Washington State Innovation Models Project

Round 2 Model Test Awardee
End of Year Report
Period: February 1, 2016 to January 31, 2017

Revised: June 23, 2017

Contents

Introduction to Healthier Washington program investments

During this active implementation year, our focus included:

Supporting Accountable Communities of Health (ACHs)

We know the best way to improve health is by focusing our efforts in the places where people live, work, and play. The nine regional ACHs are a key driver of health systems transformation. They bring together public and private community partners to tackle shared regional health goals and harness the collective impact of clinical delivery, community services, social services, and public health.

Building payment reform test models

Washington is testing four payment redesign models as part of our vision of achieving value-based purchasing. We aim to move 80 percent of state-financed health care and 50 percent of the commercial market from volume to value by 2019. Preparing the four test models has required intensive partnering and a willingness to move beyond "business as usual" when it comes to purchasing.

Shaping the Practice Transformation Support Hub

The Practice Transformation Support Hub (the Hub) supports primary and behavioral health providers as they integrate care, adopt value-based payment systems, and link with community-based services to strengthen whole-person care.

Creating a plan for improving population health

The Plan for Improving Population Health (P4IPH) moves our state's Prevention Framework—which prioritizes prevention and management of chronic disease and behavioral health issues, while addressing root causes—from "what" to "how." Work on designing strategies and ways to think about population health will lead to an actionable, focused work plan designed to identify and implement specific system and policy changes that will hardwire prevention activities into the ongoing operation of the health and health care system.

Exploring ways to strengthen workforce capacity

Healthier Washington aims to ensure the right people are delivering the right health care services, and that the right types of healthcare workers are in place to provide patient-centered and integrated care in a transformed system. These efforts are taking place at both regional and state policy levels.

Investing in data analytics and visualization

The Analytics, Interoperability and Measurement (AIM) portion of Healthier Washington will help our state build capacity to translate, analyze, and visualize data from multiple sectors.

Maintaining a strong, collaborative governance structure

No one entity or agency "owns" Healthier Washington. It is by design a collaborative effort that involves multiple partners at the state, regional and community levels. The Healthier Washington initiative includes a strong governance structure that facilitates collaborative engagement across state agencies and geographic areas.

Looking ahead

Moving into Award Year 3 (AY3), Washington's transformation efforts focus on full-scale implementation of all investments. We will also further refine and implement mechanisms for sustainability. Most important, AY3 builds on the growing momentum toward our goal of a Healthier Washington.

Overview

As Washington completes Award Year 2 (AY2), we want to thank the Center for Medicare and Medicaid Innovation (CMMI) for the contributions the State Innovation Model (SIM) resources have made this past year in our state. The CMMI investment in Washington through the SIM award accelerates the pace of health transformation in our state. The SIM grant fuels multipayer spread of transformation more quickly and effectively than if the SIM resources were not available to support these pioneering efforts.

This annual report is a summary of Award Year 2 – a busy year for the implementation and adoption of all of our strategies. Throughout the period from February 1, 2016 through January 31, 2017, our team fulfilled its goal to realize and advance our SIM proposal. Here you will find evidence of the evolution of ACHs, major infrastructure investments in our AIM projects, our Practice Transformation efforts, and four innovative payment model demonstrations. We encountered and dealt with several challenges, which we will discuss here, on our journey to beginning Award Year 3 with momentum and energy.

On December 1, 2016, the Washington State Health Care Authority (HCA) submitted the Healthier Washington Award Year 3 Operational Plan to CMMI. This submission fulfilled the state's annual obligation under the SIM grant and was reviewed and accepted with a number of Special Terms and Conditions (STCs) to ensure CMMI oversight and state accountability of critical Award Year 3 milestones.

Because of our determined planning and program design, our AY2 accomplishments were many and broad:

- ACHs all made progress toward greater maturity and functioning, and each launched a SIM project to transform health in their region.
- Payment Model 1 (Fully Integrated Managed Care) went live on April 1, 2016.
- Payment Model 2 established a financial model and identified participants for the alternative payment methodology (APM4) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).
- Payment Model 3 (ACP) enrollment grew by 52 percent and expanded into four additional counties.
- Payment Model 4 launched with two lead organizations in a rural and urban setting.
- The Hub and Plan for Improving Population Health websites went live. Our strategic partner, Qualis Health, began hiring coaches and connectors.
- Washington State certified several patient decision aids, the first state in the country to do so.
- We organized our AY3 work by "goals" and built a new portfolio management tool to support our alignment across Healthier Washington.
- We hosted a successful Healthier Washington symposium in October in Seattle, attended by 250 key stakeholders.
- We achieved active participation and collaboration across state agencies (HCA, Department of Health, Department of Social & Health Services, etc.) in the development of ACHs, AIM, P4IPH, the Hub, and Workforce Development.
- Separate from SIM funding but not from Healthier Washington goals, HCA and the Centers for Medicare and Medicaid Services reached an agreement for a five-year Section 1115 waiver, called the Medicaid Transformation Project Demonstration. This Demonstration allows up to $1.5 billion of federal investment to help drive Medicaid transformation – accelerating Healthier Washington's trajectory to better health, better care, and lower costs. The Demonstration builds on key components of the SIM grant, including physical/behavioral health integration and payment model reform, and will feature ACHs in the development and support of Medicaid transformation initiatives.

Washington SIM accomplishments, milestones, and measurable outcomes – AY2

Community empowerment and accountability

Accountable Communities of Health

State Activities

- We defined foundational requirements for the evolving ACH entities. The minimum expectation: each ACH's primary decision-making body must include voting members from the following categories:
- One or more primary care providers, including practices and facilities serving Medicaid beneficiaries;
- One or more behavioral health providers, including practices and facilities serving Medicaid beneficiaries;
- One or more health plans, including but not limited to Medicaid managed care organizations; if only one opening is available for a health plan, it must be filled by a Medicaid managed care organization (MCO);
- One or more hospitals or health systems;
- One or more local public health jurisdictions;
- One or more representatives from the tribes, Indian Health Services (IHS) facilities, and Urban Indian Health Programs (UIHPs) in the region, unless alternative mechanisms are agreed upon by the ACH, including tribes, IHS facilities and UIHPs in the region.
- Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in the region. This includes, but is not limited to, transportation, housing, employment services, education, criminal justice, financial assistance, consumers, consumer advocacy organizations, childcare, veteran services, community supports, legal assistance, etc.

These are the principles we developed during AY2 for ACHs to abide by as they evolve:

- *Balanced*: ACH partners and members represent a broad perspective of health and health care coverage, considering the entire population within the region and a broad understanding of health and social determinants.
- *Representative:* ACH partners involved in decision-making serve on behalf of a sector or population.
- *Tiered and participatory*: ACH partners participating in regional transformation projects and other regional work actively inform project design and ACH decisions. To meet both the balanced and participatory principles, decision-making and project design will occur at multiple levels, recognizing that the final ACH decision-making may rely on subject matter experts (SMEs) and specific "design teams" to inform priorities and strategies.

- *Accountable*: ACHs and participants in health systems transformation are accountable to each other and the communities within the region, with clearly defined, transparent mechanisms to facilitate vetting and decision-making. This includes the expectation that individual community members (e.g., consumers, Medicaid beneficiaries, those who will be impacted) will be included in the decision-making processes.
- *Flexible*: Within the framework outlined in this document and in partnership with the State, each ACH should consider the unique regional environment and implement a structure that works best for the region.

Regional Activities

Year 2 for the Accountable Communities of Health was very much dedicated to exploring and testing how to best respond to community priorities in a thoughtful and coordinated way. The specific activities included ensuring the right staff were present, transitioning to legal entities, meeting with key regional partners and stakeholders, and developing project proposals specific to regional needs and trends.

The number one priority for ACHs is to develop the infrastructure and capacity for ongoing collaboration and community-led decision-making within Washington's health systems transformation effort. All ACH activities in AY2 reinforced this priority, and an annual survey was conducted by the Center for Community Health and Evaluation (CCHE) to better understand what ACH partners themselves are experiencing and seeing within the ACH development process. While some ACH activities relate to specific projects, much of the ACH effort is meant to create a forum for partners to better align existing resources and programs in a way that acknowledges all factors that impact health. This survey is one of the best indicators of how ACHs are making a difference today in the broader context of collaboration and regional health improvement, recognizing many respondents have participated in the ACH effort over the past two years. Here are a couple of highlights:

- Like last year, nearly all survey respondents agreed or strongly agreed that ACHs are making a positive contribution to health improvement and are a worthwhile use of their organization's time and resources.
- Similar to last year, there was strong agreement among survey respondents that ACHs are making progress on key outcomes related to their ability to positively affect regional community health. More than 75 percent of respondents across the state agreed or strongly agreed to eight of nine items related to ACHs having positive effects in their region.

In 2016, ACHs launched a weekly ACH leads call that is in addition to regular calls and convenings hosted by the HCA. We believe these calls result in more aligned messaging, increased coordination, and a better mechanism for elevating and/or addressing common challenges and opportunities. These weekly leads calls are an example of the important capacity and infrastructure development that has occurred and reflect the spirit of collaboration that exists across the state. One lead put it well: "I heard from other regions some ideas that I'd love to bring to our region and scale up...learning from what other regions are doing on health priorities that we have too."

In 2016, ACHs moved from theory to practice with the selection of their first projects. ACHs were required by the HCA to select and submit a proposal for their project by July 31, 2016. All nine ACHs successfully submitted proposals by the deadline, demonstrating capacity to identify community needs, consider various options and make an informed decision as a collective. ACHs were required to articulate the unique role of the ACH within the context of the project (not simply an ACH pass-through).

The process of selecting and planning their first collaborative health improvement projects was a critical exercise for ACHs. As part of their project proposals to HCA, the ACHs were required to identify potential outcomes, indicators, and data sources for measuring progress. The majority of projects chosen related in one way or another to whole person care and care coordination.

The lessons learned about priority setting, project measurement, and transparent decision-making will help ACHs as they take on future opportunities, such as spreading projects or policy and systems level changes that contribute to health systems transformation. Several ACH projects continue to this day and we expect to see measurable outcomes that could demonstrate the return on investment for sustainability. Several other projects experienced implementation barriers, which reinforces the value of the exercise. ACHs are also looking to the Medicaid Transformation Demonstration as a mechanism to spread and scale projects considering the limited funding dedicated to project-specific activities to date.

Below are a few additional examples of decision-points ACHs addressed in AY2.

- Agreement regarding legal ACH structure and transition of backbone organization role, as applicable.
- Defined accountability of the backbone organization and staff to the ACH.
- Evolution of the region's cascading engagement structure.

Plan for Improving Population Health

- A beta version of the *Roadmap to Population Health* website was developed and released to partners and stakeholders for review and comment. Input was gathered and synthesized, informing edits and additions to the web-based resource. One change that came directly from stakeholder feedback was to call the website a *Planning Guide* rather than a *Roadmap*.
- An external-facing *Population Health Planning Guide* Version 1.0 was released September 30, 2016. Internal and external stakeholders and partners were notified of the release and invited to provide additional feedback to inform Version 1.2 that was released February 1, 2017. Access the Guide here.
- We continued work with partners/stakeholders on enhancing and refining the *Planning Guide* website, including ACHs, local public health partners, MCO leaders, partner organizations, health equity advisory members, the Health Innovation Leadership Network (HILN), and tribal and state leaders.
- The Washington State Public Health Association annual conference was held in October 2016, featuring Dr. Sanne Magnan, co-chair of National Academy of Medicine Population Health Improvement Roundtable as keynote speaker (sponsored by P4IPH/SIM). Workshops held throughout the three-day

conference focused on health care/public health partnerships to improve population health.
- Stakeholder events held in Spokane and Seattle, also featuring Dr. Magnan, provided technical assistance from national experts and garnered input from health care, public health and community partners who will be implementing population health improvement strategies in their communities and at the state level.
- CCHE is facilitating a third-party examination of the Plan for Improving Population Health, working closely with the Department of Health and Health Care Authority. A set of deliverables and timeline has been developed, with an initial focus on diabetes through targeted engagement of local health jurisdictions.

The P4IPH Planning Guide is truly best viewed from its location on the Hub portal: http://www.waportal.org/population-health/about-population-health-and-planning-guide. The guide offers tools and resources that can be applied not only to SIM but also to specific health issues and complementary projects. It offers a proven framework and a common vocabulary.

By the end of year 2, a workshop was held to develop a driver diagram for population health (diabetes and well-child visits). Drawing on research, best practices, national expertise, and input from local stakeholders, participants identified the key elements of a population health approach that may be effective in improving health and reducing costs. These key elements may be applied to multiple health issues:

- Align strategies
    - *There are tools and resources available for each of these elements on the website*
- Assess needs
- Build sustainability
- Determine goals
- Engage partners
- Identify populations
- Implement interventions
- Measure results

The Planning Guide contains useful information for the ACH communities (or a single community partner coalition, or multi-sector partnership) to obtain guidance and technical assistance to achieve greater population health.

Intended Use:

Beginning with health care system strategies that support value-based payments, a population health approach expands to include community-clinical linkages and broad population strategies. In the short-term it can lead to a reduction in health care costs

and improved health outcomes for identified groups. Ultimately, it can lead to greater health and well-being for the people of Washington State – the goal of the Healthier Washington SIM program.

Outcomes, learning and next steps:

- From the DOH perspective, our next step with the Planning Guide is to build it out, using the framework of the three buckets of prevention, to help our partners align strategies and interventions optimally.
- The tools and resources embedded in the Planning Guide are meeting a critical need for regions throughout the state, especially as funding becomes available to address health issues. This planning guide is essential to help Washington assess its needs and plan interventions.
- The newness of this approach to health systems transformation among our partners has stimulated some significant group learning about the issues. There is greater awareness in the communities and in the provider community about the social determinants of health. Progress in AY2 is evident in an emerging understanding about how working together will help achieve results.
- Putting the Planning Guide on the portal is a step forward for modeling community clinical linkages on a broader level. The reception has been enormously positive.
- Next steps: the tools will continue to evolve based on input from stakeholders. We continue integrate population health into resources available within the portal.
- Sections of the planning guide will be enhanced for each population. Health equity components will be expanded for each population in AY3. This expansion represents the integration of a population-specific strategy with the broader population health approaches.

Practice transformation

Practice Transformation Support Hub

Well before the end of AY2, the Hub vendor, Qualis Health, had begun hiring experienced coaches and connectors in several of the nine regions of the state. All of these individuals are seasoned practice transformation workers with established relationships and concrete knowledge of the Hub's goals.

The Coach/Connectors were able to get out into the field immediately in the fourth quarter to begin talking to providers, getting a sense of the issues in the region, and beginning to build relationships with the local ACH members. After combining the Coach/Connector roles – both functions (coaching and connecting) were live in Washington State as of the fourth quarter, and coach/connectors spanned multiple regions until full staffing was achieved.

The development of the portal was also well under way – with a successful live date in January 2017. Statistics have demonstrated positive use of the portal in Award Year 3.

- Quarter 4 saw the official launch of the Hub. Qualis Health began rapid hiring, training and deploying of the combined Coach/Connector role in each ACH region.
- Practice Coach/Facilitation/Training (PCFT) and Connector Contracts were signed for AY3.
- The Hub portal launched on January 8, 2017. It has been a well-received launch and the feedback and input received from our stakeholders and providers has been very positive.

Shared decision making

- Washington was the first state to certify patient decision aids (PDAs) for maternity care. Staff participated in a review process and discussion with national stakeholders during this period to develop a national process to certify patient decision aids. The National Quality Forum is building this process from the learnings from Washington State's experience.
- In early January, HCA launched a second open call for PDAs for consideration for certification. The request during round two is for PDAs that address total knee or hip joint replacement, and lumbar fusion – aligning with recommendations from the Bree Collaborative. This request supports requirements in the Model 3 ACP contracts for the networks to incorporate shared decision making with the use of PDAs into a quality project that focuses on improvement in these three areas. The first round of certification led to the certification of five PDAs that address maternity care.
- An obligation to use the approved PDAs is incorporated into the ACP contracts under Payment Model 3. Each of the named ACP entities has begun using PDAs in their practices for certain maternity, orthopedic, or spine treatment. Although we had a contract for technical assistance to these entities, most embraced the new tools on their own and did not require assistance. Many of them also made changes to their electronic health records to accommodate the use of the tool and provide documentation that these tools were provided to patients.

Workforce

- The Health Workforce Sentinel Network released the results of their November-December data collection on workforce gaps, which represented 178 facilities across Washington State. The dashboard is public and allows those who access the data to filter by accountable community of health, practice type, and others.
- The Community Health Worker (CHW) Task Force created a policy recommendations report reflecting their findings and learnings for the creation of effective and robust use of CHWs to improve health outcomes and care coordination. Four ACHs chose SIM projects with CHW components, integrating these task force recommendations in their work.

http://www.wtb.wa.gov/healthsentinel/findings-overview.asp

The Sentinel Network's quarterly report provides a snapshot of health workforce activity for the last three to four months as reported by Sentinel Network key informants. Key data is reported by type of facility and Accountable Community of Health (ACH). The data and reporting supports the individual ACH or their key workforce partners (hospitals, behavioral health clinics, etc.) to develop a user-driven custom data inquiry and analysis tool to monitor changes in their specific region or area and create comparisons to other ACHs and across the state. Data may be used by health care employers and planners to manage ongoing recruitment and retention, as well as for use by the ACHs to inform workforce capacity assessment and monitoring needs from a demand perspective.

The findings are presented in a format that allows individual users to create their own analysis by facility or occupation type with accessible comparison data to support analysis of how the user's workforce issues compare to others in similar facilities, settings, or occupations across the state or within an ACH. The report includes data from all reporting periods to allow the user to assess changes in response and impact of changes on analysis by facility type.

Response Counts by facility type for each ACH: Provides bar graph of responses by ACH and provides a Washington State map divided into ACH regions with ability to select and display/compare specific facility type results for all regions.

Occupation Changes: This table includes a report of percent of reported occupations with workforce changes in the past three to four months by type of facility. Displays by facility type the number and percentage of reported occupations showing exceptionally long vacancies, increased or decreased demand, deployed staff in new roles, changes to orientation/onboarding processes, changes to employee training and total occupations reported.

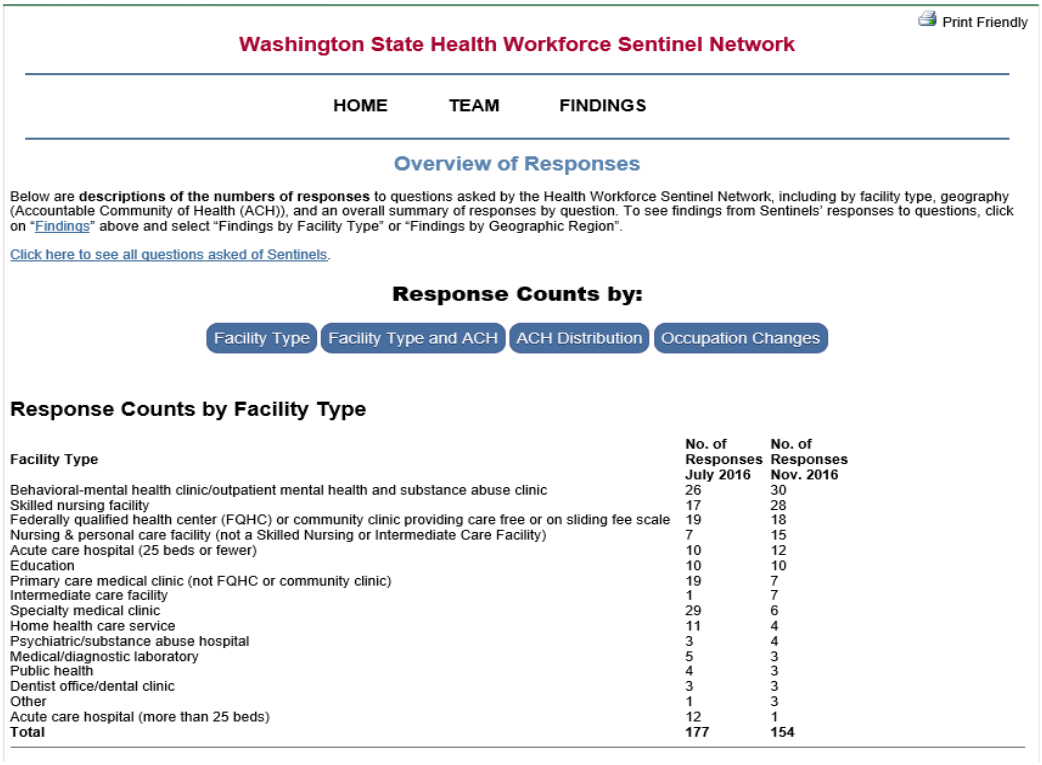
- Table includes an explanation of how to interpret results
- Table includes a summary of conclusions by reporting key findings of workforce changes to assist user in interpreting the findings.

Below are sample screen shots of selected data reporting and analysis. Comprehensive reporting and analysis may be found at the Health Sentinel Workforce website: http://www.wtb.wa.gov/healthsentinel/.

- The Community Health Worker (CHW) Task Force created a policy recommendations report reflecting their findings and learnings for the creation of effective and robust use of CHWs to improve health outcomes and care coordination. Four ACHs chose SIM projects with CHW components, integrating these task force recommendations in their work.
- The Washington State Department of Health (DOH) currently sponsors a CHW Training Program that incorporates the March 2016 CHW Task Force recommendations for Core CHW training and education programs: http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/CommunityHealthWorkerTrainingSystem

- Funding support comes from multiple grants to the Department of Health's Prevention and Community Health Division with capacity for up to 500 CHW participants annually.
- DOH offers a 30-hour core curriculum training series over eight weeks with six weeks online curriculum/study and two in-person days offered regionally across Washington State. Core training includes roles and boundaries, core professional skills (communication, documentation, organization, assessment, service coordination) with case study skill development exercises.
- CHWs who successfully complete the core training may participate in disease- or condition-specific training and core health professional development topics after successfully completing core curriculum (up to 70 hours available training).
- Training is offered and completed by CHWs in each of the nine ACH regions.
- At least four ACHs are currently developing plans to implement Pathways HUB Care Coordination models for Project 2B: Community-based Care Coordination. The Pathways HUB model deploys CHWs to provide care coordination activities through participating ACH partner agencies and providers. In support of these ACHs and their evolving care coordination models, the DOH Community Health Worker and Prevention and Community Health staff are collaborating with ACH leaders to discuss opportunities for the development and implementation of a curriculum to address Pathways HUB CHW certification requirements. The training will build on the existing DOH CHW training and skills program and add new content designed to meet Pathways HUB Care Coordination model requirements.

Screenshots: Sample Health Workforce Sentinel Network reporting



Print Friendly

Washington State Health Workforce Sentinel Network

HOME TEAM FINDINGS

Overview of Responses

Below are **descriptions of the numbers of responses** to questions asked by the Health Workforce Sentinel Network, including by facility type, geography (Accountable Community of Health (ACH)), and an overall summary of responses by question. To see findings from Sentinels' responses to questions, click on "Findings" above and select "Findings by Facility Type" or "Findings by Geographic Region".

Click here to see all questions asked of Sentinels.

Response Counts by:

Facility Type | Facility Type and ACH | ACH Distribution | Occupation Changes

Response Counts by Facility Type

Facility Type	No. of Responses July 2016	No. of Responses Nov. 2016
Behavioral-mental health clinic/outpatient mental health and substance abuse clinic	26	30
Skilled nursing facility	17	28
Federally qualified health center (FQHC) or community clinic providing care free or on sliding fee scale	19	18
Nursing & personal care facility (not a Skilled Nursing or Intermediate Care Facility)	7	15
Acute care hospital (25 beds or fewer)	10	12
Education	10	10
Primary care medical clinic (not FQHC or community clinic)	19	7
Intermediate care facility	1	7
Specialty medical clinic	29	6
Home health care service	11	4
Psychiatric/substance abuse hospital	3	4
Medical/diagnostic laboratory	5	3
Public health	4	3
Dentist office/dental clinic	3	3
Other	1	3
Acute care hospital (more than 25 beds)	12	1
Total	**177**	**154**

Response Counts by Facility Type for each Accountable Community of Health (ACH)

Note: Each facility could serve clients/patients in more than one county, which is why the totals in the chart below are greater than the totals in the table above.

Click on a facility type below to highlight the number of responses from each data collection period.

Move your cursor over each bar to see the number of responses.

Click below the last label to reset.

- Acute care hospital...
- Acute care hospital...
- Behavioral-mental h...
- Dentist office/denta...
- Education
- Federally qualified h...
- Home health care se...
- Medical/diagnostic l...
- Nursing & personal...
- Other
- Primary care medic...
- Psychiatric/substan...
- Public health
- Skilled nursing facili...
- Specialty medical cli...

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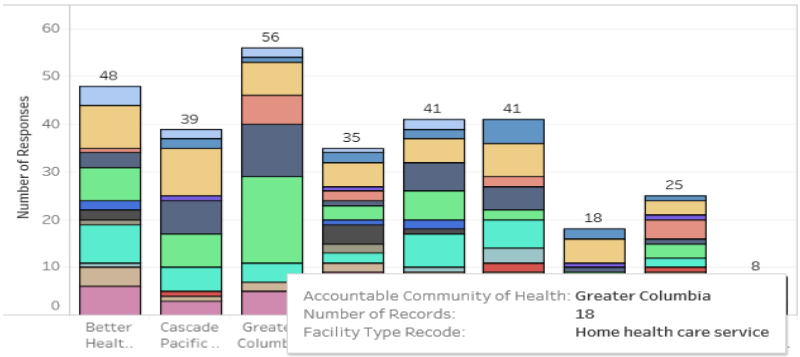
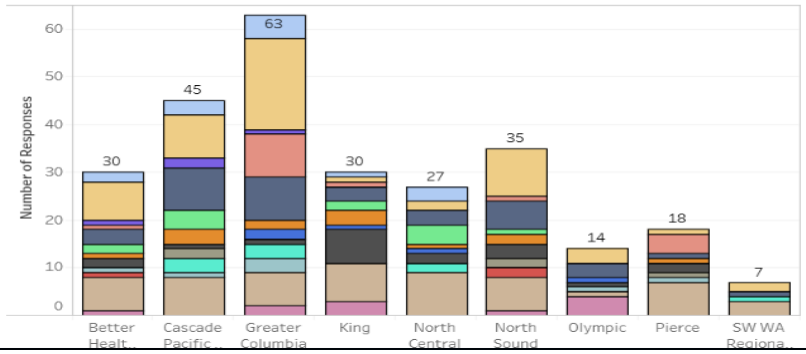
Data collected June 15, 2016 - July 30, 2016



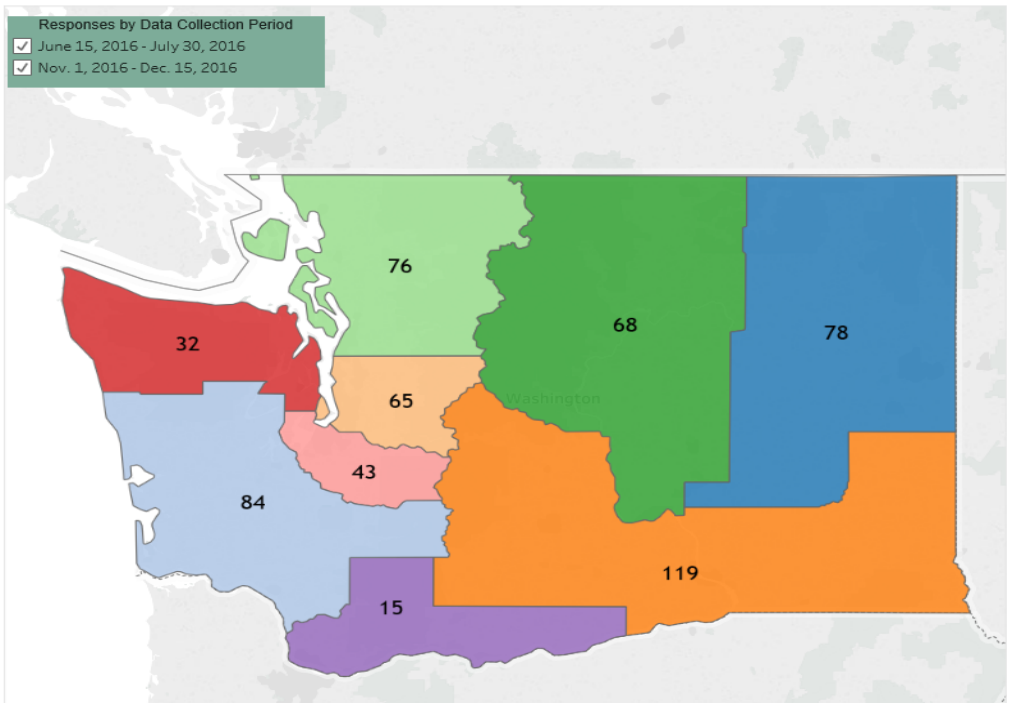
Data collected Nov. 1, 2016 - Dec. 15, 2016



Response Counts for each Accountable Community of Health (ACH)

Note: Each facility could serve clients/patients in more than one county, which is why the totals in the chart below are greater than the totals in the table above.

I. **Hover over the map** to show data for the selected Accountable Community of Health.
II. **Select** a single data collection periodto show responses for each period.



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Findings as reported by facility type

Click on the buttons to explore the results by question topic; use the menu that will appear in the sidebar as you scroll to explore findings by other questions.

Click here to see all questions asked of Sentinels.

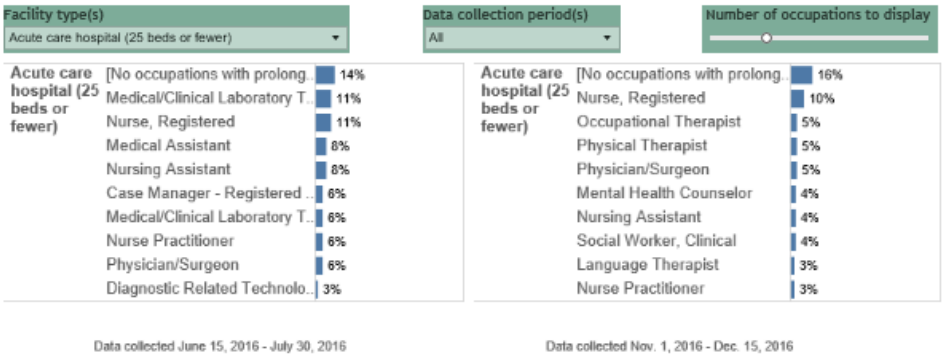
Vacancies | Demand Increase | Demand Decrease | Onboarding | Training | New Roles | New Occupations

Vacancies

Sentinels were asked: "Recently (in the past 3-4 months), has your facility type experienced exceptionally long vacancies for any open position? If yes, for which occupations and what are possible reasons why?"

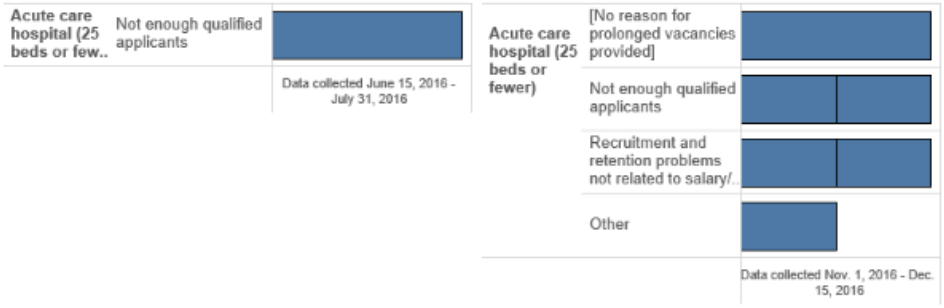
I. **Select a facility type(s)** to begin exploring data. Ctrl/Cmd + Click to show multiple facility types.
II. **Select** the data collection period(s) and the number of occupations to show for the selected facility type(s)..
III. **Reasons: Click on an occupation** (or Ctrl/Cmd + Click on multiple occupations). Move your cursor over the bars to see respondents' comments.

Prolonged Vacancies by Facility Type



Reasons For Prolonged Vacancies

Click on an occupation above (or Ctrl/Cmd + Click on multiple occupations). *Move your cursor over the bars to see individual comments.*



Occupation Changes

Percent of reported occupations with workforce changes in the past 3 – 4 months, by facility type

Interpretation: The denominator in each cell represents the total number of occupations with workforce changes reported for each facility type (more than one occupation could be reported for each facility type). The numerator in each cell represents the number of occupations for which the Sentinel answered "Yes" to the survey question indicated at the top of each column. The last column shows the mean number of occupations with workforce changes reported for each facility type (the number of occupations reported by each Sentinel could be different for each survey question).

Conclusions: The table shows three things: 1) From the 178 Sentinel facilities, approximately 726 occupation types were reported to have experienced workforce changes in the previous 3 – 4 months; 2) The total number of occupations reported to have experienced workforce changes varied by facility type (5 – 172), although this depended on the number of responses from each facility type (see "Overall number of facilities that responded statewide" above); 3) The percentage of reported occupations that experienced workforce changes (as indicated by the length of the blue bars) was relatively high for the exceptionally long vacancies and increased demand questions; was lower for the orientation/onboarding and training questions; and was rare for the decreased demand and new roles questions.

Data collected June 15, 2016 - July 30, 2016

Facility Type	Occupations with Exceptionally Long Vacancies[a] (n/N, %)	Occupations with Increased Demand[b] (n/N, %)	Occupations with Decreased Demand[c] (n/N, %)	Deployed Workforce in New Roles[d] (n/N, %)	Changes to Orientation/ Onboarding of New Employees[e] (n/N, %)	Changes to Training for Existing Employees[f] (n/N, %)	Total Occupations Reported (mean)
Acute care hospital (25 beds or fewer)	31/36 (86%)	25/36 (69%)	0/36 (0%)	4/36 (11%)	13/35 (37%)	11/36 (31%)	36
Acute care hospital (more than 25 beds)	59/116 (51%)	42/116 (36%)	0/116 (0%)	1/116 (1%)	7/117 (6%)	26/116 (22%)	116
Behavioral-mental health clinic/outpatient mental health and substance abuse clinic	73/96 (76%)	55/96 (57%)	3/96 (3%)	10/97 (10%)	24/98 (24%)	56/95 (59%)	96
Dentist office/dental clinic	3/6 (50%)	3/6 (50%)	0/6 (0%)	0/6 (0%)	0/6 (0%)	2/6 (33%)	6
Education	8/15 (53%)	10/15 (67%)	0/15 (0%)	4/16 (25%)	2/15 (13%)	2/16 (12%)	15
Federally qualified health center (FQHC) or community clinic providing care free or on sliding fee scale	87/169 (52%)	86/171 (50%)	1/171 (1%)	5/172 (3%)	7/175 (4%)	36/172 (21%)	172
Home health care service	19/21 (90%)	10/21 (48%)	0/21 (0%)	1/22 (4%)	10/22 (46%)	5/22 (23%)	22
Medical/diagnostic laboratory	0/5 (0%)	0/5 (0%)	0/5 (0%)	0/5 (0%)	0/5 (0%)	0/5 (0%)	5
Nursing & personal care facility (not a Skilled Nursing or Intermediate Care Facility)	9/14 (64%)	4/13 (31%)	3/13 (23%)	1/13 (8%)	2/13 (15%)	2/13 (15%)	13
Other (Billing office, intermediate care facility or specialty [except psychiatric/substance abuse] hospital)	10/11 (91%)	6/11 (55%)	1/11 (9%)	2/11 (18%)	5/11 (45%)	11/11 (100%)	11
Primary care medical clinic (not FQHC or community clinic)	34/69 (49%)	36/68 (53%)	0/68 (0%)	4/68 (6%)	10/68 (15%)	12/69 (17%)	68
Psychiatric/substance abuse hospital	5/9 (56%)	2/10 (20%)	0/10 (0%)	0/11 (0%)	2/11 (18%)	1/11 (9%)	10
Public health	4/6 (67%)	2/6 (33%)	0/6 (0%)	0/6 (0%)	1/6 (17%)	2/5 (40%)	6
Skilled nursing facility	36/79 (46%)	37/78 (47%)	2/78 (3%)	2/78 (3%)	24/81 (30%)	36/79 (46%)	79
Specialty medical clinic	37/70 (53%)	29/71 (41%)	0/71 (0%)	4/72 (6%)	26/70 (37%)	26/72 (36%)	71
Total	415/722 (57%)	347/723 (48%)	10/723 (1%)	38/729 (5%)	133/733 (18%)	228/728 (31%)	726

[a] Recently (in the past 3-4 months), has your facility type experienced exceptionally long vacancies for any open positions?
[b] Recently (in the past 3-4 months), did your facility type experience an increase in the usual demand for specific occupations?
[c] Recently (in the past 3-4 months), did your facility type experience a decrease in the usual demand for specific occupations?
[d] Recently (in the past 3-4 months), has your facility type deployed its existing workforce in significantly new roles?
[e] Recently (in the past 3-4 months), have there been changes to onboarding/orientation priorities for new employees for any occupations at your facility?
[f] Recently (in the past 3-4 months), have there been changes in the training priorities for your facility's existing workforce for any occupations?

Payment redesign

Payment Model 1: Early Adopter of Medicaid Integration

- We launched integrated financing of physical and behavioral health in the Southwest Washington region on April 1, 2016.
- Once launch activities were completed, a large amount of work and focus was put into ensuring the model was moving forward successfully and that issues were managed and resolved.
- Upon implementation, daily calls took place with providers and the managed care organizations (MCOs) for early identification and resolution of issues as they

arose. These meetings decreased in frequency over time and as fewer issues were identified.

- Early warning data was monitored to ensure no negative trends were affecting access and services for individuals with behavioral health challenges.
- Arrangements were made with out-of-region substance use disorder providers and behavioral health organizations to address clients accessing out-of-region services and client transitions.
- Technical assistance and problem-solving was provided to address administrative and operational changes at the state, MCO and provider levels (i.e. payment issues, data systems, data collection changes and reporting; interpreter services processes, etc.)
- Managing challenges around navigating systems for specific client groups (such as individuals residing in ZIP codes that cross county lines/regional service areas; individuals with protected addresses; American Indian and Alaskan Native substance use disorder carve-out; clients of behavioral health services only; etc.)
- New system processes were developed; such as for individuals in long-term inpatient setting like the state hospitals.
- Technical assistance and collaboration was ongoing as the MCOs learned about managing a new population.
- Coordination was formalized with the Department of Social and Health Services, Behavioral Health Administration on administrative processes, messaging, collaboration for statewide continuity, and the transition/coordination of oversight authority.
- Contracting for amendments and monitoring was ongoing.
- HCA staff coordinated a number of regional meetings to build relationships and provide technical assistance to regions exploring becoming "mid-adopters." HCA received binding letters of intent from the three counties that make up the North Central Region, with an anticipated implementation date of January 2018.

Payment model 2: Encounter-based to Value-based

This payment model moves providers to a value-based purchasing (VBP) system, allowing them the flexibility to maintain their innovative and integrated delivery models, and accelerate the effectiveness of VBP initiatives. While ensuring federal requirements are met, the model shifts participating Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from an encounter-based system to a per-member-per-month (PMPM) rate. The rate will be prospectively adjusted based on quality performance.

Successful response on letters of intent was the product of direct stakeholder efforts to cultivate model understanding and support. Over 2016, numerous stakeholder engagements helped to outline questions and concerns about model components. These engagements not only were used to communicate state interests in the model, but also were used to help inform model development needs. It is also important to note that positioning of these conversations in a candid and collaborative format resulted in strong stakeholder support for the ultimate model, which was the fourth iteration of alternative payment methodologies, referred to as APM4.

Overview of funded activities:

- Seven working sessions in 2016
  - Structured with targeted goals
- Facilitation and model development support
  - SME model review and development
- Direct association engagement
- Engagement of Managed Care Organizations

Critical Access Hospital (CAH) Payment and Delivery: In 2016, there were four direct working sessions and several other direct engagements with Washington Rural Health Preservation (WRHAP) CAH stakeholders. The WRHAP collaborators were engaged to identify barriers to small CAH sustainability with the move toward value-based purchasing.

The culmination of 2016 WRHAP engagement efforts are encapsulated in the January 2017 WRHAP report "Delivering High-Value Healthcare Services in Rural Areas of Washington State" (WRHAP report). This report has analyzed the current challenges faced by a subset of CAHs, and seeks to identify meaningful solutions that could be supported by WRHAP CAHs and state agencies. There are several key findings:

- The current system of payment and delivery is unsustainable on the long-term. Sustainability can only be achieved through payment reform and new delivery modalities.
- The impetus for change to a new payment mechanism that supports small CAHs on the longer-term is both timely and widely endorsed among varying stakeholders.
- There is interest in fundamentally redesigning payment for a wide array of services in rural regions.
- Service delivery must endorse a longer-term vision that at a minimum includes supports for emergent care, primary care and swing-bed care.
- There is interest in incorporating other services into the CAH payment reform model over time, including rural health care services, nursing facility services, and other long-term care home and community-based services.
- Phased implementation recognizing financial risk of small rural providers is likely required.
- There is clear interest from small rural providers in making value-based purchasing work in their region.
- Payment reform must include multiple payers if there is an expectation of significant changes in the way care is delivered.
- Transitional support is likely required on the near-term to account for redesign efforts.

These findings have helped to inform model development needs for voluntary participation in a new model of payment and care delivery, and has helped to align next

steps for model development. As alluded to above, key outcomes have been definition and ultimate buy-in on the types of services that need to be addressed under a new model, the basic structures of model design, and outstanding elements that need to be addressed for successful implementation. This process has positioned CAH model development for rapid turnaround to CMS needs and requests as it relates to detail model development needs in 2017, and will help to inform CMS and multiplayer engagement during 2017.

- Payment Model 2 requested letters of intent (LOIs) to adopt APM4 early in 2017. There was strong response to the request, signaling the considerable interest in APM4 and representation of the progress made. Of the 26 FQHCs, 13 submitted LOIs, and of the 55 RHC organizations, 13 submitted LOIs. The LOI denotes those FQHCs and RHCs that are willing to move forward with a memorandum of understanding and are ready to adopt APM4 in mid-to-late-2017.

Payment Model 3: Accountable Care Program and Multi-Purchaser

- We had a successful open enrollment in November; enrollment in our ACP program increased 25 percent for each network. On an annual basis, membership in the ACPs increased 50 percent from 2016-2017. Currently, there are 16,000 enrollees.
- HCA has engaged additional purchasers, payers, and providers through a variety of activities and is planning a fall 2017 purchaser conference.

Payment Model 4: Greater Washington Multi-Payer

In short, Model 4 tests the theory that providers need new and expanded sets of patient-level data in order to take on financial and clinical accountability, improve care coordination practices, and better manage population health. The goal is to increase the adoption of value-based payment (VBP) arrangements among participating providers and payers by increasing providers' access to patient data across multiple payers and by aligning quality measures used to assess provider performance.

In 2017, the HCA executed contracts with two provider groups, Northwest Physicians Network (NPN) and Summit Pacific Medical Center (Summit), that will respectively lead an urban and a rural demonstration of the model. Each provider group has committed to:

- Leveraging a shareable data aggregation solution with the capability of integrating data from multiple payers
- Supporting provider partners in the adoption and acceleration of VBPs
- Engaging additional payer partners in the model
- Providing HCA with semi-annual progress reports.

Similarly, HCA has committed to sharing attributable medical and pharmacy claims data extracts from the public employees Uniform Medical Plan (to NPN only) and Apple Health (both provider groups), to provide technical assistance and connections to care

transformation resources, and explore leveraging the state's purchasing power and stakeholder relationships to incentivize broader participation in the model.

Before development and execution of the contracts, HCA conducted activities to engage payers and provider groups throughout the state. After describing the original intent of Model 4, we learned from stakeholders that a more reasonable approach would be to do a pilot model test. We identified four key goals of the model test (multi-payer engagement, accelerating VBP, proliferating care transformation and the state Common Measure Set, and Medicare engagement.

An internal decision document detailing four potential paths forward was developed and discussed with Healthier Washington and HCA leadership. This led to pursing the pilot projects with NPN and Summit due to their readiness and aligned core business strategies.

By the end of the fourth quarter, we had executed contracts with two provider groups for two separate demonstrations of Payment Model 4 (one rural, one urban). Both contractors completed Grant Year 2 deliverables by the end of January, including a baseline report on quality measures (ACP measures + well-child visits + asthma medication management) and agreements with two additional payers to participate in the model.

Analytics, Interoperability and Measurement (AIM)

Strengthening the Analytics Interoperability and Measurement of the Health Care Authority (HCA) will lead to a foundational platform to inform the implementation of the Center for Medicaid and Medicare Innovation (CMMI). It will also allow for measurement of the success of broader Healthier Washington initiatives, including integration of behavioral and physical health, ACHs, the Hub, and payment redesign.

Establishing the Analytics, Interoperability, and Measurement (AIM) program within HCA will allow HCA staff and partners to effectively leverage data and analytics in service of the goals of the grant, and create infrastructure for the analytic support of health systems transformation once the SIM resources are exhausted.

Tableau:

Tableau is a business intelligence (BI) tool that can help create visually appealing reports, charts, graphs and dashboards. These reports are interactive and can easily be shared in multiple platforms, including an internet interface. Tableau is designed to meet the requirements for analysis and exploration of business data. It is an industry leading software product that is used widely to develop and share dashboards, interactive reports, and offers scalability. The Healthier Washington Data Dashboard located here (https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard), is built using Tableau.

Master Data Management (MDM):

Master data management is comprised of processes, governance, policies, standards, and tools that define and manage critical data and serve as a single point of reference. Master data includes reference information about key entities like patients, customers, providers, locations, and the relationships between them. Master data management technologies provide services and tools to consolidate, cleanse, govern, and share data. Effective MDM is a prerequisite for a well-constructed and usable data warehouse. The need for master data management becomes most obvious as you integrate data across applications to transform business processes. MDM automatically maintains extensive metadata information in the form of history and audit information. It maps attributes from the source system to the target data model.

Purpose/Function of DSAs:

Data Sharing Agreements (DSA) supports the Healthier Washington initiative by providing information to Accountable Communities of Health (ACHs). ACHs need this community and county data to conduct regional health assessments, health improvement planning, and measurement of health outcomes. This information will empower ACHs to address regional health priorities and engage in population-based activities related to improving health and reducing health care costs. In order to meet regional health need objectives and expectations, ACHs must be able to address community health needs with the use of innovative data. ACHs need health mapping capabilities through improved statewide data analytics and integration. Developing a data share agreement is an effective and efficient means of meeting this need for the ACHs.

The AIM investment area made great progress in the final quarter of the planning year. Highlights included:

- Work with Providence CORE on Healthier Washington's Dashboard Reporting Tool (DRT) version 3. Versions 1 and 2 were delivered in AY2 and very well received.
- AIM promoted inter-agency Heath Information Technology (HIT) partnership:
  - AIM facilitated the procurement of Tableau Enterprise Server for the Department of Health and continued enhancing the Behavioral Risk Factor Surveillance System (BRFSS) survey for Washington.
  - AIM catalyzed the procurement of Master Data Management (MDM) and Data Model solutions for the HCA Decision Support team. The first release rolled out successfully on January 31, 2017.
  - The AIM team worked closely with payment model design team to understand current conditions and patterns of clinic use.
- Data Sharing Agreements (DSA) with North Sound and Olympic Accountable Communities of Health took AIM's relationship with ACHs to a new level of maturity.
- Rolled out release of "Healthier Washington Data Dashboard," an interactive visualization of select measures relevant to ACHs. Release two of the Dashboard was on November 14, 2016.
- AIM selected Truven Analytics as the vendor for MDM solution to support AIM. Initial release of MDM solution successfully launched in late January 2017.

- We issued a Request for Proposals (RFP) and selected Truven for a "Data Model," to support the design of an enterprise data warehouse for HCA and AIM.
- The Public Employee Benefits Board (PEBB) Program data was acquired from Milliman and is being made available to University of Washington for payment model 3 evaluation.
- AIM ended AY2 having successfully committed to spend down plans and met carryover targets to continue support strategic investment opportunities.
- The AIM team completed an important step in process standardization with an intake request and peer review process. The HCA Decision Support unit, Enterprise Data Management and Analytics, is developing similar standards for analysts across the agency.
- The Office of Financial Management (OFM) procured a vendor for the All-Payer Claims Database (APCD) and established a schedule of implementation and deliverables for AY3.

Performance Measures

The Washington State Common Measure Set for Health Care Quality and Cost provides the foundation for all of our clinical quality improvement efforts across Washington. The measures create a way to standardize how performance is measured as a state. The HCA will use a subset of these measures in all contracting arrangements, both with managed care and with public employee benefits. The measures in the contracts are for reporting, while a subset is used for incentive-based payments that have quality benchmarks attached to them.

The HCA is working to ensure, where possible, that the measures are used in the SIM driven payment model contracting arrangements, in both the FIMC contracts, payment model 2, and the ACP contracts. The goal is to have the same subset of measures tied to payment across all VBP contracts, where it makes sense, to ultimately reduce the number of measures clinical providers are required to track and report on, and to track impact of the new models across the state.

- In December, the Performance Measures Coordinating Committee (PMCC) increased the number of measures to 56, adding three pediatric measures:
  - Well Child Visits in the First Fifteen Months of Life
  - Follow-up Care for Children Prescribed ADHD Medication, and
  - Audiological Evaluation No Later than 3 Months of Age.
- In December, the second public reporting results for the Statewide Common Measure Set were released.

Evaluation

- To address evaluation questions relevant to early implementation of the Practice Transformation Support Hub, in January 2017 the University of Washington team conducted five key informant interviews with agency and vendor leads at DOH, HCA, UW PCI-Lab, and Qualis Health. Of particular interest was our

observation that there is clarity in mission and vision in each of the three Hub objectives.

- Center for Community Health and Evaluation analyzed and distributed the 2016 ACH member survey, both in aggregate and by individual ACHs, to identify areas of strength and opportunities for growth in five domains of ACH development (membership, governance, mission, backbone functions, and community engagement) as well as ACH member satisfaction and perceived regional impact. They finished 2016 annual ACH site visits and interviews with key stakeholders across all nine regions.
    - Report can be read here.
- The DSHS Research Data and Analysis (RDA) team constructed, maintained and continues to enhance a Medicaid claims evaluation database, delivered a plan for the evaluation of Model 1 and assisted with analysis on Critical Access Hospitals, part of Model 2.
- HCA became acquainted with RTI, federal evaluation contractor, and began discussions to support federal evaluation.
- The Healthier Washington Evaluation team completed some basic modeling to gauge the impact of Healthier Washington on the following basic proof statements:
    - What is the effect of SIM on population health and health equity across population groups in Washington?
    - What is the effect of the SIM on quality of care in Washington State, particularly for those persons living with physical and behavioral health comorbidities?
    - What is the effect of SIM on the annual growth of health care costs per capita in Washington State?

Summary of implementation challenges, barriers, or delays in the previous test year

Mid-adopters

We are proud to have finalized an agreement with the North Central region to migrate to fully integrated managed care by January 2018. In spite of this, there will need to be considerable effort to motivate other regions to move forward with integration. We will continue to look for ways of incentivizing other counties to become adopters of integration in 2018 and 2019, before the legislatively mandated deadline of 2020.

Practice transformation alignment

Washington State has a number of federal awards to advance practice transformation. We asked for guidance from CMS/CMMI/TCPi as to how to handle the potential conflicts in our environment. Of particular concern was how to increase provider choice and empowerment to select the best practice transformation resource for each unique need. The key players in Washington (awardees of TCPi or other PTN funding) were slow to come to the table to share information until this guidance was received.

Decision support – AIM

Our HIT strategy evolved during the year to envelop AIM into the agency's broader HIT goals to achieve a decision support and analytics infrastructure. SIM funding for AIM was a catalyst for purchasing a Master Data Management tool and a Data Model, though the funding was ultimately not sufficient to procure the entire "stack" – e.g. a data warehouse and analytics tool. The HCA stepped up to propose some agency and federal funds from Medicaid to advance the overall analytics capabilities of the agency and pursue the strategies funded by SIM – an implementation challenge with a path forward.

Model 2

Our APM4 model and CAH model grappled with model design and stakeholder engagement, as well as the right approach for obtaining Medicare partnership. While the model had a worthy conceptual plan, support was slow to emerge. It was late in AY2 when we were successful in obtaining several letters of intent to participate in APM4.

Summary of how the cooperative agreement funds were used

- The charts below combine Award Years 1 and 2.
- Award Year 1 is fully spent at $19,084,546.
- Award Year 2 is underspent by $2,947,046. We have submitted a Carryover Request to CMMI for this amount, and are pursuing approval to continue spending Award Year 2 funds during Award Year 3.
- We are preparing an Award Year 2 Budget Amendment to properly fund supplies purchases made during the year.
- During Year 2 budget planning, it was assumed that Year 1 carryover would be sufficient. Funds in other categories have been identified to eliminate this overage.

Investment Area	Award Year 1 Budget	Award Year 2 Budget	Award Year 1+2 Total Budget	Award Year 1+2 Expenditures	Award Year 2 Carryover
Community Empowerment and Accountability	3,289,338	3,669,797	**6,959,135**	6,831,947	127,188
Practice Transformation	1,212,663	2,966,270	**4,178,933**	3,067,256	1,111,677
Payment Redesign	2,454,881	1,524,071	**3,978,952**	3,585,331	393,621
Analytics, Interoperability and Measurement (AIM)	9,466,716	2,655,752	**12,122,468**	11,008,370	1,114,098
Project Management	2,660,948	2,647,420	**5,308,368**	5,107,905	200,463
TOTAL	**19,084,546**	**13,463,310**	**32,547,856**	**29,600,809**	**2,947,047**

Budget Category	Award Year 1 Budget	Award Year 2 Budget	Award Year 1+2 Total Budget	Award Year 1+2 Expenditures	Award Year 2 Carryover
A. Personnel	2,858,745	2,732,211	**5,590,956**	5,068,276	522,680
B. Fringe Benefits	857,623	861,279	**1,718,902**	1,659,401	59,501
C. Travel	70,429	69,159	**139,588**	91,319	48,269
D. Equipment	0	0	**0**	0	0
E. Supplies	157,861	0	**157,861**	172,524	(14,663)
F. Consultant / Contracting	9,995,302	6,256,595	**16,251,897**	13,936,600	2,315,297
G. Construction	0	0	**0**	0	0
H. Other	5,061,112	3,511,936	**8,573,048**	8,557,437	15,611
TOTAL Direct	**19,001,072**	**13,431,180**	**32,432,252**	**29,485,557**	**2,946,695**
Indirect	83,474	32,130	**115,604**	115,252	352
TOTAL	**19,084,546**	**13,463,310**	**32,547,856**	**29,600,809**	**2,947,047**

The way forward: a vision for acceleration and sustainability at all levels

Health Innovation Leadership Network

In the public and private sectors, the Health Innovation Leadership Network is a critical success factor in the spread, scale and sustainability of the Healthier Washington strategies. The five accelerator committees focused on clinical engagement, rural health innovation, collective responsibility, equity, and physical-behavioral integration worked hard throughout the year to determine problem statements and action pathways for effective public-private partnership and solution-focused leadership, laying the groundwork for continued engagement in Award Years 3 and 4.

Sustainability Strategies

Ultimately, we are thinking of the sustainability of Healthier Washington as the sustaining of health systems transformation, and less about the sustaining of individual Healthier Washington projects and siloed efforts. For this reason, holistic, goal-based sustainability, relying on value-based purchasing strategies, strategic partnership opportunities, and innovative financing is what will drive us to the transformed system we seek. In addition, each Healthier Washington effort has AY3 milestones dedicated to

the sustainability of any positive outcomes beyond the life of the SIM grant. CMMI has made clear that a focused sustainability plan must be devised early to build toward later sustainability. In AY2 the services of Berry Dunn was procured to assist in the modeling of possible financial sustainability strategies. That report will be available by mid-2017 and will aid us in our approach to scale, spread, and motivate adoption of this work statewide.