter work, each region is unique; therefore support from the state is necessary to ensure as smooth a transition as possible.

Due to the staggered approach with this model, six regions and two transitional counties will be fully integrated into managed care by the end of the SIM period, meaning that operations are embedded into state agency business and therefore sustainable. The remaining regions will transition on July 1, 2019 (North Sound region), and January 1, 2020 (Thurston-Mason, Great Rivers, and Salish). For this reason, sustainability planning is not being undertaken in the same way as it has been for other SIM projects. Healthier Washington has been in close partnership with other state agency divisions since the beginning, and there is now a reliable template for the future of this work. Some agency staff currently funded by SIM are either transitioning to sit within the Medicaid program and be a part of that reporting structure, or have already moved to this arrangement in the past year to ensure the activities are fully embedded in the operational program. In addition to providing operational support for the model, state agency staff perform many functions related to convening regional workgroups and engaging stakeholders. This work will continue for the mid- and on-time adopters in 2019 and 2020.

From early results and the continued commitment of our partners, we know that the integrated managed care model has many strengths. The model improves the current system by making a single health plan accountable for the full array of physical and behavioral health services and health outcomes, eliminates Access to Care Standards<sup>4</sup>, ensuring that Medicaid enrollees receive ongoing behavioral health treatment at the appropriate level of care, and promotes a whole-

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<sup>4</sup> The statewide Access to Care Standards describes the minimum standards and criteria for clinical eligibility for behavioral health services for the Behavioral Health Organization (BHO) care delivery system. This includes mental health and substance use disorder (SUD) services. Medicaid enrollees are eligible for all outpatient and residential levels of care and clinical services in the Medicaid State Plan based on medical necessity and the Access to Care Standards that now include qualifying substance use diagnoses and the American Society of Addiction Medicine (ASAM) Criteria.

person approach to care by breaking down the silos between physical and behavioral health care, offering improved care coordination for patients and more seamless access to the services they need.

Several implementation challenges have become clear through our early and mid-adopter work. Most notably, the transition to the integrated managed care model disrupts behavioral health provider administrative and billing processes. MCOs have very different administrative processes for billing, coding, reconciliation, and prior authorizations than the current Behavioral Health Organizations. Thus, behavioral health providers have to adjust their processes in order to operate successfully in this new managed care environment. To mitigate this challenge, the mid-adopter regions have developed provider readiness workgroups to discuss these changes and facilitate technical assistance for behavioral health providers. HCA has also encouraged the mid-adopter regions to use their SIM mid-adopter incentive funding, as well as their integration incentives under Medicaid Transformation, to fund this technical assistance.

An additional challenge is the required reassignment of Medicaid enrollees to a new MCO if their current MCO was not selected as an integrated managed care MCO in that enrollee's Regional Service Area. HCA mitigated this impact by creating communications workgroups in

## Sustainability in practice: Medicaid managed care organization contract changes

As a health care purchasing agency that manages contracts with managed care organizations (MCOs), HCA uses contracting as a vehicle to drive toward value-based purchasing and integrated managed care. This process requires amendments to the five MCO contracts, which used to be undertaken on an ad-hoc basis. Since we began our health system transformation efforts, the agency has developed a structured process for handling language change amendments in order to ensure predictability, adequate time, and appropriate review and vetting by all parties.

"One word can make a huge difference," said Alison Robbins, Manager of Medicaid Program Operations and Integrity at HCA.

The new process counts on multiple agencies, teams, workgroups, and divisions to collaborate on language and terms. Change requests must be submitted via an issue paper and an online form that can be indexed and stored in a repository. The increased collaboration has resulted in more precise and less error-prone amendments. As each contract amendment moves through both Medicaid operations and Medicaid leadership teams, ancillary processes can be triggered for follow up.

For example, for a January 1, 2019 contract start date, the following process is important. (Note: This represents a process example; content is subject to change):

- July 31, 2018: Potential contract language submitted using the Contracts Change Form
- August 31, 2018: Comments on draft amendment due from multiple internal and external groups, including executive leadership, budget, and CMS
  - Internal subject matter experts (SMEs) respond to questions/comments from reviewers
- September 19, 2018: Draft amendment sent to MCOs for review
- October 4, 2018: Questions/comments from MCOs sent to SMEs
- October 24, 2018: SME responses to above questions due
- December 6, 2018: Amendment to MCOs for signature

While this process continues to be refined, it provides a predictable structure to support positive outcomes: primarily that contracts are executed on time, language changes result in actions that are feasible and have the desired effect, and other mechanisms to achieve the desired outcomes are considered. The process also allows for vetting and approval from multiple parties with a stake, including the state, CMS, and MCOs.

Contracting is an important vehicle in sustaining our innovations in Washington State. This process strikes a balance between thoughtfulness and efficiency, allows for appropriate transparency and review, and reduces unnecessary work. Improvements in processes and systems at the state level are a key area to consider as health systems transformation moves forward.

each region that develop materials and identify strategies for disseminating information. HCA also sends communications to affected Medicaid enrollees notifying them of this change, and makes the necessary enrollment updates.

As noted, this model will achieve full spread and scale by 2020 when the three remaining regions transition on January 1. Integrated managed care also lays the foundation for clinical integration by including both physical health and behavioral health providers in the same integrated network. This will improve care coordination and communication between providers, while also increasing access to care for Medicaid enrollees. Furthermore, this model removes separate standards, breaking down silos and allowing providers to obtain licensure for behavioral health services if desired, and offer additional services or clinically integrated models for whole person care.

### Reconciliation of original secondary drivers: integrated managed care<sup>1</sup>

<b>Secondary driver</b>	<b>Status</b>
Integrate Medicaid purchasing of physical and behavioral health services within accountable MCOs.	Work is ongoing. To be completed by 2020 per statute.
Create internal MCO processes and structures.	Work is ongoing. To be completed by 2020 per statute.
Improve service delivery process to increase access to integrated services.	Work is ongoing. To be completed by 2020 per statute.
<p>HIT secondary drivers:</p> <p>(1) Gap: New capabilities are needed in order to build a system to receive necessary non-encounter behavioral health data. Depending on design decisions in the North Central region, ProviderOne changes may be needed.</p> <p>(2) Gap: Coding for “native transactions” with integrated managed care/MCO and Medicaid Management Information System (MMIS).</p> <p>(3) Gap: Project to bring DBHR into HCA may require infrastructure work or system enhancements.</p> <p>(4) Expand alerts: Expand the ability to inform providers of critical events.</p> <p>(5) Make alerts to providers and care coordinators available when Medicaid covered individuals enter correctional settings to support continuity of mental health and substance abuse treatment and inclusion of care coordinators in the overall treatment planning as needed.</p> <p>(6) Gap: HCA will install a new Fraud &amp; Abuse Detection System (FADS) in AY3/4.</p>	<p>(1) Work is ongoing. To be completed by April 2020 per our Corrective Action Plan (CAP) with SAMHSA.</p> <p>(2) Work is ongoing. To be completed by April 2020 per our Corrective Action Plan (CAP) with SAMHSA.</p> <p>(3) DBHR was brought into HCA on July 1, 2018, as scheduled. Infrastructure and system enhancement work is ongoing.</p> <p>(4) Incomplete. See <a href="#">HIT Roadmap</a>.</p> <p>(5) Incomplete. See <a href="#">HIT Roadmap</a>.</p> <p>(6) Incomplete. Gathering requirements. Implementation scheduled for 2019.</p> <p>(7) Incomplete. Behavioral health providers not yet targeted for electronic</p>

(7) Gap: Behavioral health electronic health records.	medical records, interoperability, or storage of data in the Clinical Data Repository.
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## Primary driver: Payment Model 2: Encounter to Value

### Alternative Payment Methodology (APM) 4

On July 1, 2017, 16 federally qualified health centers (FQHCs) began using a new alternative payment methodology for Medicaid managed care enrollees that provides additional flexibility in delivering primary care services, expands primary care capacity, and creates financial incentives for improved health outcomes while meeting federal requirements. FQHCs and rural health clinics (RHCs) are essential providers of care to Washington’s Medicaid population.

APM4 aligns these providers with the state’s VBP model, giving them the flexibility to expand on innovative and integrated delivery models, and accelerate the effectiveness of VBP initiatives on both a state and federal level. While ensuring federal reimbursement requirements are met, APM4 attempts to shift from encounter-based requirements by moving the clinics to a per-member-per-month (PMPM) rate, which will be prospectively adjusted based on quality performance.

HCA will determine prospective adjustment percentages annually based on the clinic achieving quality improvement score targets. Clinics that demonstrate quality improvement and attainment against their quality baseline will continue to receive their full PMPM rate. Clinics that do not demonstrate quality improvement and attainment will be subject to downward adjustment of their PMPM rate in future years. In total dollars, downward adjustment of the PMPM rate will never go below encounter-based equivalent payment amounts. After being adjusted downward, clinics can earn back the full benefit of the baseline PMPM rate (as trended by the Medicare Economic Index) upon meeting quality improvement targets.

Each clinic will be measured by seven quality measures from the Washington State Common Measure Set:

1. Comprehensive diabetes care - poor HbA1c control (>9%)
2. Comprehensive diabetes care - blood pressure control (<140/90)
3. Controlling high blood pressure (<140/90)
4. Antidepressant medication management
  - a. Effective acute phase treatment
  - b. Effective continuation phase treatment (6 months)
5. Childhood immunization status - combo 10
6. Well-child visits in the 3rd, 4th, 5th and 6th years of life
7. Medication management for people with asthma: medication compliance 50%
  - a. (Ages 5-11)
  - b. (Ages 12-18)

The goal of APM4 is to allow clinics to improve access to care by focusing on improvement against specific quality measures, and allow clinicians to work at the top of their license. This payment methodology provides flexibility for primary care providers to have a larger member panel without the burden of increasing the number of face-to-face patient encounters, thus expanding primary care capacity in medically underserved areas. APM4 is also intended to

incentivize alternatives to face-to-face visits and allow clinics to offer more convenient access to primary care services.

#### Sustainability analysis: Alternative Payment Methodology (APM) 4

Although the initial cohort has launched, there is still work to be done to embed the required financial and performance data analysis activities into the business of HCA. Much of this has already been transitioned into HCA's Finance Division, though the work is still being led by the Healthier Washington initiative. Our VBP team is primarily responsible for putting together a sustainability plan, which is already in process. Currently, implementation oversight and participant management is supported by the VBP team. The Healthier Washington Analytics, Interoperability and Measurement (AIM) team develops and supports delivery of APM4 participant performance. The HCA Finance Division supports financial reconciliation and rate calculations. Longer-term sustainability and APM4 modification will be outlined in the sustainability plan under development by the VBP team. Sustainability is contingent upon the formal evaluation of the payment model.

Additional funding may be required for spread and scale and modifications to APM4 over time. The timeline and approach for these spread-and-scale activities are still in development and will require staff time and strategic planning efforts that include internal and external partners. Depending on the ultimate approach post-SIM, legislative support may be necessary to bolster the continued survival and potential spread of the model. The VBP team is reviewing and will recommend approaches for sustainability of APM4. Early review of strengths and weaknesses of the model and strategies for sustainability are provided here for consideration.

The greatest benefit of APM4 is that the model fundamentally links participants to financial accountability of quality performance without waiving federal provisions. This means that participants have aligned financial incentives to continually improve outcomes for Medicaid managed care clients. At its core, APM4 encourages participants to think about their business differently and provides the flexibility to perform. Anecdotally, current APM4 participants are beginning to change their business to meet performance requirements of the model. The focus is no longer on trying to encourage "visits," but rather on improving the health of the patient.

There are several opportunities to improve APM4 in the future. Foremost, the payment methodologies for FQHCs and RHCs are complex and onerous. While Washington is not unique in this, APM4 builds upon this framework and is relatively complex to implement, both financially and in terms of quality measurement. This administrative burden makes it difficult for smaller providers to participate in the model. Second, there is a gap-year between quality performance and rate adjustments. Exploration of options that minimize the lag between performance and financial impact would be desirable. Last, smaller providers are challenged to reach a large enough population to take on risk under the model. Options that help to manage this risk and provide a large enough client cohort for adoption of the model should be explored.

Some of these opportunities for improvement will be addressed in the final SIM report, due to be released in spring, 2019, in tandem with the formal evaluation of the model performance. In addition to exploring ways to reduce administration of the model, increase the strength of the incentives, and modifications for smaller providers, the sustainability report will address administration of the model and recommend an approach for continued stakeholder development. The sustainability plan will be reviewed and approved by HCA executive leadership and may require legislative engagement.

## Washington Rural Multi-payer

The Washington Rural Multi-payer Model seeks to transform health in Washington's rural regions to ensure care focuses on whole-person health, build healthier communities through regional and collaborative approaches, and ensure sustainable access to health care in rural areas. By changing the way providers are paid, and aligning payments with incentives to transform the delivery system, Washington can build sustainable solutions for payers and providers that increase health access across rural communities.

Currently, access to care is limited in rural regions, and rural populations tend to have higher risks of morbidity and mortality. Rural providers face thin or negative margins and underutilization. Providers face recruitment and retention challenges. The Washington Rural Multi-payer Model seeks to address these issues through fundamental transformation of the rural health delivery system.

The core provider in rural regions tends to be the local hospital; however, cross-staffing and value creation relies on creating more timely interventions that push clients outside the hospital. Based on this, the Washington Rural Multi-payer Model being explored addresses primary care and hospital services under a budgeted approach that rewards value. The vision is that by redesigning rural health through new health system financing, population health management, addressing the health care workforce, and leveraging HIT, Washington State will ensure that rural residents achieve greater health and wellbeing and can readily access care when needed. The goal is to improve the health of rural Washingtonians and preserve access to care in a manner that is sustainable and better serves the health needs of local populations. The opportunities to health plans and providers are:

- **Access to data:** Providers will have access to integrated, multi-payer, population health data to manage their attributed population to drive care pathways.
- **Flexibility:** Providers will be given flexibility in the way care is delivered and will have sustainable financing for new innovations that reduce cost and improve care. Primary care teams can be developed that are built outside of the "visit."
- **Predictability:** Providers will manage to a predictable budget and will not be forced to manage to the number of visits. This budget will include allocated payments from all participating payers to help to create sustainability over time.
- **Care transformation:** By addressing primary care in the model, focusing on owned clinics, providers will be incentivized to coordinate across the care continuum and will be able to drive better health outcomes by moving care upstream and outside the hospital. With established budgets, providers will be able to scale services without being financially penalized.
- **Shared accountability:** Accountability will be shared between providers and payers. It will not be entirely incumbent on the provider to perform, but will be a partnership between payers and providers.
- **Incentive payments for quality:** Providers will have the opportunity to receive incentive payments for improved outcomes and reduced costs.

## Sustainability analysis: Washington Rural Multi-payer Model

The sustainability strategy of the Washington Rural Multi-payer Model is to fully develop a proposal, seek stakeholder endorsement of the approach, and seek early agreement with CMMI for continued development of the model by the end of SIM. The Washington State Legislature,

HCA, DOH and other partner agencies, and stakeholders have all signaled interest in development of a new payment model that encourages sustainability and practice transformation. By design, these efforts will leverage the efforts of Medicaid Transformation and will supplement rural provider transformation.

SIM resources and efforts have been leveraged to support early model development and agreements. These resources are being used to support pre-planning, early development, and closing any interim gaps. Once strategies are finalized, and as the model enters further negotiations, sustainability strategies will be identified and resource gaps will be addressed. Some state resources have been identified to continue this work after the SIM period, as well as staff and resources from Medicaid Transformation.

Planned sustainability investments include:

- Model development and refinement efforts
- Data development and analysis, including Medicare data development
- Stakeholder development and agreements
- Governor and legislative support and engagement
- Pre-implementation design and development

Areas that require additional resourcing will be identified in the progress report developed and delivered to CMMI per the agreed upon special terms and conditions. Functionally, HCA will be the principal lead for continued model development post-SIM. DSHS, DOH, and other state agencies will be critical contributing partners to model development, in tandem with the Governor and legislative engagement.

### Reconciliation of original secondary drivers: Encounter to Value and Rural Multi-payer<sup>1</sup>

<b>Secondary driver</b>	<b>Status</b>
Introduce a value-based alternative payment methodology in Medicaid for FQHCs and RHCs.	APM4: Complete. Work is embedded into HCA operations.
Pursue flexibility in delivery and financial incentives for participating Critical Access Hospitals (CAHs).	RMP: In process. Expanded to a broader Rural Multi-payer Model. Currently under development/negotiation.
Test how increased financial flexibility can support promising models that expand care delivery options such as email, telemedicine, group visits and expanded care teams.	APM4: Complete. Formal evaluation underway.
Secondary driver: Model 2 analytic support from AIM/DSHS-RDA, tool and material development from AIM Medicare data for CAH work, potential ProviderOne updates, tool built for FQHC/RHC APM 4 payment.	APM4: Complete. Work product developed. RMP: In process. Work products under development.

### Primary driver: Payment Model 3: Accountable Care Program (ACP) and Multi-purchaser

Washington is working with the Puget Sound High Value Network LLC and the UW Medicine Accountable Care Network to test a new accountable delivery and payment model, known as the Accountable Care Program (ACP), embedded in our Public Employees Benefits (PEB) program.

The ACP provides “best in class” patient service and experience and access to high-quality and timely service at a lower cost.

Each network under the ACP delivers integrated physical, behavioral health, and substance use disorder services, and assumes financial and clinical accountability for a defined population of Public Employees Benefits (PEB) program members. ACP networks are reimbursed based on their ability to deliver quality care and keep enrollees healthy. Networks have agreed to risk-based contracts, assuming clinical and financial risk of members who choose one of the network options during open enrollment. Networks also participate in upside gain-sharing for members who attribute to a network during the year. The original vision also included exploration of spread and scale, as well as employing a multi-purchaser strategy to spread use of accountable care benefit options statewide.

To-date, we have successfully implemented the ACP model and embedded the operations of the program into HCA’s PEB program. While we consider this implementation and operationalization a tremendous success, we are continuing to work on sustaining the affordability of the model for members, expanding the model into new counties, strengthening provider networks in existing counties, and exploring the provision of similar benefits for Washington State school employees, a new group of members assigned to HCA for benefit access beginning January 2020.

Payment Model 3 has also included non-ACP work, including the engagement of purchasers in Washington to take on these types of benefit options for their employees. There has been work to expand health literacy and health equity when it comes to selecting health plans and ensuring consumers receive high-quality care and understand their benefits.

### Sustainability analysis: Accountable Care Program

Healthier Washington has successfully implemented the Accountable Care Program into HCA operations, and these value-based benefit options have not been supported by SIM dollars in AY4. Instead, they have been owned and operated by the PEB program at HCA, in consultation with cross-division colleagues. While the focus in the coming years is to maintain the model, work will continue to expand geographically, to maintain and strengthen existing provider networks, and ensure we are using our state purchasing power to support and hold networks accountable for the health of the population we serve. Because this model is already operational, a sustainability plan in the traditional sense is not necessary because these activities have already taken place and are now part of the general business of the program.

With regard to spread and scale, we have a significant opportunity to expand these efforts with our new cohort of approximately 300,000 Washington State school employees coming into HCA’s portfolio for health care purchasing in 2019 with coverage effective in 2020. The School Employee Benefits (SEB) program also has a board and is separate but aligned with HCA’s PEB program. The SEB board is moving in the direction of offering similar value-based options for school employees, aligning with and emulating the ACP design. HCA is exploring an amendment with a network that includes providing accountable care services to school employees. This is a positive move forward for Healthier Washington, in that school employees are spread across the state to a greater degree than entities participating in PEB. Providing an accountable care benefit option will allow a better opportunity to provide value-based care across the state, especially to populations in rural areas.

In terms of the parts of this payment model that are not directly linked to the ACP, HCA's policy division is committed to innovation in VBP. Within the HCA policy division, we have an Office of Paying for Value, which provides agency purchasing direction to ensure alignment across HCA's programs. It also continues to spearhead multi-purchaser engagement in partnership with HCA programs to encourage other purchasers to integrate VBP strategies into their contracts, like our requirement for self-insured third party administrator to offer a similar ACP product as an offering to their private market members. Specific activities include engaging other public and private purchasers and sharing best practices, contract language, VBP tools and resources; focusing on health literacy and health equity and infusing these concepts into Medicaid and public and school employee programs and services; and researching and making policy recommendations on innovative VBP projects as we have with our current work on bundles and centers of excellence.

### Reconciliation of original secondary drivers: Accountable Care Program and Multi-purchaser<sup>1</sup>

<b>Secondary driver</b>	<b>Status</b>
Enrollment/participation in ACP options, January 2016.	Complete.
Expansion of ACP to larger population of public employees, 2017.	Complete.
Purchaser engagement to spread and scale model and VBP strategies.	Complete for the SIM period. Work is ongoing.
HIT:  (1) Data aggregator funding to support Payment Models and providers as they adopt risk-based contracts (Model 3, 4, 2).  (2) HCA to determine SOW for AY3 relative to products available via the Washington State All-payer Claims Database (WA-APCD).	(1) Not complete, we are still exploring this. See HIT Roadmap.  (2) Complete.

### Primary driver: Payment Test Model 4: Greater Washington Multi-payer

Payment Model 4 aimed to test integrated data platform capacity to support providers to improve care coordination, better manage patient populations across multiple payers, and engage in VBP models. Expanding provider access to more comprehensive sets of claims and clinical data will create greater confidence in their ability to measure, track, and perform against quality metrics. Further, aggregating claims and encounter data will give providers more information at the point of care. Integrating data across multiple payers and delivery systems is essential to presenting providers with a unified view of their patient population. These are necessary conditions for providers to comfortably assume financial accountability for patient populations.

Northwest Physicians Network and Summit Pacific Medical Center are contracting with HCA to pilot urban and rural demonstrations, respectively, of the Greater Washington Multi-payer Model. Providers within each network will leverage a shareable data aggregation solution to coordinate care, integrate data across multiple payers, and support the adoption of VBP models.

These health care providers have committed to engaging additional payers over time in this aligned strategy focused on population health management, while HCA will share attributable claims data from a state employee health plan and Medicaid, provide technical assistance around care transformation, and incentivize broader participation in the model test.

### Sustainability analysis: Greater Washington Multi-payer

Our final deliverables under SIM for this model test include robust reports from each network that will describe the activities necessary to sustain the model, or elements of the model, after the SIM period. While there are no current plans to continue the funding for this work, our goal is to continue sharing data with each provider organization and continue to monitor the use and efficacy of this platform. Ultimately, we will be left with a deliverable that will allow us to think critically about ways to incorporate this approach into other work streams that are under our purview. For example:

- Would there be ways to incorporate this data aggregation strategy into our ACP or Rural Multi-payer demonstration?
- Would the final deliverable be able to act as a roadmap for networks to independently engage in data aggregation arrangements with the state and multiple payers?
- Is there a path forward for Medicare participation, thus expanding the model test to a true multi-payer arrangement post-SIM?

The HCA Office of Paying for Value is tasked with receiving the final deliverables from the two networks and using these final reports and sustainability plans to inform continued work and answers to the questions above.

Because Model 4 was more of a supportive strategy test than a payment model, there are many lessons that can be gleaned, and much more creative ways this work can be implemented. For the purposes of the SIM grant and the investments made therein, Payment Model 4 was a short-term investment to mine these learnings and test the impact of such a data aggregation strategy. We are committed to analyzing the final deliverables and working with the networks to identify and implement next steps, or provide technical assistance for the networks to take these steps on their own. The vision will become much more concrete once the final deliverable is received from the networks in.

A primary challenge for each provider group in sustaining the operation of this model is the financing for the data aggregation solution. Each group has used contract funds to support financing the subcontracted data vendor. While the claims data shared by HCA is critical and of significant value, financing for the data solution will be a question. We are confident that, over time, as more payers commit and participate in a common strategy of data sharing, spread and scale of this model or a similar model could demonstrate value to participating providers. HCA will also strive to identify other investment areas that might take advantage of the data aggregation solution investments to-date as well as the internal process of extracting and sharing attributable claims data.

Strengths of the model include the robust partnerships and relationships made between HCA and the two contracted provider organizations. Each organization has played leadership roles in other SIM or SIM-related activities and venues, including leadership in regional ACHs, membership and leadership roles with the Medicaid Transformation's advisory group, the Medicaid Value-based Purchasing Action Team, and providing ad-hoc insight to HCA on real-world realities of rural and independent practices. HCA intends to maintain close relationships

with each organization and seek to sustain the data sharing strategy and facilitate each provider group to transform their practices and engage in VBP arrangements. We hope to build on this model for additional contracting, innovation, and systems transformation purposes. We are actively considering ways in which to leverage the internal processes HCA developed to share this data to other ends (e.g., implementing bundled payment models for episodes of care in Medicaid). This includes adding language in our MCO contracts requiring each MCO share their client assignment data with HCA monthly (HCA uses client assignment files to pull and share the relevant data for Payment Model 4 partners).

Weaknesses of the model include challenges implementing the processes for extracting and sharing data and onboarding MCOs. Challenges in implementing this model led to a significant delay in establishing active data transmission. These challenges ranged from HCA implementing the requisite code in the data extraction process, to the data vendor passing the state’s Office of Cybersecurity Security Design Review, to MCOs being slow to implement the encryption and secure file transfer protocols necessary to transmit the client assignment files securely to HCA. We have overcome these challenges for the most part, and have established better internal and external relationships in order to facilitate knowledge transfer and process implementation. As Model 4 partners became more familiar with Washington State data security standards, processes and implementation moved forward more smoothly, and this will continue to improve over time. HCA has conducted active outreach to MCOs to facilitate their implementation of the requisite standards, and is seeking to add requirements to their contracts that would lead to each MCO establishing this process beginning on January 1, 2019, which should remove this barrier to implementing new projects based on this infrastructure in the future. Currently, the pilot with the two participating networks will end with SIM on January 31, 2019.

### Reconciliation of original secondary drivers: Greater Washington Multi-payer<sup>1</sup>

<b>Secondary driver</b>	<b>Status</b>
Secure lead organization to convene payers and providers to advance an integrated multi-payer data aggregation solution and increase adoption of VBP strategies.	Complete. Secured two lead organizations to pilot a rural and urban demonstration of the model.
Align the data aggregation solution with clinical and financial accountability (from Payment Test Model 3) centered on the Washington Statewide Common Measure Set.	Complete. The model includes the set of measures utilized in Payment Model 3.
Leverage and expand existing data aggregation solution that includes at least one or more payers and/or provider groups.	Complete. Each contracted provider group has expanded the payers involved in the data aggregation solution.
Provide resources and state-purchased health care data to accelerate building common infrastructure of integrated claims-based and clinical data.	Complete. HCA has provided multiple forms of technical assistance to onboarding data infrastructure for each contracted provider group.
HIT: (1) Data aggregator funding to support Payment Models and providers as they adopt risk-based contracts (Model 3, 4, 2); (2) HCA to determine SOW for AY3 relative to products available via the WA-APCD.	Not complete. See HIT Roadmap.

## Primary driver: Analytics, Interoperability, and Measurement (AIM)

The Healthier Washington Analytics, Interoperability, and Measurement (AIM) investment area was developed to work collaboratively across state agencies and public and private sector partners to break down data-related silos, address long-term needs for health data management solutions, services, and tools, and serve as a tool to implement health improvement strategies in Washington. AIM was originally developed as an investment strategy to support the analytics across all of the SIM initiatives, as well as part of the overall HIT strategy and agency decision-support needs. AIM was also meant to support the creation of a dedicated and sustainable research and analytics team, and to provide the platform and tools to facilitate implementation, formative evaluation, and continuous improvement through the four-year SIM project. We originally included our measurement work under AIM, which was dedicated to the development and implementation of the Statewide Common Measure Set.

Since the SIM grant was originally deployed, this work has evolved into three separate but aligned work streams: data and analytics, performance measurement, and HIT/HIE. These three categories are described separately, since they involve distinct goals, teams, and sustainability strategies. Please note there were no original secondary drivers for data and analytics, performance measurement, or HIT/HIE, as this SIM-funded strategy was a cross-cutting and support structure.

### Data and analytics

The SIM grant allowed for investment in agency capacity to undertake advanced research and analysis in health-related data, including the production of measures and data products in partnership with the Research and Data Analysis (RDA) division at DSHS and population health measure experts at DOH. During the SIM period, this work was undertaken by a team of dedicated analysts, epidemiologists, actuaries, and research specialists. Primary responsibilities included data support and analysis for ACHs and the four payment models, as well as the full SIM evaluation from the University of Washington and RTI International. The team also provided significant support to Medicaid Transformation, helping to support measure development and data products for ACHs to help with Medicaid Transformation project development and implementation. Due to the evolved maturity of this team, the decision was made in July 2018 to change the name from Analytics, Interoperability, and Measurement (AIM) to Analytics, Research, and Measurement (ARM). This change points to the evolving nature of the team, which is focused on the creation of innovative data products, research expertise, and targeted community support to help entities, including ACHs, to use data to inform population health initiatives in their regions. Despite this change, interoperability is still a goal of Healthier Washington, carried out by a separate but close-working interagency Health IT team.

### Sustainability analysis: data and analytics

The continuing role and purpose of the ARM team is to be a center of analytic excellence and support for ACHs in implementing their Medicaid Transformation projects, increasing the capacity of the agency's clinical team to analyze data to inform continued transformation and purchasing policy, provide targeted support to the Washington Rural Multi-payer Model initiative, and provide support to the Washington State All-Payer Claims Database (WA-APCD).

This work will primarily be owned by HCA since HCA holds primary responsibility for Medicaid Transformation, and DOH and DSHS already have data analysis divisions with full funding and capacity to continue this work in partnership with HCA.

Necessary inputs for sustaining the ARM team cross three investment domains:

- **People:** Staff and training for continued professional growth and incentivizing retention
- **Process:** Program and enterprise data governance allowing access to data sources and tools for advanced analytics; expansion and automation of data sources
- **Technology:** Enterprise-wide data management; data systems and architecture

Ongoing support will require the agency making a commitment for full agency funding by the end of Medicaid Transformation funding. Options for support may include legislative action (budget approval), leveraging new state or federal funding opportunities beyond Medicaid Transformation, or exploring alternative financing approaches.

The strength of the model is the opportunity to continue support for health transformation in Washington. The need for advanced analytics will continue. Sustaining the ARM team provides continued and expanded opportunity to support the agency's clinical teams with evidence-based information for program development, implementation and evaluation.

Weaknesses include difficulty recruiting and retaining staff in a competitive economy with uncertain visible commitment to embedding advanced analytics into formal program evaluations and program redesign efforts. Our advanced analytics can demonstrate the value of informing better decision making across the health system, and once demonstrated, the ARM team could serve as a center of excellence and critical state resource to provide guidance, technical assistance, and custom data products to payers and providers throughout Washington.

### Performance measurement

Performance measurement under SIM has primarily been undertaken through the development, maintenance, and reporting of the Washington State Common Measure Set for Health Care Quality and Cost. The Common Measure Set is a list of measures that enables a consistent and standard way of tracking important elements of health and health care performance and is intended to inform public and private health care purchasing. It helps determine how well the health care system is performing and will enable a shared understanding of areas that should be targeted for improvement. Having broad agreement around the Common Measure Set for Washington helps to focus and align efforts by key stakeholders to address specific opportunity areas in our state. The measures focus on access, prevention, acute care, and chronic care.

In the early years of SIM, the focus of the Performance Measures Coordinating Committee (PMCC), appointed by the Governor, was on the development and ongoing curation of the measure set. As the SIM period closes, discussions on the future role of the PMCC are being explored, as they are interested in continuing in an expanded role. While we will continue to leverage the Statewide Common Measure Set as our “North Star” for selecting measures for our purchasing contracts, we will also continue to ensure the measure set can play an active role in health systems transformation measurement and alignment and evolve to the next generation of measurement and program evaluation.

### Sustainability analysis: performance measurement

Ongoing support to convene the PMCC is needed to ensure the measure set is continually revisited, discussed, and curated in an active and relevant way. The Washington Health Alliance provides these services for the state. We do not have funding to continue this role but are actively looking for ways to support this quarterly process.

HCA's Clinical Quality and Care Transformation (CQCT) division developed a process to identify, implement, and monitor measures for state purchasing contracts. The Quality Measurement, Monitoring, and Improvement (QMMI) process brings together multi-agency partners to identify appropriate measures for state purchasing contracts, using the Statewide Common Measure Set as the starting point for selection. Measurement activities, including management of the PMCC has been transitioned to CQCT, to align with the work of the QMMI process. However the PMCC continues to own management of the Statewide Common Measure Set, so if state resources are not identified, they will need to identify a way to support this work themselves.

The development of the Statewide Common Measure Set under SIM complements the monitoring currently conducted through the CQCT and the Chief Medical Officer is the co-chair of the PMCC, meaning this work has already been transitioned to HCA. We are working closely with our partners at the Washington Health Alliance as well. HCA staff support is currently being provided by the Practice Transformation Manager within the clinical division and will remain beyond SIM.

The strength of the current partnership with the Washington Health Alliance has brought strong partners and interest to the table due to the community ties and positive reputation built over 11 years of work with providers, payers, and purchasers. There isn't scaling that needs to occur, but a slight change of scope for the work of the Performance Measures Coordinating Committee is needed, as they have expressed a desire to move to a more action-oriented role, rather than passively continuing to add measures. This evolved role could include additional development and promotion of the common measure set, or monitoring and oversight of the measure set based on reporting results. For example, the group felt that they could leverage their collective positions to promote a smaller core group of quality measures that the state can then focus efforts on across all contracts to drive towards real change, instead of having a larger set of measures inform contracting that have less impact.

We are currently exploring this with them and what this means for the future.

### Health Information Technology and Health Information Exchange (HIT/HIE)

Since the SIM grant was implemented, our HIT/HIE vision, capabilities, and goals have evolved to maturity. In 2017, Healthier Washington established the HIT Strategic Roadmap and Operational Plan that identifies tasks needed to support service delivery and payment transformation. The development of this plan was a massive interagency effort, for the first time incorporating state-led Health IT/health information exchange planning and work into one document, regardless of agency or funding source. The HIT Strategic Roadmap and Operational Plan also incorporated the HIT activities from the SIM program. In 2018, the roadmap is largely focused on identifying and advancing the data needed by the state, ACHs, and providers; technology tools needed by providers for interoperable HIE; and existing infrastructure projects (i.e., services offered by the statewide HIE organization, OneHealthPort [OHP], including the Clinical Data Repository [CDR] service). Generally, the tasks in the HIT Operational Plan focus on data, data analytics, data governance, HIT/HIE (including addressing the training needs of ACHs), financing, master person identifier, provider directory, and evaluation.

### Sustainability analysis: HIT/HIE

Future work is categorized into three main areas:

1. Enhancing the statewide HIE solution, the Clinical Data Repository (CDR) for Washington State that is more fully populated with valuable clinical data and accessible as one solution for multiple entities
2. Providing technical assistance and expertise to ACHs and the state as a whole for the implementation of Medicaid Transformation, since Medicaid Transformation has HIT/HIE protocols and requirements
3. Finding viable solutions to address key HIT/HIE gaps, including consent management for the exchange of substance use disorder information protected by 42CFR

This work was always embedded into HCA and DOH operations, undertaken by a robust team of agency funded HIT professionals. Funding comes from a variety of sources, including the federal 90/10 match program under the HITECH act, Medicaid Transformation funding, and state general funds across agencies. HCA's HIT team works in close partnership across agencies and divisions, since there is a recognition that this work must be done as a state, and that our agencies hold differing resources, data, and expertise. We crafted the Strategic Roadmap and Operational Plan to have tasks and deliverable owners from each agency. We continue to meet monthly to discuss implementation progress and risks/issues arising through implementation. The work associated with HIT/HIE implementation is woven throughout the landscape of Healthier Washington. Moving forward, it makes sense to think of the distinct roles we can all play in advancing viable HIT/HIE solutions, providing sound recommendations to payers and the community, and supporting providers in the use of these new technologies to support person-centered care and improve population health outcomes.

The HCA has drafted an HIE CDR Roadmap that identifies key exchange capabilities that will need to be supported and implemented to support service delivery transformation. For example, the Roadmap identifies provider exchange using the CDR for substance use disorder (SUD) information, discharge summaries, and care plans as content needed to support Medicaid Transformation. Supporting the expansion of CDR content will require funding. In addition, critical components of the care continuum lack electronic health records (EHRs) needed to enable HIE (e.g., many behavioral health providers). When possible and appropriate, the state will seek the use of enhanced federal funding available through CMS and also identify private sector funding to support the development of needed HIE capacities.

Leveraging and expanding on the use of the statewide HIE organization, OneHealthPort (OHP) and the services provided by OHP, including the CDR, is a strategic and financial strength for longer-term transformation. Rather than each provider having to acquire and implement multiple interfaces to securely exchange individual health information, providers in conjunction with their EHR vendors can build an interface that enables the transfer of information to and from the CDR to other providers using an infrastructure that protects the privacy and security of individuals' health information. HCA intends to build on this critical infrastructure and enhance the type of information that can be exchanged. While expanding OHP services is a cost-effective approach to supporting HIE that will improve the quality of care, advance care coordination, and reduce unnecessary health care costs; these enhancements are not free. As described above, the state will seek the use of enhanced federal funding and private sector funding to support enhancements.

In addition to enhancing services offered by OHP, to support robust HIE, the state will need to engage payers and providers across the care continuum. The state continues to assess how contracts with MCOs can be leveraged to encourage the use of HIE to support care coordination.

In addition, many behavioral health providers will need assistance in the acquisition and use of HIT to enable the exchange of health information, including SUD information. The state is in the process of developing the 2019 update to its HIT Operational Plan that will address the tasks and timelines needed to address these and activities. The updated HIT Operational Plan will be submitted to CMS for approval.

## Healthier Washington as a system

While this Strategic Roadmap has largely been a discussion of individual projects, we think about this work as a way toward a Washington where people are healthier, providers find joy in their work, care is delivered in a person-centered way, and costs are reasonable. This vision of a Healthier Washington is shared by our Governor, our state health agencies, and our partners. In order to think about the future of this work, it is important to categorize it by strategies and business processes, rather than by disparate parts.

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### Paying for value

This strategy represents our key driver to health system transformation. Also called value-based purchasing and value-based payment, this strategy shifts the way we pay for care to reward providers when they achieve better health outcomes for their patients. Washington has used its position as a marketplace leader to drive transformation and accelerate the adoption of value-based care strategies. We consider this to be the fundamental building block of a transformed system, relying on the additional business processes below for success.

### Strategic partnerships

The state government and its agencies alone cannot compel or sustain health systems transformation. We must rely on public-private partnership and all sectors at the state and community levels doing business differently to ensure Washington State sustains and continues to advance a healthier Washington.

### Capacity and infrastructure

State agencies and other public and private organizations must build effective and appropriate innovations into fundamental business processes. Innovation requires collaboration and the building of new interagency partnerships to enhance and leverage the capacity and competencies necessary to redesign our system to deliver population health-focused, integrated, and person-centered care.

### Inclusion and equity

In order to transform and sustain a quality health system, we need to think about who has historically not been at the table, and how we can implement strategies that reduce health disparities. Including social determinants, using a health equity lens, and focusing on wellness is critical.

### Communication and storytelling

All transformation and sustainability efforts are supported by a foundation of data-driven communication and storytelling. How we measure success and communicate our work is critical to keeping momentum going, and translating how this work is impacting the people and families we serve.

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## Paying for value

Healthier Washington was designed to leverage the power of innovative financing to transform and sustain a better health and wellness system. Using appropriate financing and incentives, advancing alternative payment models, and ultimately rewarding quality and value over volume, we will continue to fundamentally change the system and take better care of people and their families; physical, behavioral, and social service providers; and the health system as a whole. All of our continued work rests on this primary principle, and we will continue to work toward a future where our health care dollars encourage population-based care, high-quality care delivery, improved patient experience, and smooth coordination of care.

## Strategic partnerships

Much of the work under Healthier Washington will either need to be embedded into state agency operations or handed off to be a community asset. Both of these processes require new partnerships and relationships. On a holistic level, we will continue to maintain our Health Innovation Leadership Network, a large group of high-level decision-makers in health related fields across the state. We are also planning to maintain our Healthier Washington Executive Governance Council, a monthly convening of our three health agency directors, to ensure our overall vision for state-directed health efforts is aligned and that we are acting on feedback from the community in a proactive way. We will also continue close relationships with ACHs, since they are regional entities in the best place to understand and communicate what is most needed in their communities. They are also catalyzing changes in relationships between partners and ensuring that both traditional and non-traditional health and wellness partners are represented in these transformed relationships, which will provide the basis for sustaining a transformed system.

### Sustainability in practice: Chronic Disease Self-management Education

Chronic Disease Self-management Education (CDSME) is a cross-division, cross-agency initiative with a long record of success. The Department of Social and Health Services (DSHS) is the primary grant coordinator, working closely with the Department of Health (DOH) and HCA in the execution of its components. A notable challenge for DSHS is that they often are not brought in to conversations on chronic disease management projects at the regional level. Opportunity exists for Washington to ensure all of the associated partners can contribute to the conversation.

In Pierce County, the Accountable Community of Health was interested in a Medicaid Transformation project related to chronic disease prevention and control. Both the ACH and the DSHS teams expressed passion and energy for chronic disease initiatives, which provided a rich environment for collaboration. DSHS approached the ACH with an offer to support the dialogue, including community connections and partnerships, provider engagement tactics, lessons learned, implementation support, and sustainability strategies. The invitation to partner was accepted and the work is ongoing.

It is clear that all parties are sincerely committed to the work of Healthier Washington. In spite of this, there are natural barriers to collaboration and alignment. These barriers include staff capacity limits, competing priorities, a desire to keep workgroups small, and lack of knowledge about resources or similar work happening elsewhere. Our DSHS colleagues worked to mitigate these challenges, choosing to educate, share, and teach instead of keeping their tools and resources to themselves.

## Capacity and infrastructure

One of the most impactful outcomes of the SIM grant has been the investment in state capacity to change the way business is done, to move from supporting traditional models of care into innovative models that reward value and care for the whole person, and strengthen the link

between the clinic and the community. This capacity has come in the form of new staff with new specialties, like the ARM team, the ability to develop and begin implementing Medicaid Transformation, which has provided a glide path to accelerate the foundational elements started under SIM, and space to convene conversations among state agencies and partner organizations to speak frankly about roles and responsibilities in a new environment.

Because Medicaid Transformation is aligned, many SIM staff will transition to state implementation of Medicaid Transformation, and expertise will be used to provide technical assistance and recommendations for ACHs and other entities implementing this work. The data infrastructure and processes we have started under SIM will continue, supporting Medicaid Transformation implementation, as well as other agency initiatives that advance VBP and integrated care. Now that the ACP is a viable option within our PEB program, we have shifted our infrastructure to deliver this person-centered care that supports provider networks in taking on risk-based arrangements.

### Inclusion and equity

An area where we have been placing increasing emphasis is how to infuse health equity into our policies and programs as a matter of course. Our public-private leadership in Washington have made it clear that this equity lens is a priority, one that should be tied to concrete and measurable activities and outcomes. We have activated our Health Innovation Leadership Network around this topic and their last two meetings focused on health equity, racism, and definitions and concepts around health equity. Focusing on wellbeing, including social determinants of health, and using data to inform decisions about how to reduce disparities is built into our vision, through HCA's CQCT division, the Health Innovation Leadership Network's Communities and Equity Accelerator Committee, and staff at multiple agencies dedicated to equity. While we do not yet have a work plan for the strategic implementation of health equity, we are working on this and it will continue to develop as the year progresses.

### Communications and storytelling

One aspect of our work this year is the sustainability and future vision of the Healthier Washington brand identity. We engaged a contractor to research and make recommendations as to how we should use the brand moving forward, whether we should keep it after the SIM period ends, and what we want the brand to conjure in the minds of our partners and the public moving forward.

Research included one-on-one interviews with stakeholders at HCA, DOH, ACHs, the Governor's office, and others, to get their thoughts about the Healthier Washington initiative.

Preliminary findings from this work suggest that keeping the brand identity is important to the future of this work, and that more thinking is necessary to keep the Healthier Washington brand alive and ensure it has the right communication tools to send appropriate and understandable messages.

Key takeaways from these interviews:

- Stakeholders believe the Healthier Washington initiative is achieving success.
- People see value in a unified brand to achieve our outcomes.
- There is opportunity for a refresh of the brand to add clarity and improve our messaging.

HCA will move into a new phase of work that includes establishing a steering committee, holding mapping sessions, and developing an updated brand strategy. This effort does not include changing the “look and feel” of the brand (logo, color scheme, etc.), but rather revising how we think and talk about Healthier Washington.

While this work is ongoing, we should have a robust set of recommendations around a future communications strategy closer to the end of the year.

Storytelling is also a fundamental part of how we communicate about Healthier Washington, and help connect the work to the people we serve. We have continued to capture stories through our Voices of a Healthier Washington Story Bank, and will continue to do so through the end of the year. We are also exploring alignment with other story banks maintained by HCA, including incorporating Healthier Washington stories into the Voices of Apple Health Story Bank.

## Next steps: A bridge to the future

We are fortunate in Washington to have received SIM funding, as well as technical assistance and support from CMMI. This allowed us to work more closely with partners, provide funding to our community, and work with others to operationalize ideas and processes to move us forward in achieving the quadruple aim. Although the funding period is ending, the work will continue, and we are committed to continuing this work.

As we look to the future of Healthier Washington, we have several high-priority focus areas. These include Medicaid Transformation through our Section 1115 waiver agreement with CMS, our Rural Multi-payer effort, maximizing state agency capacity and resources, and seeking legislative appropriation for the continuation these efforts. We are also paying attention to signals from our state legislature and health system, and will work toward stabilizing our behavioral health system, providing a coordinated multi-agency response to the opioid crisis, ensuring access and uniformity in primary care, and connecting health services and community services for whole person health and wellness. We will continue to listen to the people and families in Washington, our state legislature, and our close working partners in the community, to understand needs and gaps and shift priorities as needed.

We know from experience that this work is not easy and is successful only with approaches that are transparent, inclusive, and multi-sector. We perceive challenges ahead when it comes to coordination and alignment, as well as the realities of time-limited and scarce resources. We pledge to move forward despite these challenges, taking particular care to focus on aligning efforts, and planning for the strategic use of resources and new funding opportunities to continue. We look forward to SIM evaluation reports from the University of Washington, our partners at the DSHS-RDA, the Center for Community Health and Evaluation (CCHE), and our federal evaluators, to provide expert analysis of the impact of SIM investments. We hope to use this information to inform future approaches to health system transformation.

Washington State is proud to be an innovative player in advancing the quadruple aim of better care, smarter spending, healthier populations, and provider satisfaction. SIM is one of many resources that has moved us toward a better future, and we look forward to continuing this important work.

AIM	Quality Outcome Targets	Investment Area	Primary Drivers	Secondary Drivers	Metrics		
What are you trying to accomplish? What will be improved-by how much or how many and by when?			What do you predict it will take to accomplish this aim?	What will be required for this to occur	What data will be used to track progress (how much and by when)?		
<p><b>QUADRUPLE AIM</b></p> <p><b>Better Health, Better Care, Lower Costs, Satisfied Providers</b></p> <p>By 2019, Washington's health care system will be one where:</p> <p>90% of Washington Residents and their communities will be healthier.</p> <p>All people with physical and behavioral (mental health/substance abuse comorbidities) will receive high quality care.</p> <p>Washington's annual health care cost growth will be 2% less than the national health expenditure trend.</p>	<p>Behavioral Health: Percent of adults reporting 14 or more days of poor mental health* (in Overall UW SIM Evaluation)</p> <p>Tobacco: percent of adults who smoke cigarettes* (in UW Overall SIM Evaluation)</p> <p>Plan readmission rate by all-causes <b>down</b> in UW Overall SIM Evaluation)</p> <p>Child and adolescents' access to primary care practitioners* (in UW SIM Overall Evaluation)</p> <p>Mental health treatment penetration* (in UW Overall SIM Evaluation)</p> <p>Personal care provider <b>up</b> in UW Overall SIM Evaluation)</p> <p>Chronic care engagement with personal care provider <b>up</b> in UW Overall SIM Evaluation)</p> <p>First trimester care* (in UW Overall SIM Evaluation)</p> <p>Psychiatric hospitalization readmission rate* (in UW Overall SIM Evaluation)</p> <p>Potentially avoidable emergency department visits <b>down</b> in UW Overall SIM Evaluation)</p> <p>Adult access to preventive/ambulatory health services* (in UW Overall SIM Evaluation)</p> <p>Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%)* (in UW SIM Evaluation)</p> <p>Childhood immunization status* (in UW SIM Evaluation)</p> <p>Patient Experience: provider communication (CG-CAHPS)* (in UW SIM Evaluation)</p> <p>Patient Experience: Communication about medications and discharge instructions [HCAHPS] <b>up</b> in UW Overall SIM Evaluation)</p> <p>Well-child visits* (in UW SIM Evaluation)</p> <p>Annual per-capita state purchased health care spending growth relative to state GDP* (in UW SIM Evaluation)</p> <p>Medicaid spending per enrollee* (in UW SIM Evaluation)</p>	Community Empowerment and Accountability	<p>Accountable Communities of Health (ACHs)</p> <p>Plan for Improving Population Health</p>	<ul style="list-style-type: none"> <li>Define vision, build foundation for ACHs to collaborate in region</li> <li>Develop and strengthen regional partnerships so that collaboration can lead to complementary and collective health improvement activities</li> <li>Participate in broader Healthier Washington activities, including delivery system transformation</li> </ul> <p>HIT Secondary Driver: (1) Additional build out of the HW regional dashboards to include additional measures based on prioritization. Analytic support and coaching for ACHs (support could be provided by CCHE, AIM and/or regionally, e.g., LHJs). (2) Support to develop strategic connections between the dashboard and evidence-informed strategies to address identified population health issues. (3) DOH &amp; RDA data supports – increase in support for data extracts (FTEs). (4) Washington Health Alliance Community Check-up Report – maintenance and enhancement, (5) Addition of PEB data – for evaluation and dashboard enhancement.</p> <p>Develop and strengthen regional partnerships so collaboration leads to complementary and collective health improvement activities.</p> <p>HIT Secondary Driver: P4IPH website migration to UW, addition of well-child tools. New interfaces. New analytics; additions to ProvidenceCORE data dashboard.</p>	<ul style="list-style-type: none"> <li>Number of technical assistance summits to address priority topics</li> <li>Number of times the advisory board meets</li> <li>Toolkit available for distribution</li> </ul>		
		Practice Transformation	<p>Practice Transformation Support Hub</p> <p>Shared Decision Making</p> <p>Workforce/Community Health Workers (CHWs)</p>	<ul style="list-style-type: none"> <li>Understand the practice transformation training and technical assistance needs of providers to inform Hub services</li> <li>Make tools and resources available online informed by needs of providers</li> <li>Refer and provide training, technical assistance and facilitation services</li> <li>Develop regional health connector role and establish linkage between practice community and public health.</li> </ul> <p>HIT Secondary Driver: Provide help providers live in a digitized world. Connect HIT with practice transformation. Coaching will involve TA on optimizing use of electronic health records, use of Shared Decision Making, data analytics in the clinic.</p> <ul style="list-style-type: none"> <li>Provide training and practice coaching opportunities on shared decision making implementation.</li> <li>Promote and spread the integration of shared decision making and use of certified patient decision aids in clinical practice</li> <li>Develop a multi-state Shared Decision Making Innovation Network</li> </ul> <p>HIT Secondary Driver: Help providers automate SDM in their EHR.</p> <ul style="list-style-type: none"> <li>Engage community health workers</li> <li>Survey the health care industry and make targeted investments to address identified workforce needs</li> </ul> <p>HIT Secondary Driver: Support for Industry Sentinel network to administer survey and provide results.</p>	<ul style="list-style-type: none"> <li>Number of sessions by type of stakeholders involved, <b>summary of results</b></li> <li>Website analytics and user satisfaction</li> <li>Number of training, <b>number of participants</b>, and satisfaction with trainings</li> <li>Key informant interviews with stakeholders</li> <li>Proportion of eligible practices receiving training</li> <li>Number of certified decision aids</li> <li>SDM Innovation Network formed</li> <li>Initial survey implemented through portals, results shared.</li> </ul>		
		Payment Redesign	<p>Payment Test Model 1: Integration of Physical and Behavioral Health Purchasing</p> <p>Payment Test Model 2: Encounter-based to Value-based for cost based reimbursements</p> <p>Payment Test Model 3: Public Employee Benefits Accountable Care Program (ACP)</p> <p>Payment Test Model 4: Greater Washington Multi-Payer Data Aggregation Solution</p>	<ul style="list-style-type: none"> <li>Integrate Medicaid purchasing of physical and behavioral health services within accountable managed care organization (MCO)</li> <li>Create internal MCO processes and structures</li> <li>Improve service delivery process to increase access to integrated services</li> </ul> <p>HIT Secondary Driver: (1) Gap: We need some new capabilities in order to build a system to receive necessary non-encounter BH data. Depending on design decisions in the North Central region, we may need ProviderOne changes, (2) Gap: Coding for native transactions with FIMC/MCO and MMIS, (3) Gap: Project to bring DBHR into HCA &gt; may require infrastructure work or system enhancements, (4) Expand Alerts: Expand the ability to inform providers of critical events, (5) Make alerts to providers and care coordinators available when Medicaid covered individuals enter correctional settings to support continuity of mental health and substance abuse treatment and inclusion of care coordinators in the overall treatment planning as needed, (6) Gap: HCA will install a new FADS system in AY3/4, (7) Gap: BH Electronic Health Records</p> <ul style="list-style-type: none"> <li>Introduce a value-based alternative payment methodology in Medicaid for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).</li> <li>Pursue flexibility in delivery and financial incentives for participating Critical Access Hospitals (CAHs).</li> <li>Test how increased financial flexibility can support promising models that expand care delivery options such as email, telemedicine, group visits and expanded care teams.</li> </ul> <p>Secondary Driver: Model 2 analytic support from the AIM team/DSHS-RDA, tool and material development from the AIM team Medicare data for CAH work, potential provider one updates, tool built for FQHC/RHC APM 4 payment</p> <ul style="list-style-type: none"> <li>Enrollment/participation in ACP options, January 2016</li> <li>Expansion of ACP to larger population of public employees, 2017</li> <li>Purchaser engagement to spread and scale model and value-based purchasing strategies</li> </ul> <p>(1) Data aggregator funding to support Payment Models and providers as they adopt risk-based contracts (Model 3, 4, 2) (2) HCA to determine SOW for AY3 relative to products available via the APCD</p> <ul style="list-style-type: none"> <li>Secure lead organization. To convene payers and providers to advance an integrated multi-payer data aggregation solution and increase adoption of value-based payment strategies</li> <li>Align the data aggregation solution with clinical and financial accountability (from Payment Test Model 3) centered on the Washington Statewide Common Measure Set</li> <li>Leverage and expand existing data aggregation solution that includes at least one or more payers and/or provider group</li> <li>Provide resources and state-purchased health care data to accelerate building common infrastructure of integrated claims-based and clinical data</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of population impacted by Payment Test Model</li> <li>Number of providers participating by Payment Test Model</li> <li>Number of provider organizations participating by Payment Test Model</li> <li>Percentage of population impacted by Payment Test Model</li> <li>Number of Providers participating by Payment Test Model</li> <li>Number of provider organizations participating by Payment Test Model</li> <li>Percentage of population impacted by Payment Test Model</li> <li>Number of Providers Participating by Payment Test Model</li> <li>Number of provider organizations participating by Payment Test Model</li> </ul>		
		Additional measures (and Sources) included in UW SIM Evaluation: Mortality measures (DOH and CDC); Adult Mental Health: Not Good (BRFSS); Adult Physical Health: Not Good (BRFSS); Adult Impairment Due to Poor Health (BRFSS); Adult Self-Rated Health (BRFSS)				<p>HIT</p> <p>(1) Data aggregator funding to support Payment Models and providers as they adopt risk-based contracts (Model 3, 4, 2) (2) HCA to determine SOW for AY3 relative to products available via the APCD</p>	

# Memorandum

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**To:** Bonnie Wennerstrom

**From:** NORC TA Team

**Subject:** SIM Sustainability Planning

**Date:** October 12, 2018

**CC:** Allison Marlatt

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## I. Overview

To support Washington's sustainability planning efforts, the non-partisan and objective research organization (NORC) technical assistance team facilitated a meeting on September 10, 2018 with key community partners and state agency staff from the Health Care Authority, the Department of Health, and the Department of Social and Health Services. This convening, entitled, "The Future of Healthier Washington: Co-Developing Continued Roles for Statewide and Community Partners," was a reflective discussion focused on the roles and strategic partnerships necessary to ensure enduring transformation of Washington's community health and wellness system.

A foundational principle of the Healthier Washington sustainability framework is that change needs to occur at a systems level rather than at a programmatic one. Moreover, the achievement and sustainment of a healthier Washington is fundamentally about shifting the way partners work together within a system, rather than in individual silos, to improve the health of the population. The convening sought to elicit feedback from partners and state agencies about their continued role in delivery system transformation efforts, and understand what types of support community partners would need from each other and state partners to be successful.

This memo summarizes proceedings from the day, and offers key reflections on common themes. The memo is divided into the following sections:

1. Key Takeaways and common themes;
2. Accomplishments and key partnerships achieved under SIM;
3. Description of partners' roles in furthering Healthier Washington;
4. Report out of roles by Healthier Washington's strategy; and
5. Support that community partners and HCA need to further transformation efforts.

## II. Main Takeaways

This section includes insights and themes heard throughout the day.

- General support from all community partners is needed to advance the objectives of Healthier Washington. Similarly, there was the consensus that meaningful change will be effected in partnership rather than by actors working in their silos.

- There was a strong desire for common definitions and standardization. Specifically mentioned were “value” and “performance”, and a call was made to collectively define what value means for specific components of Washington’s transformation efforts, such as in the integration of physical and behavioral health. There was also a call for alignment around measures.
- There was the desire for strong leadership from state agencies around standardization, particularly as it relates to Accountable Communities of Health (ACHs). While participants agreed that ACHs are hubs for innovation, there was a call to distill innovations into standard policies and recommendations, and that this distillation is the state’s role to lead. For example, stakeholders indicated that while the state encourages ACHs to promote health equity, there is ambiguity as to what constitutes health equity and the ways in which ACHs should address it.

### III. Reflections on SIM and Key Partnerships

The following section provides a summary of the reflections from community and state partners on the key successes and accomplishments achieved during the SIM period. Some participants also shared thoughts on new and/or strengthened relationships that occurred as a result of the SIM initiative.

- Working with HCA and MCOs on VBP contracts to further evolve contracts and move toward risk.
- Moving more dollars into VBP arrangements; but still need to develop new and additional types of models and to build, strengthen and boost their effects on better outcomes, cost for members. Next phase of work will focus on engaging specialists (not just PCPs). Also need to work on rural areas which haven’t had as much involvement. SIM is reinforcing that transformation isn’t just about payers interested in payment.
- 2017 was the first year with withhold data from MCOs.
- SIM helped to formalize stakeholder collaboration. Successful connections with hospitals, and elevation of social determinants of health. Proud of relationship with county government and with county officials who see value in ACHs.
- Proud of the expansion of APCD and data on 4 million lives in state, including some self-insured. Launched health dashboard (Community Checkup) and supports PMCC and common measure set.
- In their role evaluating ACHs, impressed to see the formation of health system-community relationships.
- Voices of a Healthier Washington tells stories of how Healthier Washington is affecting individuals, and explains concepts of Healthier Washington (e.g., VBP). Partnerships to develop a council of communications professionals to discuss how they talk about transformation across different organizations involved in transformation.
- Practice transformation support hub, and engaged practices and behavioral health agencies on BH integration.
- Obtained shared savings during first year with HCA. Building relationships with providers who were previously competitors. Development of Virginia Mason Centers for Excellence bundles with no readmissions.
- Strong partnerships with ACHs to ensure training matches the work they are doing on the ground. Listening to provider voices around concerns and problems to amplify message to HCA and others.
- Working through SIM to advance VBP, collaborating with competitor MCOs in the state (e.g., by encouraging providers to use resources available to them). Interacting with ACHs for new public-private partnerships.

- Development of the Statewide Common Measure Set. Leveraged existing relationship with Washington Health Alliance and their relationships with stakeholders—demonstrating the importance of having plans at the table to develop common measure set and now reporting on those measures. Developed a process for certifying shared decision-making aids; learned lessons in how to do that and hoping to share that with other states.
- Behavioral health integration and successful establishment of ACHs; that the fact that these ideas have largely been embraced across the state.
- The partnership with MCOs and understanding the readiness of providers and how that varies. Restructured the system for improved BH integration. Greater collaboration within the HCA to make transformation possible.
- SIM established building blocks for Medicaid transformation. The achievement of fully integrated managed care. VBP — doubled-down on commitment for VBP goals. Developing a shared language in how to talk about VBP. Interagency relationships and partnerships.
- Success with long-acting reversible contraceptives even though some major health systems don't want to participate. Commitment to equity and developing relationships with tribes, now with all 8 tribes engaged in the ACH board.
- Seen the growth of ACHs as a small idea into a key element of transformation. Question of how to keep advancing the work without leaving people behind?
- Success of developing partnerships – the whole environment (the PH of the system) has changed. Trying to quantify partnership across clinical and community entities is the next step.
- Creation of a “scholarship” to help small practices undertake transformation shows the commitment of PCPs to transformation.
- Relationship with tribes is different than other stakeholders because it's a government to government relationship. Through SIM, HCA has been able to leverage the state's knowledge working with tribes and apply that to the next phase of Medicaid transformation.
- Funded discussions between providers and community organizations, including on BH integration—moving tangibly and rapidly because of experiences through SIM in discussing problems and developing solutions. Successfully identified an HIT vendor to share data across stakeholders.
- Key success was helping to facilitate new providers/community relationships and then seeing them continue and grow afterward.
- SIM provided a foundation and environment for three health agencies to work together in a new way, and has helped to engage other stakeholders as well.
- Hadn't been very involved in SIM but are now benefiting from Medicaid transformation efforts. More communication across stakeholders and awareness that no one can do it alone; partnerships are essential.
- With paying for value, the major challenge was in taking principles and turning them into changes in how the state purchases health care. There is still room to go but progress has been made. There also has been alignment across programs (e.g., Medicaid and PEBB using similar measures).
- Bringing together state evaluation partners, and sharing data to support evaluation of SIM. Major success was the wisdom of SIM leadership to embed evaluators in the work of SIM—greatly helped by developing of those relationships and willingness of partners to cooperate.

#### IV. Partners' roles post-SIM

The following role descriptions were collected from the worksheet that meeting participants filled out during the convening.

- Policy development across state agencies and partners. Developing long-term financial sustainability based on shared savings.
- State-based evaluation/obtaining 2018 data.
- Sustainment of new collaborations. Identification of individual business cases to sustain ACH project initiatives.
- Engaging primary care practices and BHAs on bi-directional integration and foundational practice transformation. Partner with many – HCA, DOH, MCOs, provider organizations—to develop tools and resources for WA Resource Portal.
- ACP continuation as self-insured health plan. BH integration. Shared decision making implementation, and reduce variation in VBP by <10%.
- Move away from fee-for-service. Provide incentives (HCA) to encourage providers to work with community partners.

#### V. Exercise Report Out: Roles by Strategy

Participants were asked to break out into three groups, organized by the Healthier Washington Strategies-- paying for value; ensuring health focuses on the whole person; and, building healthier communities through a collaborative regional approach. Participants were then asked to consider the roles of each partner, as well as sectors more broadly, within each strategy, as well as identify what else needs to happen to ensure the success of each strategy. Below summarizes the learnings from the group exercise.

##### **Paying for value**

- There is still variation in how value is defined
  - There is continued need to revisit our value-based contracting arrangements to ensure they are moving toward the intended outcomes.
  - There is a continued need to engage purchasers in pursuing value-based contracts for employees/beneficiaries.
  - It is important to continually revisit our measures. Are they effectively addressing the improvements we want to see?
- Things still to do are:
  - Work at statewide level to define value, including health system partners in the discussion.
  - Encourage use of common measures to allow comparison of performance across the system.
  - Develop common ways to collect, analyze and share data.

##### **Ensuring Health Focuses on the Whole Person**

- How do we continue to move along the integration continuum, realizing our vision of clinical integration as well as financial and administrative?

- The standard definition of a 'behavioral health provider' currently leaves out many critical service providers. There is a need to come up with a common understanding and definition of behavioral health integration that includes all relevant provider types and include them in the conversation.
- We still have critical gaps and needs when it comes to the flow of data and records. How do we share data across EHRs and ensure information is being captured and flowing appropriately to support care coordination, while also adhering to applicable patient protections?,
- There is a critical need to support providers in delivering behavioral health services. These providers are taking care of our most vulnerable clients and are under great stress).

### **Building Healthier Communities through a Collaborative Regional Approach (ACHs)**

- Clinical-community linkages are a critical part of moving to value-based payment arrangements, yet definitions and expectations are still undefined. Payers are a key voice in this process, as well as other traditional and non-traditional system partners.
- There is a need to address the appropriate resourcing of community and social service providers, in addition to the clinical system.
- There is a need to consider standardization: What needs to be standardized statewide, and where is there room for innovation and difference across sectors and regions?

## **VI. How partners and HCA can continue to support each other in furthering transformation efforts**

The following section summarizes areas of support identified by community partners and HCA that are required to drive the Healthier Washington movement.

- Continue to bring payers and purchasers to the table.
- Keep working to define value.
- Move forward on health equity.
- Encourage standardization among ACHs.
- Continue to make connections across providers to achieve meaningful behavioral health integration.