HealthierHere

Quality Improvement Strategy

The Quality Improvement Strategy is a living document and is continuously updated; this version of the Strategy reflects updates from July to December 2019.

Introduction

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

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

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

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

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

HealthierHere's expectations around clinical and tribal partner QI are further detailed in the clinical summaries under "Utilize Population Health Management Tools." Expectations include:

- Use EHRs and registries to (1) identify individuals and the services they need and (2) share integrated care plans and summaries of care, as appropriate and allowed by law, with primary

care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.

- Measure and monitor against a defined set of indicators to track progress.
    - HealthierHere developed a dashboard based on Medicaid claims data that provides insight into regional performance and, where feasible and appropriate, partner-level performance data.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

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

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

HealthierHere's QI expectation for community partners is that their quality monitoring approaches are value-driven and based on the unique needs of the organizations and the communities they serve. Informed by clinical measures, HealthierHere will work with community partners in 2020 to establish culturally responsive measures, including "proxy measures" that track progress related to the impact of SDoH on clinical metrics. While proxy measures will be developed with community partners by Q2, anticipated examples of proxy measures may include, but are not limited to, the following: increased numbers of clients accessing the physical and behavioral healthcare system, increased numbers of clients accessing substance use disorder treatment and prevention services, increased numbers of community-based chronic disease support and self-management programs, and increased numbers of community members utilizing the services of traditional healing and medicine to achieve improved health outcomes. These proxy measures will capture the impact of SDoH services provided in a community setting and the anticipated correlation to improved health outcomes through demonstrating a positive impact on the Medicaid Transformation Project (MTP) metrics, including through reducing the numbers of unnecessary emergency department visits. This reporting will take place semi-annually, in sync with the reporting calendar for clinical partners.

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

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

HealthierHere's core value of equity will be woven throughout our work. QI success is not simply achieving clinical metrics, but also moving partnering providers on the continuum of being increasingly culturally and linguistically appropriate and relevant for the people they serve. Trainings on "Targeted

Universalism" and "Othering and Belonging" were provided to all clinical and tribal partners in 2019 and will be provided to community partners in 2020. Additionally, HealthierHere's Equity Measures Workgroup developed and recommended a set of equity measures based on feedback from HealthierHere governance committees and stakeholders. These efforts were guided by HealthierHere's Equity Definition and Guidelines, approved by the Governing Board. HealthierHere will collect and report on baseline data for these equity measures in 2020.

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

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

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

1. Build Infrastructure and Capacity

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

Learning and Co-design Collaboratives – All Partners

HealthierHere established Learning Collaboratives for each of its four transformation projects, and these convenings evolved into Co-design Collaboratives in the second half of 2019. These in-person meetings provide a rare opportunity for partners from different sectors – along with representatives from managed care organizations (MCOs), key stakeholders, and subject matter experts – to collaboratively identify common challenges and work toward solutions. These events support continuous QI because community, clinical, and tribal partners are able to share best practices, discuss strategies and tools for effectiveness, and work together to improve project metrics on regional and organizational levels. The focus is often on improving existing workflows, as well as testing new ways of doing things. Ideas that arise from the collaboratives can be translated to PDSA or other rapid-cycle tests of innovation.

Following one of the initial meetings, a representative from one of the five MCOs operating in King County reached out to a lieutenant from a south county jail following the lieutenant's presentation. Together they arranged tours and made further introductions. Now they are working in a cross-sector partnership to determine the best approach for providing in-person transitional care support for people who are soon to be released from the facility.

Training and TA – Clinical and Tribal Partners

Clinical and tribal partners identified training needs and participated in a prioritization process with HealthierHere to guide initial training investments. Based on clinical partner input, HealthierHere has invested in trainings that will directly address their needs. Initial investments support a Value-Based Payment (VBP) Academy for BHAs, Collective Ambulatory optimization,

Whole Person Integrated Care training for clinical partners, the development of a training fund that partners can access to support their unique needs, and a summit of community and clinical partners to develop innovations.

VBP Academy. HealthierHere is contracting with Comagine Health (formerly Qualis Health) to provide BHAs with training, TA, and practice coaching to support ongoing QI. Specifically designed for BHAs, the VBP Academy is an intensive 10-month curriculum that guides BHAs through practice transformation. The curriculum includes population health, risk stratification, QI, and PDSA cycles. Throughout the 10 months, practices are supported in the development and implementation of a QI transformation project that focuses on one of the P4P metrics within HealthierHere's MTP Portfolio. The curriculum ends in January 2020.

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

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

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

Partner Training Fund. With the understanding that partners may be in different places with respect to their training needs, HealthierHere is in the process of establishing a partner training fund. This flexible resource will support partners that pursue additional training opportunities

beyond HealthierHere's system-wide training investments. One such offering currently underway is the purchase of 250 licenses to participate in the Institute for Healthcare Improvement's Open School courses, to be shared with partners that would not otherwise have access to that resource.

Partner Summit. In Q2 2019, in collaboration with Bridging Health & Community, HealthierHere convened community, clinical, and tribal partners for a full day to build and deepen partnerships; work toward a shared vision for how community, clinical, and tribal partnerships will improve health outcomes; and begin a conversation about focusing on collaborative innovations designed to impact P4P metrics.

Training and TA – Community Partners
In 2020, HealthierHere will provide training and TA to community partners focused on building organizational capacity to measure the effectiveness of programs and services and the correlation to improved health outcomes. The TA and training will include implementing culturally appropriate and responsive QI strategies and processes. In early 2020, HealthierHere will identify priority training and TA needs for community partners.

HealthierHere anticipates the partner training fund will support eligible community partners' training expenses related to (1) providing or promoting SDoH services and supports for members of the MTP focus populations consistent with HealthierHere's MTP projects and/or (2) developing infrastructure and capacity to partner with healthcare providers to improve health outcomes.

Incentive Package
To encourage and reward ongoing QI activities for clinical and tribal[1] partners, HealthierHere created a Pay for Progress incentive package. Clinical partners will earn payments for completing various assessments and improving on selected metrics. While some incentives focus on hitting defined targets, others emphasize improvement over self (IOS). HealthierHere will monitor clinical and tribal partners' progress to learn about and share best practices, adjust investments and/or training opportunities, and identify clinical partners that may need a higher level of support. In 2019, HealthierHere structured its Pay for Progress incentives around four "bundles" – Clinical, Population Health, VBP, and Equity; these are described in more detail in Section 3. Incentives for 2020 and future years will be determined annually.

In 2020, HealthierHere will establish community partner benchmarks and milestones tied to financial incentives.

2. Co-design and Create Blueprints for Improved Models of Care
HealthierHere intends to bring clinical, community, and tribal partners together to co-design blueprints for system-wide integrated care in King County. The focus areas for exploration in 2019 and 2020 include shared care planning, SDoH screening, cross-system data infrastructure/integration, and a regional CIE. HealthierHere will employ continuous QI strategies to test and pilot a shared care plan specific to hospital transitions in 2020.

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

Additionally, in 2019 HealthierHere was selected to participate in the Data Across Sectors for Health (DASH) Mentor Program. The DASH Mentor Program is a national peer-to-peer learning network of the Robert Wood Johnson Foundation, and includes a 10-month mentorship to advance our local efforts to share and use multi-sector data to improve community health. The mentorship cohort was led by HealthInfoNet with a focus on integrating SDoH data with clinical data. Topics included investigating existing technical capacity, assessing current resources available, and exploring how multi-sector data will be used in day-to-day workflows. The program concluded in October 2019 and informed HealthierHere's CIE planning and early implementation work.

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

HealthierHere is currently funding three projects through the Innovation Fund:

- Two projects that aim to build community-based capacity for low-barrier and drop-in medication-assisted treatment access
- One project that aims to reduce the volume of low-acuity 911 calls by improving community support linkages via first responders

Additionally, HealthierHere is exploring launching community partner-led innovation projects in 2020 that will test innovative solutions to SDoH service provision related to P4P metrics.

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

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

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

These methods are described briefly below.

1. Semi-annual Assessment
The primary method HealthierHere will use to measure progress is to establish a set of process measures or milestones tied to payments through clinical, tribal, and community partner contracts and assessed through semi-annual reports. Payment to clinical, tribal, and community partners will be tied to completion of the reports and/or achievement of certain targets to ensure progress toward

transformation. At this stage, the milestones are foundational and are tied not to any specific project but to the infrastructure and SDoH services (for community partners) necessary to support population health, QI processes, and value-based care. All clinical, tribal, and community partners are expected to implement and make progress on these foundational activities during 2020. HealthierHere recognizes that clinical, tribal, and community partners are all starting in different places. Therefore, the incentives have been structured to reward improvement no matter the baseline.

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

Clinical and Tribal Partners

Clinical and tribal partners earn payments for completing various assessments and improving on selected metrics. While some incentives focus on hitting defined targets, others emphasize IOS, thereby encouraging more mature partners to improve above and beyond their current state. In the course of monitoring partners' progress, HealthierHere is able to identify clinical partners that may need a higher level of support. The Pay for Progress measures fall into four bundles: Clinical, Population Health, VBP, and Equity. The measures in each bundle are listed in the table below.

Figure 1. **Clinical and Tribal Partners Pay for Progress Bundles**

Clinical	Population Health	VBP	Equity
• Maine Health Access Foundation (MeHAF) assessment • Opioids survey • Use of Whole Person Care screenings/ assessments • Use and optimization of Collective Ambulatory platform	• Empanelment • Registry functionality • Risk stratification	• Health Care Payment Learning & Action Network (HCP-LAN) status and goals	• Equity training • Equity assessment • Equity action plan

Clinical and tribal partners will be measured semi-annually through a report electronically submitted to HealthierHere. Half the milestones are measured as a binary – completed or not completed – and the other half are structured to assess IOS, using a simple scale inspired by validated tools such as the MeHAF and Patient-Centered Medical Home Assessment. The use of self-assessment scales will allow HealthierHere to quickly and easily monitor how clinical and tribal partners are progressing in various areas and provide targeted assistance to clinical and tribal partners who may be stalled or falling behind. The equity assessment follows a similar

structure, allowing HealthierHere visibility into the progress clinical and tribal partners are making toward becoming more equitable and culturally/linguistically accessible organizations with authentic community and consumer voice incorporated into decision-making. All clinical and tribal partners will submit their self-assessments with the contractual understanding that HealthierHere will perform site visits and conduct routine audits to ensure accuracy of the information submitted to HealthierHere. As part of their 2020 Pay for Progress contracts, clinical and tribal partners will be incentivized to develop a QI project that ties to one of HealthierHere's P4P metrics. HealthierHere will review partners' proposed projects prior to launch to ensure that all required components, including equity, are included. The AIMS Center and Comagine Health will support partners in both project development and implementation. For more details on the Pay for Progress requirements and methodology for calculating progress, see the appendix.

Community Partners
In 2020, HealthierHere will establish benchmarks and milestones for community partner transformation efforts and tie them to financial incentives. HealthierHere will work with partners to clearly define benchmarks and milestones that allow for quantitative and qualitative measurement of progress. Final benchmarks/milestones will be captured in community partner contracts along with agreed-upon deliverables and deadlines. Community partners will report on progress twice a year.

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

In the fall of 2019, HealthierHere practice transformation managers began visiting clinical and tribal partners on a semi-annual basis. Moving forward, clinical and tribal partners will have an annual site visit, with 50% of partners being visited in the first half of the year and 50% in the second half of the year. Beginning in mid-2020, HealthierHere community and tribal engagement managers will visit community partners on a semi-annual basis and schedule follow-up visits as needed.

3. Co-design Collaborative
In mid-2019, as community partners began to work more closely with clinical and tribal partners, HealthierHere's Learning Collaboratives transitioned to the Co-design Collaborative. As the Co-design Collaborative took shape in late 2019, the four distinct project-specific Learning Collaboratives evolved into a single, larger convening that brings together community and clinical partners. While participants from across clinical, community, and tribal organizations still have the opportunity to discuss a specific project area, as appropriate, the larger cross-sector format also affords the opportunity to focus on larger, system- and community-wide connections. In response to partners' positive feedback about interacting with key clinical, tribal, and community partners, HealthierHere at times includes unstructured, informal networking time. The 2020 Co-design Collaborative meeting schedule will be finalized in early 2020.

4. Ongoing Communication with Training and TA Contractors

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

HealthierHere plans to enter into contracts with external organizations beginning in 2020 for training and TA for community partners. At the outset, HealthierHere's community and tribal engagement managers will work directly with community and tribal partners to provide coaching on reporting progress toward transformation. HealthierHere views reporting and monitoring as tools for identifying areas of need and will work with partners to reduce power dynamics that occur in the course of what could be perceived as audits.

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

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

1. Inform the clinical, community, or tribal partner that their scores indicate they are not making sufficient progress. This initial outreach is likely to happen via both email and a phone call, from the assigned practice transformation or community and tribal engagement manager.

2. Regardless of communication channel, emphasize HealthierHere's desire to help the practice succeed in our Pay for Progress or milestone incentive metrics and, ultimately, in practice and system transformation.

3. Involve leadership and additional staff as necessary.

4. Schedule an in-person meeting (or, if not practical, an extended virtual meeting) to discuss and analyze the situation in greater depth. The purpose of this meeting is as follows:

    a. Identify the data and source that indicate insufficient progress.
    b. Understand the context of the data, including its accuracy.

c. Determine the workflow(s) and/or process(es) that influence the metric(s) in question.

5. If the low score is due to a data reporting error (identified through 4.b, above), work with the clinical, community, or tribal partner to correct the data source and/or report generation.

    a. Confer with the HealthierHere data analyst to further define and understand the reporting discrepancy.
    b. Engage external experts, as necessary, to provide on-site training and TA.
    c. As appropriate, connect the clinical, community, or tribal partner with other organizations that may be able to provide guidance, such as those with experience with a similar reporting error and/or EHR.
    d. Monitor meetings, TA, and other consulting services provided.
    e. Monitor ongoing reporting to determine if the discrepancy has been adequately addressed.

6. If the low score is due to workflow(s) and/or process(es) that influence the metric(s) in question (4.c, above),begin process improvement efforts.

    a. Identify process(es) that influence the metric in question.
        1. In some cases, more than one process may influence the metrics. It may be appropriate to focus on only one process at a time, or on a sub-process, possibly defined by patient sub-population, geographic area, or other criteria.
        2. Secure leadership buy-in to focus on the process or sub-process.
    b. Initiate a PDSA cycle/rapid-cycle strategy to address the process or sub-process, led by either a HealthierHere staff person or external consultant, depending on the process and organizational capacity.
    c. Continue on-site training and check-ins as the clinical, community, or tribal partner executes PDSA cycles/other rapid-cycle strategy.
    d. As appropriate, connect the clinical, community, or tribal partner with other organizations that may be able to provide guidance, such as those with experience with a similar process or patient population.
    e. Monitor meetings and other consulting services provided.
    f. Monitor ongoing reporting to determine whether the clinical, community, or tribal partner is making sufficient progress.
    g. Gather and share best practices that may help other clinical and tribal partners succeed in meeting Pay for Progress incentive metrics and community partners succeed in achieving benchmark/milestone incentives.

HealthierHere maintains open dialog with clinical, tribal, and community partners and encourages ongoing communication. HealthierHere strives to provide many opportunities for our clinical, tribal, and community partners to express concerns and provide feedback. Although each clinical and tribal partner is assigned to a practice transformation manager and community partners are assigned to a community and tribal engagement manager as that organization's primary contact, partners are encouraged to interact with any member of the HealthierHere staff as they see fit. HealthierHere provides formal and

informal opportunities for communication. At the same time, HealthierHere actively monitors our partners' progress and concerns. Opportunities for interaction include, but are not limited to:

- Semi-annual reporting
- Site visits
- Co-design Collaborative meetings
- Governing Board and committee meetings

Through all of these interactions, as well as others, HealthierHere monitors and tracks the barriers identified by partners, whether those barriers arise from adherence to the clinical summaries or challenges of the implementation process. During the 2019 site visits to clinical and tribal partners, practice transformation managers discussed general project and transformation progress with partners, enabling HealthierHere to distinguish between general progress and action driven in response to barriers. From there, HealthierHere and the clinical and tribal partners can move forward to assess, determine, and monitor mitigation strategies.

Specific to the Pay for Progress incentives, HealthierHere will:

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

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

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

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

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

- Regular in-person Learning and Co-design Collaboratives organized around projects
- On-site practice coaching on whole-person care and the Collective Ambulatory platform
- VBP Academy

- Ongoing partner learning webinars
- Community partner summits and convenings

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

Workshops and Summits
HealthierHere sponsors periodic workshops on topics of interest to our stakeholders. In the fall of 2019, for example, HealthierHere – through its partnership with the King County Integrated Care Network – hosted a workshop for BHAs on negotiating VBP arrangements from a place of power; the workshop featured Adam Falcone, a nationally known lawyer with VBP expertise. And in early 2019, HealthierHere hosted a community summit highlighting lessons learned from Medicaid consumers through a small-grants program. In the spirit of community-based participatory activities, HealthierHere anticipates also hosting a summit to highlight best practices.

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

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

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

Indigenous Nations Committee
In 2020, the Indigenous Nations Committee will become a formal committee of the Governing Board. The purpose of this committee is to proactively engage Native-serving CBOs, Indigenous professionals, traditional healers, American Indian (AI)/Alaskan Native (AN)/Indigenous (I) story-tellers, AI/AN/I Elders, AI/AN/I cultural experts, and beneficiaries of services to ensure that their voices influence and guide the decision-making of HealthierHere. The Equity and Engagement team will report recommendations and committee updates to the Governing Board on a semi-annual basis.

Community Grants Program
The goal of the Community Grants Program is to engage CBOs and Medicaid beneficiaries in King County to ensure their voices guide and influence HealthierHere's work. Through the 2018 and 2019 Community Grants Program, HealthierHere resourced CBOs to engage with Medicaid beneficiaries

in their communities and collect surveys to understand their experience with the healthcare system. Community members who participated in the 2018 and 2019 surveys include Medicaid recipients in King County identified as people of color, low income, immigrants, refugees, Asian American, Pacific Islander, LGBTQ/Two Spirit, AI/AN/I, houseless/homeless, youth (ages 18-26), and those dealing with behavioral health conditions. The 2018 Community Grants Program results were shared with stakeholders, committees, partners, and community members. A similar communication strategy will be implemented in 2020 to communicate results from the 2019 Community Grants Program.

APPENDIX

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

Clinical and Tribal[2] Partners

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

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

Community Partners

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

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

linguistic accessibility of services and a slight majority (51%) said they conduct monitoring, while the rest said they either do not monitor it at all or do not monitor it in any formal way. HealthierHere will be contracting with a subset of community partners who demonstrated readiness for partnering with HealthierHere to implement transformation efforts.

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

Pay for Progress Methodology

The Pay for Progress IOS methodology was shared with partners in the attached *2019 Clinical Practice Transformation Reporting Workbook*.

HealthierHere's partners will report on Pay for Progress milestones on a semi-annual basis. Half the milestones are measured as binary – completed or not completed – and half are structured to assess IOS, using a simple scale inspired by validated tools such as the MeHAF and PCMH-A. The Pay for Progress reporting workbook includes the scale for each IOS milestone. Partners review the characteristics of each level of the scale and self-identify where they stand.

The Pay for Progress measures fall into four bundles – Clinical, Population Health, VBP, and Equity. As shown in the table below, six out of 12 metrics will be scored on IOS.

Figure 2. **Pay for Progress Measures**

Clinical	Population Health	VBP	Equity
• MeHAF assessment* • Opioids survey • Use of Whole Person Care screenings/ assessments* • Use and optimization of Collective Ambulatory platform*	• Empanelment* • Registry functionality* • Risk stratification*	• VBP training • HCP LAN status and goals	• Equity training • Equity assessment • Equity action plan
**Measures/milestones structured as IOS*			

During the site visits completed in the fall of 2019, multiple partners shared that it is difficult to make meaningful and measurable change in just a few months and that limited capacity impacts their ability to make significant change. As a result, HealthierHere amended the payment methodology for the December reporting period to minimize the risk-bearing portion of the "up-to" amount on IOS metrics. Under this new methodology for IOS metrics, partners will receive 80% of the up-to amount for completing their reporting obligations and are eligible to receive a 20% bonus payment for showing any IOS. Below is a breakdown of the IOS payment up-to amounts and a summary of the proportion of IOS to flat rate for submission for December 2019 payments. HealthierHere will revisit the payment methodology in future reporting periods and update as necessary.

Figure 3. **Amended Payment Methodology for December, IOS Incentives**

Metric	BHA's 80% for Submission	BHAs, 20% for IOS	FQHCs, 80% for Submission	FQHCs, 20% for IOS	Hospitals, 80% for Submission	Hospitals, 20% for IOS
MeHAF Assessment*	$8,400	$2,100	$7,000	$1,750	$5,600	$1,400
Whole Person Care Screening/Assessments	$6,300	$1,575	$5,250	$1,313	$4,200	$1,050
Use & Optimization of Collective Ambulatory	$6,300	$1,575	$5,250	$1,313	$4,200	$1,050
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	$10,800	$2,700	$9,000	$2,250	$7,200	$1,800
Registry Functionality	$10,800	$2,700	$9,000	$2,250	$7,200	$1,800
Risk stratification	$10,800	$2,700	$9,000	$2,250	$7,200	$1,800
TOTAL, December Reporting Period IOS Incentives	$53,400	$13,350	$44,500	$11,125	$35,600	$8,900

Figure 4. **Amended Proportion of IOS to Flat Rate for Submission, Total December Payments**

	BHAs	FQHCs	Hospitals
Total 'Up to' Amount: Improvement Over Self	$13,350	$11,125	$8,900
Total 'Up to' Amount: Flat Rate for Submission	$118,650	$98,876	$79,100
Risk Bearing Proportion of Total December Payment	11.25%	11.25%	11.25%

By decreasing the risk bearing proportion of payments, partners will receive a greater proportion of funds which they can direct towards increasing capacity and making investments to advance progress.

HealthierHere

2019
Clinical Practice Transformation Reporting Workbook
UPDATED for the Second Reporting Period 11/22/2019

Contents

About HealthierHere's Clinical Practice Transformation Reporting Workbook

This workbook details HealthierHere's 2019 Pay for Progress incentives. Please use this Clinical Practice Transformation Reporting Workbook (Workbook) as the tool to collect your responses and report your progress on HealthierHere's Clinical Practice Transformation Pay for Progress Incentives for 2019. You are encouraged to edit this document to collect information for your organization, but your final responses must be submitted using HealthierHere's online tool, called FormAssembly. The FormAssembly link is available here: https://www.healthierhere.org/clinical-reporting-site/. Please reach out to your designated Project Manager if you have any questions.

Reporting Requirements

Reporting requirements for each incentive will vary depending on the incentive. Some incentive metrics warrant reporting at the **organizational level**, one response for the organization as a whole. The HealthierHere champion is likely the best person to collect this information and report on behalf of the organization.
Other incentive metrics are best answered at the **individual site level.** HealthierHere has outlined three types of sites: Primary Care (**PCP**) Clinic Sites, Behavioral Health Agency (**BHA**) Clinic Sites, and Hospital Emergency Departments (**ED**).
PCP Clinic Sites: Both FQHC and hospital-affiliated primary care clinics are considered PCP Clinic Sites. HealthierHere requires one submission/response for each contracted reporting site.
Behavioral Health Agency (BHA) Clinic Sites: Community (outpatient) behavioral health clinical sites are considered BHA Clinical Sites. HealthierHere requires one submission/response for each contracted reporting site.
Hospital Emergency Departments (ED): The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care are considered ED sites. HealthierHere requires one submission/response for each contracted reporting site.
What are contracted reporting sites?
HealthierHere has negotiated with each practice partner's HealthierHere Champion to select reporting sites for 2019. The selected reporting sites are listed on HealthierHere's 2019 contracts, and the FormAssembly version of the survey has a drop-down menu with all of the reporting sites so that whomever is submitting their site's response can do so easily.

Suggested Best Practices for Completion

Organizational level incentives can be completed by the HealthierHere Champion, with input from relevant departments. For incentives that are to be completed at the site level, the Champion is encouraged to play a coordinating role, but the appropriate site administrator at each reporting site should respond based on the reality at their clinical site with input from the clinical care team.
For the MeHAF assessment, HealthierHere recommends a more intensive approach. This incentive should be completed by the clinical care team. A best practice is for clinical care team members to respond individually, then compare their answers with other team members, editing collectively to answer as a team. A staff or team meeting is an ideal venue for that discussion. Each site will then submit their own assessment to HealthierHere using the link provided by their HealthierHere Champion. If your clinical teams need support with this process, please reach out to HealthierHere.

Defining the Clinical Care Team

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

Incentives by Designated Reporting Level

		Designated Reporting Level			
Bundles	**Incentives**	**Organizational Level**	**PCP Clinic Sites**	**BHA Clinic Sites**	**Hospital ED Sites**
Clinical	**1) MeHAF Assessment**		X	X	
	2) Opioids Survey		X	X	X
	3) Whole Person Care Screenings/Assessments		X	X	
	4) Use and Optimization of Collective Ambulatory (formerly PreManage)	X			
Population Health	**1) Assignment to a Practice Panel, Care Team, or Caseload (Empanelment)**		X	X	
	2) Registry Functionality		X	X	
	3) Risk Stratification		X	X	
VBP	**1) VBP HCP LAN Status and Goals**	X			
Equity	**1) HH Equity Training**	X			
	2) HH Equity Assessment	X			
	3) HH Equity Action Plan	X			

'*' indicates required questions.

Introductory Questions for Organizations

Current Vacancies

For each of the following categories please indicate the number of open positions your organization has listed/advertised for at least 3 months, without success filling the position. Then please enter the percentage of those total vacancies that have been open for more than 6 months, and more than 12 months.

1) Licensed Behavioral Health positions (Psychiatrist, Psychologist, Psychiatric ARNP, Mental Health RN, Mental Health Professional, Chemical Dependency Professional, Social Worker, Counselor). *

Total listed/advertised positions open for at least 3 months. _____.

Of the positions open for the last 3 months, what percentage have been open for more than 6 months? _____.
Of the positions open for the last 3 months, what percentage have been open for more than 12 months? _____.

2) Primary Care provider positions (MD, DO, PA, ARNP) *
Total listed/advertised positions open for at least 3 months. _____.
Of the positions open for the last 3 months, what percentage have been open for more than 6 months? _____.
Of the positions open for the last 3 months, what percentage have been open for more than 12 months? _____.

3) General clinical support positions (Medical Assistant, RN, LPN, Care Coordinators, Peers, Community Health Workers, Front Desk) *
Total listed/advertised positions open for at least 3 months. _____.
Of the positions open for the last 3 months, what percentage have been open for more than 6 months? _____.
Of the positions open for the last 3 months, what percentage have been open for more than 12 months? _____.

Clinical Incentive Bundle

	Designated Reporting Level			
Incentives	**Organizational Level**	**PCP Clinic Sites**	**BHA Clinic Sites**	**Hospital ED Sites**
1) MeHAF Assessment		X	X	
2) Opioids Survey		X	X	X
3) Whole Person Care Screenings/Assessments		X	X	
4) Use and Optimization of Collective Ambulatory (formerly PreManage)	X			

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

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

The Washington State Health Care Authority (HCA) adopted the 21 question MeHAF+ as a required pay for reporting requirement for all Accountable Communities of Health (ACHs), all ACHs are required to have participating sites complete the survey every six months and submit the results to the HCA. HealthierHere decided to incentivize this reporting requirement in 2019.

Instructions:

The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site's current extent of integration for patient and family-centered primary care and behavioral health care. Future repeated administrations of the SSA form will help to show changes your site is making over time. Organizations working with more than one site should ask each site to complete the SSA. Please respond in terms of your site's current status on each dimension. Please rate your patient care teams on the extent to which they currently do each activity for the patients/clients in the integrated site. The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves primary care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff. Using the 1-10 scale in each row, circle select one numeric rating for each of the 21 characteristics. If you are unsure or do not know, please give your best guess.

If you would like more guidance on how to complete the MeHAF please consult the MeHAF Facilitation Guide developed by Comagine.
https://depts.washington.edu/fammed/wp-content/uploads/2019/01/MeHAF-Facilitation-Guide-Tool_190128.pdf

A) Did a care team collectively give feedback to develop your site's response to this incentive? *
(Yes/No)

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

_____

C)

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

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

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

	1	2 3 4	5 6 7	8 9 10
2. Patient care team for implementing integrated care *	… does not exist	… exists but has little cohesiveness among team members; not central to care delivery	… is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills	… is a concept embraced, supported and rewarded by the senior leadership; "teamness" is part of the system culture; case conferences and team meetings are regularly scheduled
3. Providers' engagement with integrated care ("buy-in") *	1 … is minimal	2 3 4 … engaged some of the time, but some providers not enthusiastic about integrated care	5 6 7 … is moderately consistent, but with some concerns; some providers not fully implementing intended integration components	8 9 10 … all or nearly all providers are enthusiastically implementing all components of your site's integrated care
4. Continuity of care between primary care and behavioral/mental health *	1 … does not exist	2 3 4 … is not always assured; patients with multiple needs are responsible for their own coordination and follow- up	5 6 7 … is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only	8 9 10 … systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained
5. Coordination of referrals and specialists *	1 … does not exist	2 3 4 … is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team	5 6 7 … occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care	8 9 10 … is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement
6. Data systems/patient records *	1 … are based on paper records only; separate records used by each provider	2 3 4 … are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps	5 6 7 … use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals	8 9 10 … has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process
7. Patient/family input to integration management *	1 … does not occur	2 3 4 … occurs on an ad hoc basis; not promoted systematically; patients must take initiative to make suggestions	5 6 7 … is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under	8 9 10 … is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows

					consideration; patients/families are made aware of mechanism for input and encouraged to participate			that management acts on the information	
	1	2	3	4	5	6	7	8	9	10
8. Physician, team and staff education and training for integrated care *	… does not occur	… occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic			… is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation			… is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration	
	1	2	3	4	5	6	7	8	9	10
9. Funding sources/resources *	… a single grant or funding source; no shared resource streams	… separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies			… separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training			… fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly	
	1	2	3	4	5	6	7	8	9	10

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

2) Opioid Survey

Background:
The HCA has developed a series of questions relevant to the 'Addressing the Opioid Crisis' Medicaid Transformation Project. This series of questions constitutes a required pay for reporting requirement for all ACHs. All ACHs are required to have participating sites complete the survey every six months and submit the results to the HCA. HealthierHere decided to incentivize this reporting requirement in 2019.
Please complete the applicable questions. Responses to the follow-up questions are encouraged, though not required. Your answers may inform future strategies. This incentive will be assessed for completion only.
A) Does the ED site have protocols in place to initiate Medication Assisted Treatment (MAT) and offer take home naloxone for individuals seen for opioid overdose? *

Select all that apply:

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

Follow-up questions (optional):

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

B) Do providers at your site follow the AMDG / Washington State prescribing guidelines, Bree Collaborative and/or CDC prescribing guidelines? *

Select all that apply:

- Agency Medical Directors' Group (AMDG) guidelines / Washington State prescribing guidelines
- Bree Collaborative (BREE) guidelines
- CDC guidelines
- None of the above

Follow-up questions (optional):

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

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

Select all that apply:

- Integrated morphine equivalent dose calculators
- Links to opioid prescribing registries
- Links to Prescription Drug Monitoring Programs (PDMPs)
- Automatic flags for co-prescriptions of benzodiazepines

- None of the above

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

Follow-up questions (optional):

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

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

Select all that apply:

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

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

Select all that apply:

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

Follow-up questions (optional):

- Is MAT offered to some or all patients with OUD?
- Is behavioral care offered to some or all patients that screen positive for depression and/or anxiety?
- Do patients with OUDs who get care from your practice or clinic site typically get these services from you, or do they go elsewhere?

- What systems are in place to ensure the beneficiary is connected to the acute care and recovery services that are needed?

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

3) Whole Person Care Screenings/Assessments

Background:
As part of HealthierHere's 2019 focus on building foundational infrastructure, we are incentivizing the use of evidence-based screenings and assessments in primary care and behavioral health settings in order to improve the ability of Medicaid individuals to receive appropriate whole person care no matter the setting they first seek care. This incentive will allow HealthierHere greater visibility into how screenings are being used, whether screenings are integrated into workflows and clinical decision making, and which priority screenings are currently being used at participating organizations. The question and scale were adapted from the MeHAF, question I.2.

A)

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

B) If you are a PCP site, does your site perform any of the following screenings for behavioral health conditions?
Select all that apply

- Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST)
- Generalized Anxiety Disorder subscale (GAD-7)
- Patient Health Questionnaire for Depression (PHQ-2 / PHQ-9)

C) If you are a BHA site, does your site perform any of the following screenings for physical health conditions?
Select all that apply

- Blood pressure
- Body Mass Index (BMI)
- Diabetes (A1C)

D) Please provide any additional information you would like to share on your site's integration of whole person care screenings, including challenges, barriers, and any additional assistance needed.

4) Use and Optimization of Collective Ambulatory (formerly PreManage)

Background:
Improving rates of follow-up visits after Emergency Department visits and hospitalizations is a priority area for HealthierHere. In 2019 we are providing coordination, training, and technical assistance to implement and optimize use of the Collective Ambulatory (formerly PreManage) software within our region. The software provides notifications to enrolled providers when their assigned/empaneled patients experience an ED visit, providing an opportunity for the community primary care or behavioral health provider to reach out to the patient and encourage them to schedule and complete a follow-up visit. In 2019 HealthierHere is incentivizing the use and optimization of Collective Ambulatory as a tool to improve rates of ED follow-ups.
Please respond to the series of questions, the survey uses skip logic, depending on your answers the survey tool will prompt further questions. Your responses to the questions are correlated to HealthierHere's scale format to measure improvement over self, from Level D to Level A.
If your organization has the ability to run the report described below, please submit a copy of said report as a sample by uploading it to the online tool. Please do not submit a report that includes Protected Health Information (PHI), it should be an aggregate only.

	Does your organization currently use Collective Ambulatory? (Yes/No) *		*If yes,* can your organization run reports using Collective Ambulatory data showing what percentage of your Collective Ambulatory notifications result in a follow-up within 7 days? (Yes/No) *		*If yes*, is your organization currently working with a Comagine Health Practice Coach to **optimize** your use of Collective Ambulatory? (Yes/No) *	
Answer	No	Yes	No	Yes	No	Yes
Corresponding Level	**Level D**	**Level C**	**Level C**	**Level B**	**Level B**	**Level A**

Please provide any additional information you would like to share on your organization's use of Collective Ambulatory, including challenges, barriers, and any additional assistance needed.

Population Health Bundle

Incentives	Organizational Level	Designated Reporting Level		
		PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
1) Assignment to a Practice Panel, Care Team, or Caseload (Empanelment)		X	X	
2) Registry Functionality		X	X	
3) Risk Stratification		X	X	

1) Assignment to a Practice Panel, Care Team, or Caseload (Empanelment)

Background:
Empanelment is a key building block of population health. It is the act of assigning individual patients to individual providers and care teams with sensitivity to patient and family preference. Empanelment is the basis for population health management and the key to continuity of care. The goal of focusing on a population of patients is to ensure that every established patient receives optimal care, whether he/she regularly comes in for visits or not. Accepting responsibility for a finite number of patients, instead of the universe of patients seeking care in the practice, allows the provider and care team to focus more directly on the needs of each patient.
While empanelment has been a focus for primary care providers, it is not necessarily being practiced consistently across the system in King County and behavioral health providers have largely been left out of the conversation. In 2019, HealthierHere is committed to bringing behavioral health providers along on the same journey in order to build up their population health capacity. In order to make the empanelment concept more tangible to behavioral health providers, we are using more inclusive language to describe the concept of empanelment, defining this activity as “assignment to a practice panel, care team, or caseload.”
Additional Guidance for BHAs:
HealthierHere recognizes that the concept of a Practice Panel, Care Team, and Caseload have different connotations for primary care and behavioral health. Still, the context within which BHAs might interpret this question is related to using the assignments to a caseload and case manager from a population health perspective. Empanelment or assignment to a caseload is the first step in practicing population health. Once assigned, the practice may be able to use the assignment/empanelment to drive scheduling practices (making an effort to get the patient scheduled with their assigned case manager or another provider the

patient may recognize as a member of 'their' care team), recall practices and/or strategize on how to best support clients/patients through a team-based approach. For example, based on risk stratification, a care manager may incorporate the use of a peer support specialist or a community health worker for those who may need additional assistance to achieve desired health outcomes.
HealthierHere's question and scale for this incentive was adapted from question 9 on the PCMH-A.

A)

If I am a BHA site… Clients/Patients *	**Level D** …are not assigned to specific caseloads or care teams	**Level C** …are assigned to specific caseloads or care teams, but caseload assignments are not routinely used by the practice for scheduling or other purposes. Patients see their assigned case manager approximately less than 50% of the time. Efforts to schedule patients with their assigned case manager are largely ad hoc.	**Level B** …are assigned to specific caseloads or care teams, and caseload assignments are routinely used by the practice mainly for scheduling purposes. Patients see their assigned case manager approximately 50-75% of the time. Efforts to schedule patients with their assigned case manager are intentional.	**Level A** …are assigned to specific caseloads or care teams and caseload assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand. Case managers with higher needs clients have smaller caseloads. Clients see their assigned case manager approximately 75-100% of the time. Efforts to schedule patients with their assigned case manager are systematized across the organization.
	1	2 3 4	5 6 7	8 9 10
If I am a PCP site… Patients *	**Level D** …are not assigned to specific practice panels,	**Level C** …are assigned to specific practice panels, but panel assignments are not routinely used by the practice for administrative or other purposes	**Level B** …are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes	**Level A** …are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand
	1	2 3 4	5 6 7	8 9 10

B) How does your site use the empanelment data in practice management on a day to day basis?
C) Please provide any additional information you would like to share on your site's use of empanelment, including challenges, barriers, and any additional assistance needed.

2) Registry Functionality

Background:
A registry is defined as a list of all people in a specific population, those specific populations can be based on a range of factors, including conditions (Diabetes, Asthma, Opioid Use Disorder), social determinant needs, and others. Registries help care managers see a target population and gaps in an evidence-based

standard of care for the population, giving them the ability to see key health parameters of an entire population in a single view and fill those care gaps for the patients assigned to them.
HealthierHere is committed to increasing the use of registries and improving registry functionality as part of our foundational population health infrastructure building in 2019. While registries range from simple manual entry Excel spreadsheets to more advanced queries of Electronic Health Record (EHR) data, HealthierHere is encouraging our partners to use available technology, ideally advancing their use of registries that originate with real-time EHR data. HealthierHere's primary question and scale for this incentive was adapted from question 7 on the Quality Improvement Change Assessment.
A)

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

B) Does your organization's EHR have registry functionality for any of the following conditions?
Select all that apply:

- Diabetes
- Depression
- Serious Mental Illness
- Opioid Use Disorder
- Asthma
- Cardiovascular Disease (CVD)
- Chronic Obstructive Pulmonary Disorder (COPD)

C) How does your site use registry data in practice management on a day to day basis?
D) Please provide any additional information you would like to share on your site's use of registries, including challenges, barriers, and any additional assistance needed.

3) Risk Stratification

Background:
The process of separating patient populations into high-risk, low-risk, and the ever-important rising-risk groups is called risk stratification. Having a platform to stratify patients according to risk is key to the success of any population health management initiative. HealthierHere sees risk stratification as one of the three focus areas for building population health infrastructure in 2019. We are interested in improving routine use of risk stratification at our partner organizations. For the purposes of this incentive we are defining risk as risk of a bad clinical outcome. HealthierHere's primary question and scale for this incentive was adapted from question 9 on the Quality Improvement Change Assessment.

A)

A standard method or tool(s) to stratify patients by risk level *	**Level D** ... is not available.			**Level C** ... is available but not consistently used to stratify all patients.			**Level B** ... is available and is consistently used to stratify all patients but is inconsistently integrated into all aspects of care delivery.		**Level A** ... is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.
	1	2	3	4	5	6	7	8	9	10

B) What data does your site use to stratify risk?
Select all that apply:

- Diagnosis codes (including complicated behavioral and physical health conditions)
- Medication lists
- Insurance status
- Geocoding (by home address)
- Social Determinants of Health (housing status, food insecurity, etc.)
- Emergency Department utilization
- Other (free text box)

C) How does your site use risk stratification data in practice management on a day to day basis?
D) Please provide any additional information you would like to share on your site's use of risk stratification, including challenges, barriers, and any additional assistance needed.

Value Based Payment Bundle

		Designated Reporting Level		
Incentives	**Organizational Level**	**PCP Clinic Sites**	**BHA Clinic Sites**	**Hospital ED Sites**
1) VBP HCP LAN Status and Goals	X			

Background:
The activities in the Value Based Payment Bundle align with the HCA's goal for MCOs to reach 90% VBP provider payments by 2021. To support this statewide goal, HealthierHere will incentivize partners to provide an informational update of the percentage of their revenues that are tied to Value Based Payment contracts in 2019.

1) Value Based Payment HCP LAN Status and Goals

Please indicate the level of VBP adoption using the below formula to indicate the proportion of your organization's revenues in relation to current Value Based Payment arrangements.
Level of VBP Adoption (%) in 2019 = Total revenues originating in Value Based Payment arrangements 2019/Total Revenues in 2019
A) What were your organizations total revenues in 2019? *
B) What were your organization's total revenues that **originated in Value Based Payment arrangements in 2019?** *
C) Please review the 'Alternative Payment Models' Framework. For each category please indicate whether your organization has VBP arrangements in **any** of the following categories. Please answer Yes or No. In future reporting cycles you may be asked for the exact percentages in each category, but for this reporting period just answer Yes or No based on your best estimates. *

- Category 1:
- Category 2A:
- Category 2B:
- Category 2C:
- Category 3A:
- Category 3B:
- Category 3N:
- Category 4A
- Category 4B:
- Category 4C:
- Category 4N:

D) Please provide any additional information you would like to share on your organization's transition to Value Based Payment (VBP) arrangements, including challenges, barriers, and any additional assistance needed.

Equity Bundle

Incentives	Organizational Level	Designated Reporting Level: PCP Clinic Sites	Designated Reporting Level: BHA Clinic Sites	Designated Reporting Level: Hospital ED Sites
1) HH Equity Training	X			
2) HH Equity Assessment	X			
3) HH Equity Action Plan	X			

1) HealthierHere Equity Training

Background:

HealthierHere is committed to advancing health equity and reducing health disparities in our region. We hosted an Equity Training in October 2019, giving partners the option of attending on October 3 or October 4. HealthierHere has already collected information on Practice Partner attendance. All Practice Partners have received credit for this incentive, no additional information is needed at this time.

2) HealthierHere Equity Assessment

Background:

HealthierHere is committed to advancing health equity and reducing health disparities in our region. In the second reporting period of 2019 we will reward clinical partners for completing a HealthierHere Equity Assessment. The Equity Assessment included questions related to your organization's commitment to Equity, Cultural Competence and efforts related to your organization's provision of Culturally and Linguistically Appropriate Services (CLAS).

Completing your Equity Assessment provided HealthierHere with baseline information about your organization's commitment to equity and any steps that you have taken to incorporate equity within the delivery of your programs and services. The Equity Assessment is for informational rather than evaluative purposes and provided us a general sense of your organization's commitment to advancing equity. HealthierHere recognizes that organizations are at various places in terms of operationalizing equity and cultural competence within their organization's business policies, practices and procedures. Consequently, the Equity Assessment included questions that document your organization's Equity and Cultural Competence work while also building a shared vision for Equity in a health care setting within King County.

Instructions:

The Equity Assessment was released after HealthierHere's Equity Training in October 2019. The HealthierHere Equity Assessment was due by 11:59pm on November 22, 2019 and submissions were only accepted through the online tool, Surveymonkey.

A) HealthierHere Equity Assessment: https://www.surveymonkey.com/r/DWJR7WV

The Equity Assessment deadline was 11:59pm on November 22, 2019

3) HealthierHere Equity Action Plan

Background:

HealthierHere is committed to advancing health equity and reducing health disparities in our region. In the second reporting period of 2019 we will reward clinical partners for completing a HealthierHere Equity Action Plan.

HealthierHere recognizes that equity is a both a process and a product that is developed over time through intentional efforts and planning. Achieving equity is not a one-size fits all approach; consequently, HealthierHere acknowledges that organizations are at various stages of development in their efforts to address equity. The Equity Action Plan will give your organization the opportunity to create customized goals and worksteps related to equity, that align with your needs and capacity as demonstrated on the Equity Assessment.

Instructions:

HealthierHere released the Equity Action Plan template in early October 2019, after the Equity Training. The Equity Action Plan is due at the end of the current reporting period, 11:59pm on January 3, 2020.

A) HealthierHere's Equity Action Plan: https://www.surveymonkey.com/r/2BQ8F33

Please submit your assessment by 11:59pm on January 3, 2020.