

# State Innovation Models Test Round 2: Healthier Washington

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Sustainability Plan Part 1  
End State Vision, State Accomplishments,  
and Changes in Environment

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# Contents

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- Introduction ..... 3
  - The Healthier Washington Sustainability Framework..... 5
- Part 1: End-state vision ..... 7
  - 2019 Vision: a programmatic view of Healthier Washington ..... 8
- Part 2: State Accomplishments to Date..... 12
  - Additional state efforts..... 20
  - Financial Goals and Goal Targets ..... 22
- Part 3: Changes in State Landscape..... 24
  - Political transitions or market changes impacting SIM ..... 24
  - State insurance shifts/signals: ..... 25
  - State leadership changes ..... 25
  - Participation..... 25
  - Alignment of quality measures ..... 26
- Part 4: Lessons learned..... 27
  - Operationalization and sustainability status of SIM investments ..... 31
  - Looking to the future: Washington beyond SIM ..... 33

## Introduction

The Healthier Washington State Innovation Models (SIM) grant has been a crucial investment in transforming the health system in Washington State to one that delivers better care, realizes healthier populations, achieves smarter spending, and improves provider experience. Washington State is grateful for the approximately \$65 million investment in our state, allowing us to catalyze much of the work that had already been started, or was in idea form awaiting the arrival of resources.

While health systems transformation and innovation work began in Washington State before SIM resources were available, the SIM round 1 planning grant and the SIM round 2 test grant set in motion these efforts to be structured, scaled, and maximized.

Throughout this work, our guiding stars have remained the same: Our three strategies of health care integration for whole-person health, paying for value, and community partnerships, moving us closer to the Quadruple Aim of better health, better care, lower costs, and satisfied providers. By design, there is significant overlap in the strategies, which allows for a systems approach to transformation, as well as sustainability. For example, integration of physical and behavioral health involves innovative and value-based financing approaches, which are achieved through the strengthening of community partnerships with clinical care for the whole person, supporting financial risk through provider and community supports.

Specific focus areas for SIM investments include:

***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, bringing together public and private community partners to advance 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 for achieving better health and higher value through innovative strategies for payment, benefits, and financing. 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 and launching the four test models has required intensive community and market partnering, along with a willingness to move beyond traditional arrangements.

***Supporting clinicians through 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 (VBP) systems, and link with community-based services to strengthen whole-person care and move to VBP.

***Strengthening person and family engagement.*** Our shared decision making work is focused on the creation of a state-led certification process for Patient Decision Aids (PDAs). These decision aids allow providers and consumers to have meaningful conversations that lead to better decision making around certain procedures. This work also includes the certifying of decision aids themselves, and work to embed the use of decision aids in contracts with providers.

***Creating the Plan for Improving Population Health.*** The Plan for Improving Population Health (P4IPH) moves our state's Prevention Framework forward. Evidence, assessments, and community partnership will lead to implementable strategies to hardwire prevention activities into the ongoing operation of the health and health care system, at the community, regional, and state levels.

***Exploring ways to strengthen workforce capacity.*** Healthier Washington aims to ensure that our health and wellness system has the right workers delivering the right services in the right places, making use of innovative strategies and technologies to provide access and quality. We recognize that a transformed system that seeks to provide whole-person integrated physical and behavioral health care also needs a transformed workforce in order to do so effectively.

***Investing in data analytics and visualization.*** Maturing data and analytic infrastructure will help our state build capacity to translate, analyze, and visualize data from multiple sectors. The capacity developed will provide a foundation for moving to a transformed system that supports VBP, quality measurement, and whole-person care.

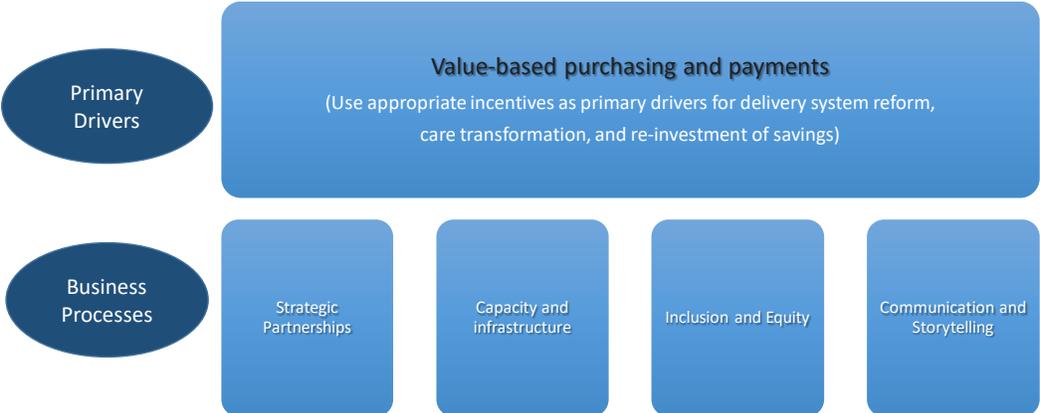
***Maintaining a strong, collaborative governance structure.*** Healthier Washington is, by design, a collaborative effort that involves an array of multi-sector partners at the state, regional, and community levels. The Healthier Washington initiative includes a strong governance structure that facilitates collaborative engagement and transparent communication across state agencies and geographic areas.

***Development a health information technology and health information exchange (HIT/HIE) infrastructure.*** While these are not all SIM investments, Healthier Washington is working to ensure foundational supports for HIT/HIE systems that can be used in whole-person care activities, person and family engagement, and VBP. We are working on a state-run Clinical Data Repository (CDR), as well as creating technical support and guidance for regional HIT investments.

More important than the success of our individual programs, we've also taken a global look at our initiative through the development of a Healthier Washington sustainability framework that elevates financial incentives and innovative payment arrangements as forerunning catalysts for health systems transformation, supported by all of the other strategies, supports, and drivers to achieve sustained and lasting change. This framework can be applied to the holistic system of efforts, and has dictated how we think about what gets left behind when the grant period ends. Instead of sustaining individual programs, we plan to sustain a community health and wellness system firmly rooted in the opportunity and incentives provided by VBP and its supports. Our partners and stakeholders across Washington are working with one another and the State in different ways, and will continue to be a critical voice in this process.

### Healthier Washington's Sustainability Framework

*Vision: Washington State's health systems work together effectively to manage and improve the health of the population*



### The Healthier Washington Sustainability Framework

The Healthier Washington Sustainability Framework focuses on the transformed system rather than its component parts. It does not rely on any single definition of sustainability, and is instead a vehicle for achieving a wide range of systemic outcomes to support the Quadruple Aim of better care, better health, lower costs, and supported providers.

Fundamentally, this framework is about:

- Using appropriate financial incentives as primary drivers for transformation and maintaining a transformed community health and wellness system.
- Shifting the way partners work together within a system to improve the health of the population, as opposed to working within individual silos.
- Sustaining the transformed business relationships in the health care system, rather than solely the programs we've created as vehicles for innovation.

Supporting this vision are business processes that must be developed around:

***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.

## Part 1: End-state vision

By 2019, Washington's health care system will be one where:

- 90 percent of Washington residents and their communities will be healthier.
- All people with physical and behavioral (mental health and substance use disorder) comorbidities will receive high quality care.
- Washington's annual health care cost growth will be 2 percent less than the national health expenditure trend.

Our vision for a transformed health system that endures beyond the life of the SIM grant is one where our three foundational strategies of paying for value, whole-person care, and strong clinical-community linkages are embedded in the health system. This future also includes a climate of partnership, engagement, and mutual support between the state, communities, providers, and the market. While each component of Healthier Washington has a vision for how the work will endure, it is important to also consider the enterprise end-state vision and how each component will contribute to this whole.

At the heart of our vision for a transformed system are appropriate financial incentives to ensure health care quality, population health management, and innovative person-centered strategies that are linked to community supports. In this new reality, people have access to the right care at the right place at the right time, regardless of whether their need is physical, behavioral, or social, if they live in a rural or urban community, or whether they use private insurance or Medicaid. Skills and partnerships have been built with providers to increase health literacy and activation in care, allowing people and their families to experience increased health literacy. Engaged people and families have the tools to make educated decisions about what benefits to choose, when to use care, and whether to obtain certain procedures. Providers at various stages of transforming their practices have tailored support and understand what it will take to enter into value-based contracts, hire appropriate staff, report on performance measures, and effectively manage their patient panels.

ACHs are a critical support mechanism for people and the provider community, since they convene the appropriate sectors to manage the health of populations. We expect them to keep their whole-population ethos at heart, working to meet requirements for the Medicaid Transformation while also considering the needs of the populations in their region, regardless of payer or demographic. We are counting on the ACHs to infuse local sensibility, health equity, and a keen eye to the future of what a transformed system looks like in their particular locality, along with their more formal role under the Medicaid Transformation in transforming care for Medicaid recipients and incentivizing traditional and nontraditional providers to move this work forward. ACHs have a central role in population health, practice transformation, the integration of physical and

behavioral health, rural health innovations, person and family engagement, and identifying how HIT/HIE can support service delivery transformation, so we expect a robust relationship between ACHs and Washington State for many years to come.

Our end state vision also includes transformed state agencies, namely the Washington State Health Care Authority (HCA), the Washington State Department of Health (DOH), and the Washington State Department of Social and Health Services (DSHS), under the leadership of Governor Jay Inslee’s office, since Healthier Washington catalyzed many innovations that have already or will soon be built into the business of state government. This transformation takes the form of improved collaboration and consultation, increased capacity for shared programs, and interoperability in data-sharing. The resultant successes also allow each state agency to focus on their own developed skills and capacity, reducing duplication and introducing increased role clarity.

We intend to continue to evolve so that ACHs can have the data and analytic support they need, DSHS staff and systems are incorporated so that behavioral health integration can be successful at the administrative level, rural health transformation work can continue, PDAs can be certified and incorporated into value-based contracts, and the benefits portfolio for public employees can include value-based options that incorporate risk and population health management. This work also requires state agencies to work together differently, since previously siloed responsibilities have become or are in the process of becoming integrated at the community level. It is critical that our future state maintains these evolved relationships.

While our Sustainability Framework allows us to focus on the systems transformation aspects of this work, it is still paramount to consider the end-state goals for each program we started under SIM. In the following table, we have put together the individual 2019 vision for each of these components, in order to illustrate the legacy we’ve been building toward and hope to achieve.

## 2019 Vision: a programmatic view of Healthier Washington

### Accountable Communities of Health

ACHs are fully functional regional conveners in their respective communities, and are conducting their projects under the Medicaid Transformation while also keeping a whole-population perspective not limited to Medicaid beneficiaries. ACHs continue to partner closely with the State, as well as all partners who contribute to health and health care. ACHs use data and analytics to both understand and manage the health of the people who live in their region, and create effective clinical-community linkages.

## Practice Transformation Support

The provider community and ACHs have heightened awareness of the importance of clinical provider support in health systems transformation, especially in moving providers to VBP. Practice transformation resources, coaching, and technical assistance are available, and there is a roadmap and evidence supporting the types of assistance that works well. Because this support is robust and easily accessible, advances in readiness for VBP, integration, and improved linkages to community resources for providers will be apparent. By 2022, each region will have both capacity for practice coaching created by the ACH efforts and practices that have developed capacity to advance their transformation work on their own. The Practice Transformation Hub Web Portal will continue with private sources of funding to host evolving practice transformation resources that can be used across the state.

## Workforce

The recommendations from the Community Health Worker (CHW) Task Force and information from the Health Workforce Sentinel Network provide a runway for meaningful health workforce policy that is focused on supporting providers in moving to VBP and integrated physical and behavioral health care, as well as link clinical and community providers as team members. This foundation can be seen in how ACHs understand and use workforce related data in their community projects, as well as how engagement of CHWs is built into health programs. Their solutions allow for dynamic care teams and better methods for keeping communities healthy. This foundational work moves us toward enhanced collaboration and engagement between ACHs and education, industry, and others focused on building innovative resources and capacity to train incumbent workers and grow the workforce of the future.

## Shared decision making

Washington State will continue to review and certify PDAs in a variety of treatment areas, allowing for a robust library of high quality aids for providers to use in support of better decision making for their patients. Purchasers will have the resources necessary to require the use of decision aids in their contracts with payers, and the state will continue to offer training and support to other states interested in pursuing this model. These activities will be built into the business of state government to empower patients and their families to seek information through positive interactions with providers in order to make the best, informed decisions for them, which take into account their personal preferences and values.

## Integrated physical and behavioral health care

As a result of integration activities, each Medicaid client will have a single entity accountable for their care. This will create a more holistic approach to care that reduces cost and redundancy, and has a profound impact on quality of life for people

with physical and behavioral comorbidities. The health agencies that administer and pay for this care will be more efficient, and the environment will promote readiness for clinical integration. By 2020, we will be fully integrated statewide. Children impacted by complex trauma, and with mental health issues, will have needed services and be healthier. Our health home vision is sustainable past our demonstration agreement with CMS.

#### Encounter-based to value-based

Under APM4, Federally Qualified Health Centers (FQHCs) and rural health clinics are held accountable for increasing the value of care delivered and are financially rewarded for delivering high quality care. In turn, this allows for innovation in the provision of care in rural areas, so that patients can have the access they need and providers can have the flexibility they need to manage their whole population.

Under the rural multi-payer demonstration, we will have reached agreements in principle on the model, and engaged in a mutually beneficial partnership among Medicare, Medicaid, and commercial payers. Through this work, rural and isolated areas will be able to better integrate and coordinate systems of care, and new financing will create a unique value proposition for both payers and providers. Mitigating exposure where necessary, the transformed system will be able to create operational efficiencies while improving the quality of care delivered.

#### Accountable Care Program (ACP)

All active Public Employee Benefits Board (PEBB) employees can proactively select a health plan and benefit from a robust health literacy campaign. PEBB members will make informed decisions about their health plans and enrollment in VBP options where providers are accountable for the cost and quality of care. Expansion of the ACP in existing and new counties takes place through the addition of more covered lives and new provider groups, which will signal to the market that it is time to move away from fee-for-service arrangements in favor of value-based options. We will continue to share our story with other purchasers to spread and scale VBP arrangements outside of state-financed health care.

#### Greater Washington Multi-payer

The Model 4 test will produce a knowledge base to help providers understand how to use data to manage the health of their populations. Multi-payer claims data will continue to be consolidated into a digestible, actionable format, facilitating population health management and VBP adoption. The lessons learned from this model will allow for continued engagement with other payers in order to support an all-payer data aggregation solution.

### Data and analytics

An advanced analytic function within state agencies is fully operationalized and sustainably funded in the agency model of data governance and decision support. A data warehouse with linkages to high-value external data sources has been built and is being used. This integrated data system is flexibly built to be modified over time to meet high-value use cases related to health systems transformation, including the transition to VBP arrangements, whole-person care, and community engagement. The agency creates reports and dashboards for internal and external stakeholders that present a consistent, timely, accurate, and clear view of agency priorities and accomplishments. Partners and stakeholders are able to access Medicaid claims and encounter data to inform decision making, while protecting the privacy of beneficiaries and complying with federal and state laws. ACHs have access to detailed Medicaid information on patients' use of services, chronic conditions, and providers. This information is available in multiple formats and has consistent designations of key sub-populations.

### Performance measures

We will continue to leverage HCA's internal Quality Measures & Monitoring Improvement (QMMI) process to identify appropriate measures to tie to VBP in contracts, ensuring alignment with the Statewide Common Measure Set to reduce the burden on providers through the reporting of quality measures. Additionally, we will continue to use the oversight of the Performance Measures Coordinating Committee (PMCC) to evaluate the implementation of the Statewide Common Measure Set, ensuring alignment with state and national measurement priorities and requirements. The Washington State All-Payer Claims Database (WA-APCD) allows for additional capacity and depth in price and quality reporting.

### Health Information Technology/Health Information Exchange

Through our integrated and aligned HIT Operational Planning activities, HCA and partners (ACHs, providers, payers, and state agencies) will collaboratively identify and support several data and HIT and information exchange activities needed to support service delivery and payment transformation. This collaborative, cross-sector approach will help ensure that we are responding to local needs and are aware of and seeking to leverage resources available across the state.

# Part 2: State Accomplishments to Date

## Accountable Communities of Health

**Original goals:** Designate regional ACHs, develop governance structure and regional capacity, participate in broader Healthier Washington activities, and develop and strengthen regional partnerships through collaboration.

**Measurable targets:** All nine ACHs are designated by meeting established requirements surrounding governance and shared vision at the regional level. All nine ACHs participate in regular collaboration events with, and independent from, state agencies. Long-term collaboration plan developed to sustain this partnership approach beyond SIM.

**Progress to date:** ACHs designated, regional priorities defined and projects implemented, partnerships established, governance and organizational structures defined and implemented, participation in Healthier Washington activities achieved, including independent collaboration among ACHs (without state facilitation).

**Activities still to complete in AY4:** Active participation in evaluation activities, participation in shared learning events, Medicaid Transformation alignment strategy developed, defined role developed for ACHs as a “partner in purchasing.” ACHs to develop a collaboration plan to sustain the statewide ACH partnership approach beyond SIM.

**Ongoing priorities:** Grow community partnerships and ACH role clarity, support ACH-led population health initiatives, and analyze options for future funding.

## Practice Transformation Support

**Original goals:** Create a culture of quality improvement and shared learning, understand the practice transformation training and technical assistance needs of providers to inform Hub services, make tools and resources available, provide and refer practices to training, technical assistance, and facilitation services in support of VBP transitions, and advance physical and behavioral health integration with a focus on small and medium-sized practices.

**Measurable targets:** Enroll 150 practices in coaching services, deliver at least three trainings to practices.

**Progress to date:** Hub defined as an entity, listening sessions across the state completed, Hub contracts executed for coach/connector support with Qualis Health, Web Portal launched and updated, small and medium-sized behavioral health practices enrolled in coaching services. Practices enrolled in Hub coaching show progress in transformation as measured by the Patient-Centered Medical Home Assessment (PCMH-A) or Maine Health Access Foundation (MeHAF) assessments administered every six

months during engagement with a coach. Hub Portal traffic shows increases in use of resources by more partners accessing more different resources posted to the site.

**Activities still to complete in AY4:** Continue to assess enrolled and non-enrolled practices, continue coaching enrolled practices, close out transition of practices and other sources of technical assistance and practice transformation support by Q4, report final summary status of practice transformation assessments and action plans for enrolled practices, and provide final aggregate assessment data to relevant workgroups, evaluators, and leaders.

**Ongoing priorities:** Options for community-directed practice transformation support once the Hub transitions away.

## Workforce

**Original goal:** Convene the CHW Task Force to develop policy recommendations for the use of CHWs in community health improvement. Recommendations will lead to a workforce that is more responsible to clients, use fewer resources, and improve client adherence to treatment. Implement and respond to the Sentinel Network, a collection of entities providing data on the types of workers and skill sets needed in the current health system. Provide strategic support and consultation to workforce development entities and efforts across the state.

**Measurable targets:** Launch Sentinel Network, support recommendations development by CHW Task Force, participate in DOH-led CHW Learning Community, sponsored by the Association of State and Territorial Health Officials (ASTHO), support development and deployment of DOH CHW strategic plan implementing CHW Task Force recommendations, explore opportunities to integrate CHW Task Force and DOH CHW strategic plan recommendations by leveraging HCA purchasing activities, participate in Health Workforce Council Steering Committee to design and implement Sentinel Network Sustainability plan.

**Progress to date:** The CHW task force was convened and produced a list of actionable policy recommendations to promote the uptake of CHWs and allow for improved outcomes. Elements of these recommendations are being implemented through Medicaid Transformation projects. The Sentinel Network dashboard was implemented and continues to publish data, at the state, ACH, and county levels. Healthier Washington has an ongoing presence in the development and implementation of workforce development strategies in Washington.

**Ongoing priorities:** Exploring continued pathways for sustainability through support of Medicaid Transformation activities. HCA is participating on a Health Workforce Council Steering Committee informing the development and implementation of a Sentinel Network sustainability plan funded by the 2018-19 Washington State budget. HCA is

participating in a CHW Learning Community. This project continues to design and implement the CHW Task Force recommendations.

### Shared decision making

**Original goal:** Develop an innovative model to certify PDAs in Washington that builds on key legislation and can be spread to other states, train and coach providers in the use of PDAs with clients, and implement the state certification model within HCA.

**Measurable targets:** Up to 300 providers will be trained in shared decision making.

**Progress to date:** The PDA certification process was developed, approved, and implemented in HCA. Language was added to the Accountable Care Program (ACP) contracts requiring the use of certain PDAs in patient care. Several PDAs in three different categories were reviewed and certified. Providers have been trained in shared decision making using an online skills course, and in the implementation of shared decision making into practice workflow with the use of PDAs. A sustainability plan has been developed and is in the process of being implemented. Engagement events have taken place in other states to spread knowledge and structures for certifying and promoting the use of PDAs.

**Activities still to complete in AY4:** Convene stakeholders to develop a roadmap for sustaining and spreading shared decision making in Washington and promoting the use of certified PDAs, develop a sustainable online training for providers, finalize implementation plan for sustaining and spreading shared decision making, develop shared decision making contract language with Managed Care Organizations (MCOs) and Medicaid Program partners for 2019 Medicaid MCO contracts, repeat process for 2019 PEBB contracts.

**Ongoing priorities:** Spread and scale: additional PDAs, more contractual obligation to use, greater reach to more providers and key stakeholders.

### Integrated physical and behavioral health care

**Original goal:** Implement activities needed to achieve integrated purchasing of physical and behavioral health (integrated managed care, or IMC) in all regional service areas by 2020.

**Measurable targets:** All regional service areas have implemented IMC.

**Progress to date:** Two regions, Southwest and North Central have implemented IMC to date, and five ACHs and two transitional counties have pledged to implement in AY4. These implementation activities include procurement of MCOs in early and mid-adopter regions, modification of information systems, approval from federal/state regulators,

implementation of early warning system, and education, outreach, and technical assistance to providers, organizations, clients, counties, and plans.

**Activities still to complete in AY4:** Continue support of North Central region through first implementation year, successfully implement IMC in the five additional regions and transitional counties, transition IMC operations to Medicaid Program staff, successfully transition the DSHS Behavioral Health Administration (DSHS-BHA) staff and administrative workload into HCA to complete agency administrative integration.

**Ongoing priorities:** Maintenance of financial integration across the state, implementation of clinical integration.

### Encounter-based to value-based

**Original goal: FQHCs/RHCs:** FQHCs and Rural Health Clinics (RHCs) to a new payment methodology (APM4) that incentivizes value over volume while still keeping these centers whole and allowing for innovative care arrangements that work better for rural populations.

**Critical Access Hospitals:** Design a new facility type designation that “right-sizes” CAHs to the community they serve. In the long term, leverage investments under Payment Model 2 to maintain Washington’s acute and primary care backbone for rural communities. Partner with CMMI to secure Medicare participation to provide a pathway for new payment and delivery models.

**Measurable targets:** Implement APM4 in a pilot selection of FQHCs and RHCs. Originally, CAH work targeted a financially stressed subset of Washington’s Critical Access Hospitals. In AY3, CAH work was expanded to endorse all rural providers in Washington State. In AY4, the target is to reach principled agreement with providers, commercial payers, MCOs, and CMS.

**Progress to date:** APM4 has been implemented in a subset of FQHCs and RHCs in Washington State.

The CAH work has evolved over AY3 of SIM to be a more inclusive multi-payer demonstration that does not look to change designation of facility type, instead focusing on all-payer participation in a new rural hospital payment model. This work has kicked off in earnest in AY4, and stakeholder engagement and model development activities are in motion, with a goal to finalize an agreement with CMS by the end of AY4.

**Activities still to complete in AY4: APM4:** Recruit additional clinics and health centers into APM4, and compile and review lessons learned for spread and scale. **Rural Multi-payer:** Agree upon a Medicare waiver for a rural multi-payer model, obtain commitment to pilot the model from providers, create an alignment and implementation plan for Healthier Washington initiatives, and reach agreement with CMS that the model

qualifies for advanced APM status under the Medicare Access & CHIP Reauthorization Act (MACRA).

**Ongoing priorities:** Robust data collection for evaluation of programs in Models 2, ongoing support of innovative care models in rural regions, implementation of rural multi-payer model after agreement with CMS.

### Accountable Care Program

**Original goal:** In order to improve the health, experience, and quality of care for PEBB members, an accountable care option for state employees will be implemented in the five-county Puget Sound region. Networks will have agreed to risk-based contracts, assuming clinical and financial risk of members who choose or are attributed to one of the network options during open enrollment. The original vision also included exploration of spread and scale of the model, as well as employing a multi-purchaser strategy to spread use of accountable care benefit options statewide.

**Measurable targets:** Engage the Washington State Health Benefits Exchange, Qualified Health Plans, and other health plans in VBP and other Healthier Washington payment models, explore implementing bundles into ACP, expand ACP into additional counties, develop and implement sustainability plan for ongoing value-based offerings in public and school employee benefits.

**Progress to date:** The ACP was implemented at HCA in the 2016 plan year, and exploratory conversations for network expansion are ongoing. PEBB member enrollment in the program has grown since its inception, from 10,000 in 2016 to 25,000 in 2018. Currently, both networks coordinate care for more than 85,000 PEBB members (designated and attributed).

During the same time, the program has expanded geographically, from five counties to nine. One or both networks in 2016 (Year 1), the only year in which results are available at this time, performed had 5 percent or greater improvement on all eight chronic condition management measures; and one or both ACPs had 5 percent or greater improvement on all four preventive care metrics.

The 2018 premium for the accountable care option is currently less than 55 percent less than Classic PPO. Also, the program had encouraging quality and financial performance in the first year.

**Activities still to complete in AY4:** Continue engaging employer groups to promote VBP, develop ACP sustainability plan, increase enrollment and state employee literacy, continue engaging health plans in Healthier Washington payment models.

**Ongoing priorities:** Improvements in health literacy, renegotiation of contracts to continue and evolve value-based arrangements, evaluation.

## Greater Washington Multi-payer

**Original goal:** Create a multi-payer network with the capacity to coordinate care, share risk, and engage a large population comprising commercial, Medicaid, public employee, and Medicare beneficiaries. Claims and clinical data integration and aggregation will provide a unified view of patient care and timely feedback to providers, regardless of payer, facilitating improved care coordination and population health management.

**Measurable targets:** In AY3, HCA onboarded two MCOs to share client assignment, files enabling HCA to extract and share encounter data with PM4 contractors. This marked the true implementation of the model. Moving forward, HCA will be able to measure and track over time the number of providers and Apple Health (Medicaid) clients involved in the model. AY4 will reveal a truer sense of the model's impact on contractor willingness to engage in VBP. Nevertheless, it will likely take more time beyond SIM to test this concept fully, a test to which we are committed.

**Progress to date:** A Request for Applications for a lead organization to coordinate the model did not receive bids, so a simpler data aggregation strategy was undertaken with a rural provider network and an urban provider network. Networks entered into subcontract agreements with data aggregation entities, and were able to receive Medicare and PEBB data to support patient care and care coordination activities beginning in AY3.

**Activities still to complete in AY4:** Explore episodes of care and/or bundled payments in Medicaid, continue supplying claims data to contractors, continue to explore incorporation of Model 4 provider network partners into ACP networks or other Healthier Washington payment models.

**Ongoing priorities:** Promote MACRA alignment, develop equity and inclusion processes, seek opportunities for scalability, defined and expanded data collection in solution, evaluation.

## Data and analytics

**Original goal:** 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 service as a key tool to implement health improvement strategies in Washington. Specific goals include: developing capabilities to gather and analyze data, provide technical assistance to support community population health management and local public health, creating the capability to share analytics across state agencies to improve population health, make data available so we can make smart changes in the health system and move to paying for value.

**Measurable targets:** Analytics, Interoperability and Measurement (AIM) is 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 research and analytics team with the platform and

tools to facilitate implementation, formative evaluation, and continuous improvement through the four-year SIM project.

***Progress to date:*** Invested in analytic infrastructure, procured a master data management tool, built data-sharing partnerships across state agencies, developed and released several versions of public-facing data dashboards, created and distributed data products to support community projects, supported Clinical Quality and Care Transformation division analytical requirements, supported data requirements for state and federal SIM evaluations; supported data acquisition and analysis for Healthier Washington payment models and evaluation efforts.

***Activities still to complete in AY4:*** Continue delivering data products for Healthier Washington payment models, conduct training for AIM staff to increase analytic capacity, coordinate and deliver analytical data needs for SIM evaluation to University of Washington Department of Health Services (SIM state evaluator) and, RTI International (SIM federal evaluator); and provide ongoing project management to AIM projects.

***Ongoing priorities:*** Increase capacity and capabilities, expand to support Medicaid Transformation, support Greater Washington Rural Multi-payer program, continued analytical support of the clinical collaboration and initiatives, and complete roll-out of WA-APCD.

#### Performance measures

***Original goal:*** Convene the governor-appointed PMCC to develop the starter set of measures for the Statewide Common Measure Set, and subsequently review and approve new measure topics to continue to evaluate and evolve the measure set over time.

***Measurable targets:*** By December 2014 the PMCC will develop a starter set of 34 common measures that will be used for public reporting and to inform state health purchasing contracts.

***Progress to date:*** The PMCC developed the starter set of measures for the Statewide Common Measure Set, and has continued to convene quarterly to evolve the set over time. The Washington Health Alliance evolved the Community Checkup Report, an annual analysis that reports on the measure set.

***Activities still to complete in AY4:*** Continue to convene the PMCC quarterly through the end of AY4, develop a process with QMMI to provide recommendations and communication to the PMCC, publicly report results for the Statewide Common Measure Set, using a web-based platform, deliver pricing and quality data for the Statewide Common Measure Set on health care quality and cost.

**Ongoing priorities:** Spread and scale: annual growth in number and quality of measures, continue to define value in terms of VBP measures, evolve the PMCC to be more engaged and active in systems transformation.

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

**Original goal:** Analyze gaps and build capacity for state HIT/HIE guidance and solutions to promote interoperability and coordinated care. While there are few direct SIM investments in this work, it is an agency alignment activity that includes SIM deliverables through the development of an HIT Operational Plan in 2017.

**Measurable targets:** We established an HIT Strategic Roadmap and Operational Plan that identifies tasks needed to support service delivery and payment transformation. The HIT Strategic Roadmap and Operational Plan 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., CDR). 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.

**Progress to date:** The HIT team has engaged with the ACHs to understand the HIT/HIE capacity of providers in their regions and developed targeted technical assistance to support the integration of HIT/HIE into their regional projects under Medicaid Transformation. To date, HCA has hosted four informational webinars that focused on assessing providers' HIT/HIE capacities; promoting a common understanding of HIT infrastructure within Washington State and efforts that are occurring nationally; providing information on the functions and data sources/systems that can be supported/leveraged by population health management systems; and the HIT foundational elements and technical capabilities that are needed to support population health management and HIE.

HCA held individual meetings with ACHs to understand their regional needs and differences, and the supports from HCA, DOH, and federal partners that would help advance the use of HIT and HIE for providers in their regions.

HCA initiated a multi-agency Substance Use Disorder (SUD) Consent Management Workgroup to address SUD consent management with a planned pilot to occur in Q3 and Q4 of 2018.

Further, HCA in collaboration DSHS, requested and received approval from the Substance Abuse and Mental Health Services Administration (SAMHSA) to streamline required behavioral health data reporting that will meet HIT interoperability goals.

**Activities still to complete in AY4:** The SUD Consent Management Workgroup will develop educational resources regarding 42 CFR Part 2, develop a standard consent form that could be used in either paper or electronic environments, plan a pilot for the (paper and/or electronic) use of the consent form, and explore consent management solutions for the electronic exchange of SUD information subject to 42 CFR Part 2.

We will gather information about the different provider directory and patient identifiers used across programs and agencies and their scope. This information will help inform the identification and consideration of options that the HCA will consider to support, enable, and sustain high quality, integrated, whole-person care across care continuum.

We will work to advance providers' use of HIT/HIE to support high quality, integrated services. HCA has provided information to ACHs regarding the functions and data sources/systems needed for population health management systems. HCA will continue work in this area, including identifying the data needs and sources to support and sustain quality measurement and improvement activities.

We continue work on establishing and articulating data governance policies regarding data sharing for data classified at different levels.

We are developing an HIE/CDR Strategic Roadmap for the next 24 months. A key milestone in 2018 will be the opening of the CDR portal.

**Ongoing priorities:** Continued implementation of HIT Operational Plan, completion of agency data warehouse and data governance processes, go-live and ongoing enhancement of the CDR.

## Additional state efforts

### Population Health Goals

Our partners in this population health work include both DOH and Kaiser's Center for Community Health and Evaluation (CCHE). In AY3, CCHE helped to guide the development of the Population Health Work Plan, create an inventory of existing initiatives, and coordinate a needs assessment, all focused on diabetes.

Dedicated efforts to create a focused roadmap for population health in Washington State are longstanding, with the pre-work for P4IPH coming from the 2014 Prevention Framework. As a reminder of the origins of this work, the objectives of the Prevention Framework are:



*On Target*

**Objective one:** By December 31, 2018, Washington State will increase the proportion of the population who receives evidence-based clinical and community preventive services that lead to a reduction in preventable health conditions.



*On Target*

**Objective two:** By December 31, 2018, Washington State will increase the proportion of the population with better physical and behavioral health outcomes by engaging individuals, families, and communities in a responsive system that supports social and health needs.



*On Target*

**Objective three:** By December 31, 2018, Washington State will increase the number of communities with improved social and physical environments that encourage healthy behaviors, promote health and health equity.



*On Target*

**Objective four:** By December 31, 2018, Washington State will increase the number of integrated efforts between public health, the health care delivery system and systems that influence social determinants of health to lower costs, improve health, improve the experience of care, and contribute to the evidence base.

## The Population Health Planning Guide

DOH has continued to support the [Population Health Planning Guide](#) to help partners throughout the health and wellness system successfully apply a population health approach to health issues in their communities. The guide is no longer funded through SIM but is still an important resource for system partners.

The guide offers tools and resources that can be applied to SIM and to complementary projects. It offers an evidence-informed framework and a common vocabulary.

Drawing on research, best practices, national expertise, and input from local stakeholders, we identified key elements of a population health approach which may prove effective in improving health and reducing costs. These key elements are aligned with evidence-based public health and may be applied to multiple health issues:

- Assess the health of the population

- Health equity
- Social determinants
- Engage partners and community
- Identify populations of concern
- Develop and prioritize interventions
- Implement interventions
- Build sustainability
- Measure results
- Communicate what is learned

Resources and tools for ACH communities (or a single community partner coalition, or multi-sector partnership) are provided in the guide for each of these elements.

The guide also provides information on specific health issues identified as priority focus areas for SIM and complementary health projects. Health issue information includes current work and initiatives, emerging issues, health equity concerns, key data and sources, and recommended strategies.

## Financial Goals and Goal Targets

In the Healthier Washington driver diagram, we articulate three clear goals:

By 2019, Washington's health care system will be one where:

- 90% of Washington residents and their communities will be healthier.
- All people with physical and behavioral (mental health/substance abuse) comorbidities will receive high quality care.
- Washington's annual health care cost growth will be 2% less than the national health expenditure trend.

The importance of the 2 percent cost growth savings cannot be overstated. This goal was also part of the Delivery System Reform Incentive Payment (DSRIP) Program application and a foundational element for receiving the Section 1115 waiver, the Healthier Washington Medicaid Transformation.

Additionally, a critical agency policy target is now: move 90 percent of state-financed health and 50 percent of commercial health care into VBP arrangements by 2021.

**Table 1** presents measures for monitoring the annual progress toward achieving an 80 percent target for state-financed health care and the 50 percent target for commercial payers. For state-financed health care, separate counts and percentages will be computed for the Medicaid and UMP populations.

Table 1. Measures for monitoring annual statewide progress toward value-based payments for state-sponsored and commercial payers

<b>Category 1 Payments: Fee-for-service with no link of payment to quality in Washington</b> <ul style="list-style-type: none"><li>• Beneficiary count</li><li>• Percentage of payments to providers</li></ul>
<b>Category 2 Payments: Fee-for-services payment linked to quality in Washington</b> <ul style="list-style-type: none"><li>• Beneficiary count</li><li>• Percentage of payments to providers</li></ul>
<b>Category 3 Payments: Alternative Payment Models in Washington</b> <ul style="list-style-type: none"><li>• Beneficiary count</li><li>• Percentage of payments to providers</li></ul>
<b>Category 4 Payments: Population-based Payment in Washington</b> <ul style="list-style-type: none"><li>• Beneficiary count</li><li>• Percentage of payments to providers</li></ul>

## Part 3: Changes in State Landscape

Washington State has made substantial progress toward health systems transformation and the movement to VBP, largely supported by the SIM grant and other multi-sectoral efforts and partnerships. However, we still have work to do in order to achieve our goal to move 90 percent of state-financed and 50 percent of commercial health care into VBP arrangements by 2021. We are continuing to spread and scale our existing efforts by leveraging our state purchasing power and practice transformation support resources, but we will not be able to meet these goals without continued partnership with CMS/CMMI and through Medicare participation.

To this end, we have participated in Requests for Information over the past year to provide input to CMMI about the type of support and programmatic elements we need to continue at the forefront of health systems transformation and achieve this support.

At the state level, there have been some changes to the health care delivery landscape, including further consolidation of health systems and continued population growth.

Many private health care entities in Washington are engaged in our Health Innovation Leadership Network (HILN) or are engaged in action committee efforts. Their active engagement allows us to gauge the “pH” of the health system and the innovations catalyzed by Healthier Washington. We will continue to use these types of partners as critical sources of information moving forward.

The PMCC is active in developing and growing the measure set, continually committed to engaging in new and more dynamic ways to drive improvements in the health system.

### Political transitions or market changes impacting SIM

Washington State’s Section 1115 waiver, [Healthier Washington Medicaid Transformation](#) (Medicaid Transformation) was approved in January 2017. The Medicaid Transformation will further accelerate and support the State’s efforts to improve the health and care delivered to our state’s Medicaid population. The effort focuses on clinical delivery system improvements in Medicaid such as addressing the opioid crisis and physical-behavioral health integration, as well as broadening the array of service options that enable individuals to stay at home and delay or avoid the need for intensive long-term services and supports.

Anticipated state policy changes:

- The Washington State Health Benefits Exchange may be exploring value-based standards and activities.

- HCA will purchase health benefits for the School Employee Benefits program (SEBB) starting in January of 2020, increasing HCA’s total covered lives to 2.5 million Washingtonians. The design and implementation of this program will require procurements for partners and may impact VBP goals in different but positive ways.

### State insurance shifts/signals:

- HCA has engaged in ongoing discussions with the Washington State Health Benefits Exchange, collaborating on strategies through which to advance VBP through Qualified Health Plans.
- HCA signed a new contract with Regence to be the Uniform Medical Plan (HCA’s self-insured medical plan for public employees) Third Party Administrator beginning January 1, 2020. The contract requires Regence to extend ACO-type models similar to HCA’s ACP, to the rest of its “book of business.” This contract also includes incentive payments and performance guarantees linked to performance on quality metrics and attainment of VBP goals.

### State leadership changes

- Sue Birch is the new Director for the Health Care Authority, replacing Dorothy Teeter.
- Cheryl Strange is the new Secretary for the Department of Social and Health Services.
- Dr. Daniel Lessler, HCA’s Chief Medical Officer, will be departing in July 2018. Recruitment is ongoing.
- Jason McGill replaced Dr. Robert Crittenden, senior health policy advisor to Governor Jay Inslee.
- Megan Atkinson replaced Thuy Hua-Ly as HCA’s Chief Financial Officer.
- Jerry Britcher replaced Adam Aaseby as HCA’s Chief Information Officer.
- Mich’l Needham has replaced Nathan Johnson as HCA’s Chief Policy Officer.

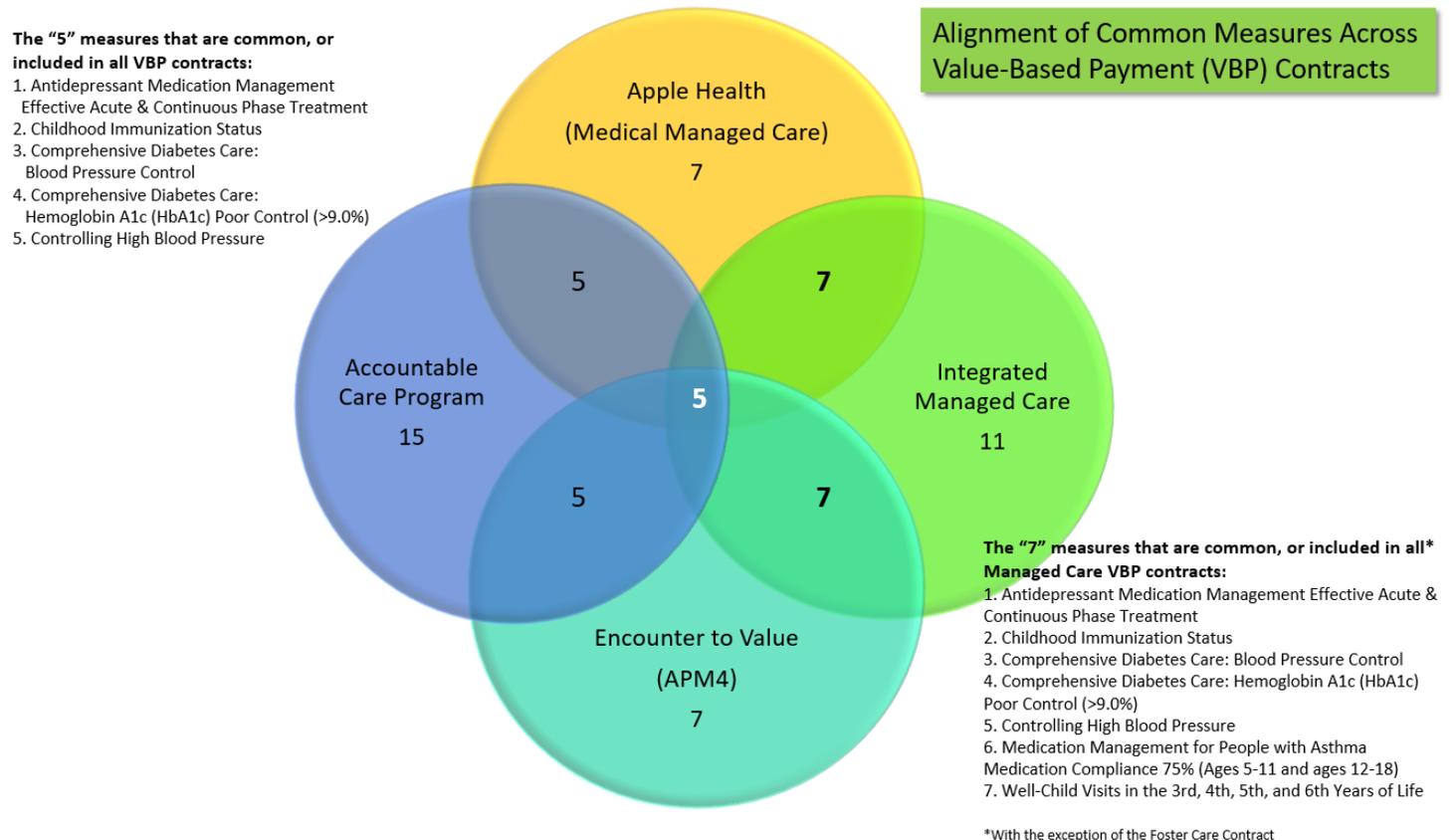
### Participation

Over the course of the SIM grant Washington has seen significant movement in payer and provider participation in VBP and practice transformation efforts. We have employed multiple methods to engage these stakeholders over the course of the SIM grant. This includes broader stakeholder efforts and alignment activities, as well as contractual agreements under the scope of SIM. These mechanisms and activities include:

- Establishing community forums through ACHs for system transformation and the cultivation of regional priorities. Regional ACHs have been active partners engaging both payers and providers at a community level in service to SIM priorities and the Quadruple Aim.
- Continued engagement and multi-stakeholder engagement through the HILN. Over the course of HILN, both payers and providers have participated as thought partners in service to health systems transformation and payment reform.
- The certification and provider implementation of PDAs.
- Implementation of four separate payment models and expansion of these payment models over time.
- Implementation of MCO quality withhold.

## Alignment of quality measures

Under Healthier Washington, we have done significant work to align quality measures in state contracts. The following figure shows a visual crosswalk of measure alignment:



## Part 4: Lessons learned

Along the way, we have learned some valuable lessons. Our sustainability framework was built upon the key learnings from the SIM grant activities. Understanding the business processes we have to leverage is critical to capturing our overall learnings from this innovation work:

***Strategic partnerships:*** Health systems transformation and innovation is not possible without relationships, and we have worked hard to build these relationships across the state. Our HILN, comprised of public and private decision-makers and advocates across the health system, is a key force for spreading this work and changing the environment to achieve the Quadruple Aim. As we move forward, we will need to continue to draw in partners from all parts of the health system, including new partners we have not yet brought to the table.

***Capacity and infrastructure:*** In order to continue transformative work, building the internal capacity to continue moving forward without additional grant funding is of critical importance. We learned early that in order to move our payment models from pilots to new ways of purchasing and delivering care, agency and community capacity investments need to be made so that work can continue. Making these realizations early, we have invested in data and analytics capacity, incorporated shared decision making processes into agency business, built integrated managed care and the ACP into agency operations, and focused on investments that allow for continued capacity and incorporation of health systems transformation work into how the state purchases, supports, and coordinates health and wellness.

***Inclusion and equity:*** We learned early on that elements in support of health equity should not be an afterthought or a box to be checked. In order to address health disparities and make gains in improving the health and wellness of everyone in Washington, specific attention must be placed on incorporating vetted health equity tools into our program and policy work, and ensuring our processes include voices that are not traditionally at the table in development and decision-making.

***Communication and storytelling:*** Through conducting this work at a high level, we learned that communicating the real impact of the work in a plain-talked, understandable way is vital to the rest of the state understanding what our aims are and how they can participate and be supported. We launched the Voices of a Healthier Washington Story Bank in Award Year 3, using real stories to communicate our work. We also have reacted to community requests to be more transparent, and have implemented webinar series, posted information to our website, and continued to have conversations and evolve the work with our community.

Within our specific initiatives, there were also a number of lessons learned:

## Accountable Communities of Health

There is a balance between developing form to support functions and allowing the form to adjust to the functions. ACHs spent a lot of time developing and forming before identifying (or the state identifying) a clear purpose and related levers. This was somewhat necessary in order for the partnerships to mature, but it also led to challenges in terms of engagement and commitment. Many adjustments to the governance and engagement structures were necessary, but the years of initial forming still better positioned ACHs to make these adjustments and to evolve more rapidly. This will likely remain true going forward as new levers and roles are identified, potentially requiring ACHs to adjust accordingly.

It has been a challenge balancing the immediate needs surrounding integration and practice transformation while recognizing the opportunity of true systems change that incorporates social determinants and a life-course approach to health and wellness. There is a tendency to think it is one or the other (clinical or upstream). ACHs are a unique construct to support this systems change that reinforces clinical-community linkages, but ACHs have looked for clear signals or levers from the payment perspective, including how we define and measure value. It's a question of which comes first, the payment to drive a new definition of value or the mechanism to link a system and support population health management in order to succeed in a new VBP environment?

## Practice transformation support

Providers engage in practice transformation activity when they can see the financial sustainability of the work they undertake: for example, they can see the business case and know what is in it for them. They understand how VBP will translate into their contracts and understand how to focus their transformation efforts on particular measures, populations or systems improvements.

Coaching and training are not as effective as separate activities: group learning complemented by targeted technical assistance and on-the-ground coaching support is more effective than any of those activities on their own.

The connector function was essential not just to support practice change in one provider setting at a time, but also to support regional and system-level changes. Transformation requires connection of the dots among payers, state agencies, providers, and community organizations. Practice Transformation can no longer be successful without being connected to larger change in the health neighborhood.

Practice transformation is often mistaken as general technical assistance and not all providers or stakeholders understand the holistic change management approach offered through evidence-based practice coaching.

Transformation activities need to be flexible and fit the resources and patient mix of any setting, whether it is an FQHC, a community behavioral health agency, or another unique practice type. One size does not fit all.

Connecting coaches with each other to share successes and insights is invaluable to improving the quality and responsiveness of coaching practice across the state.

Practice transformation support is time intensive and expensive, but necessary to support progress.

### Workforce

Practice transformation builds a foundation for framing and designing workforce development strategies and integrating workforce development planning across the health care delivery system and community-based organizations.

Workforce development will require building new partnerships and education pathways to establish new paraprofessional roles and build a focus on incumbent worker training, in order to support role redesign using new skills and competencies.

Change management strategies must be integrated into workforce development planning and implementation to support integration and partnership between health professionals and the emerging roles of paraprofessionals in a transformed delivery system.

### Shared decision making

After testing three rounds of certification of PDAs using individual consultant contracts with topic-specific experts, we learned it makes more sense to contract with one organization or entity that specializes in conducting evidence-based reviews. We learned it is more important to have experts who are able to validate the evidence, rather than those who are experts in the topic area.

It is difficult to eliminate bias in PDAs and it is very important that we maintain fidelity within our review panel and ensure they receive training on how to apply the certification criteria to the review process.

### Integrated physical and behavioral health care

Each region has operated differently under the Behavioral Health Organization structure and has its own strengths and challenges. Knowledge transfers to educate MCOs and Behavioral Health ASOs on behavioral health programs and services is critical to successfully transitioning each region, and ensuring a smooth transition for clients.

Integrated managed care has a substantial impact on behavioral health providers' billing and IT systems and processes, so it is important that these providers obtain specific billing and IT technical assistance before and during the transition.

It is critical that behavioral health agencies are upfront and clear about what payment methodology works best for them, and they should work with each payer to identify applicable invoicing procedures prior to implementation in order to avoid payment lag.

Integrated payment is only one lever to achieve whole-person care. Administrative and clinical integration designed through the person and family experience are critical components to address in conjunction with financial integration.

### Encounter-based to value-based

Data processing and transmission requires significant administration and resourcing. APM4 reporting timelines were adjusted to account for these administrative needs.

It is important to drive toward targets and timelines. However, historical issues remain and stifle further innovation. It is important to continue addressing past issues and challenges in an ongoing forum.

### Accountable Care Program

PEBB members are price-sensitive: the 2018 enrollment successes could be attributed to the new, lower program premium.

Supporting ACP networks' care transformation and financial monitoring activities with the appropriate membership and claims data is essential to the networks, challenging to implement and maintain, and is resource-intensive.

### Greater Washington Multi-payer

The process for receiving client assignment files from MCOs and using them to identify, pull, and transmit encounter data was new and ultimately very challenging to implement. It is likely we overestimated the capacity of providers and payers in Washington State to engage in a model like this to the degree originally envisioned.

### Data and analytics

Building successful analytics infrastructure requires significant coordination with the HCA enterprise approach. Flexibility to adjust to this approach as it evolved was crucial and challenging.

Engaging in positive working relationships with ACH data teams was paramount to a successful and effective data strategy and led to success in providing value-added products.

Understanding the significant level of resources required for successful and effective data management and data governance is critical to success. In addition, attracting and retaining technical staff to support the analytics program has been an ongoing challenge.

**Performance measures**

As we have continued to evolve the Statewide Common Measures Set, the PMCC has expressed interest in evolving their role. While they have expressed excitement with seeing the measures put into contracts, they feel that the publicly reported results demonstrate that as a state there are many opportunities to improve. They want a more action-oriented role, and we are currently working with them to identify how we can leverage their expertise to focus on a few key areas to promote improvement.

We continue to work on alignment of measures in the Statewide Common Measure Set with other measure initiative work and have not been able to streamline the selection of measures that inform VBP arrangements and ensure there is alignment, where possible, to reduce burden in reporting on multiple measures.

**Health Information Technology/Health Information Exchange**

If interoperable HIT concepts and strategies are woven into the design, development, and implementation of programs, policies, and guidance, the execution of these strategies will be better linked to overall objectives, and our goals of data-driven decision-making and population health management will be more easily reachable.

**Operationalization and sustainability status of SIM investments**

Initiative	Status
Accountable Communities of Health	Fully operationalized. Ready to wholly transition from SIM funding in February 2019, and will be sustained in the near term by Medicaid Transformation funding. Conversations are ongoing to determine what the policy-defined role of the ACH will be beyond 2021, through Healthier Washington sustainability planning.
Plan for Improving Population Health (P4IPH)	Fully operationalized. Population Health Planning Guide was implemented into the business of DOH. P4IPH strategies and elements have been intentionally woven into ACH work through Medicaid Transformation projects and state agency staff support.

Initiative	Status
Practice Transformation Support Hub	Practice transformation support through the Hub has been realized, and the decision has been made to phase out the formal state-managed Practice Transformation Support Hub, run by Qualis Health. State agency capacity and subject matter expertise in practice transformation remains, though the function of practice transformation support is now an external responsibility.
Shared decision making	Fully operationalized and ready to embed into HCA operations by the end of AY4. SIM funds are currently being used for training and sustainability plan development as this transition is realized.
Workforce	All SIM deliverables have been met. Work will continue around workforce development for Medicaid Transformation project support in ACH regions, in partnership with ongoing practice transformation support.
Integrated physical and behavioral health care	All required deliverables have been met to-date, and the Medicaid program continues to embed programmatic elements into agency business, with support from DSHS-BHA staff who are transitioning into HCA. Significant work to support additional mid-adopters and on-time regions by 2020 will be ongoing before this work can be fully operationalized and the changes sustainable. All elements are in place to reach these goals.
Encounter-based to value-based	<p><i>APM4:</i> All required deliverables have been met for the APM4 pilot, and many operational elements have been embedded into HCA business. Spread and scale of this work can occur without additional grant funding, and pending evaluation efforts will allow for the full development of a sustainability strategy.</p> <p><i>Rural Multi-payer:</i> Currently in development. Moving forward in partnership with CMMI to reach agreement on Medicare participation that would allow for continued development and implementation of this rural health transformation approach.</p>
Accountable Care Program	Operationalized and embedded into the business of HCA. Work will continue to sustainably increase enrollment into the ACP, and improve member experience and patient engagement. Outreach to purchasers and

Initiative	Status
	payers, and VBP alignment right-fit care transformation expectations and activities, will continue through agency staff support.
Greater Washington Multi-payer	Awaiting sustainability strategy development and continuing to develop operationalization. This pilot has led to valuable lessons in market readiness, and a robust data aggregation strategy pilot. It is likely that this work will combine with other Healthier Washington payment models and not continue as its own project.
Data and analytics	SIM deliverables have largely been met, and decisions around agency business processes are ongoing. Investments related to data and analytics have never been a project so much as a strategy to increase state capacity in this realm.
Performance measures	Awaiting sustainability strategy development. The PMCC will continue to convene post-SIM to evaluate and evolve the Statewide Common Measure Set. The WA-APCD remains in project mode at this time. Products from the APCD will be available Q3 2018.

**Looking to the future: Washington beyond SIM**

Healthier Washington, catalyzed by investments from the SIM program, have moved steadily onward since the grant period began in 2015. We have largely accomplished what we set out to, and have a multitude of partnerships, successes, and lessons learned to draw from. Deviations we took from original plans were largely due to market shifts and market readiness, the introduction of new ideas, collaborations, or evidence, and alignment with our Medicaid Transformation waiver.

However, our work has just begun. Along with continuing to implement our current efforts, we must create a vision for sustainability that is coordinated with and draws from everything else that is happening to transform the health system in Washington. We have convened a Healthier Washington sustainability strategy workgroup to create our Healthier Washington Sustainability Roadmap, comprised of members across and outside of Healthier Washington. We hope the strategic perspectives brought by those members can create an inclusive, collaborative, and feasible plan for the continued implementation and operationalization of this work. We also look to the guidance and partnership of our legislature, tribal governments, health system stakeholders, consumers, and other subject matter experts across the state.

We look forward to continuing to deliver on the SIM work, aligning with outside efforts, and continuing to transform and innovate in pursuit of the Quadruple Aim.