PUBLIC HEALTH – HEALTH CARE DELIVERY SYSTEM PARTNERSHIP

PREVENTION FRAMEWORK

	SHCIP Building Blocks	Prevention/Population Health Enhancements
1	**Quality/Price Transparency** 1. To achieve value based payment, the state must have transparent, accessible data and accurate measurements 2. Patients can make informed choices 3. Purchasers can identify value 4. Providers can highlight their performance	• Prevention Framework Partnership provides recommendations for prevention performance measures. • Price and quality data will be available at an- ACH level to support population health improvement, including demographic and geographic variations to help identify where further attention to prevention and health promotion may be needed. • In partnership with the state, the ACH will be held accountable for improvement of population health improvement increasingly overtime. **ACH criteria and process will be standardized with prevention and population health as a key component* • Performance management system should encompass an overall eye to improving the health of the population with a focus on underrepresented populations and geography. • PCMH and or PMHH recognition will be standardized and will incorporate a community centered approach.

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2	**Person and Family Engagement** 1. Create and support resources, tools, and wellness programs for patients to make informed decisions and be proactive about their own health 2. Shared decision-making 3. Initial focus will be on maternity care	• Assure that engagement strategies (including materials and other tools) -are culturally appropriate and responsive, trauma-informed, and informed by evidence to the extent possible. • Encourage clinical and community partnerships that promote health education, access to coverage and care, and the use of recommended clinical preventive services and screenings. • Support the delivery of preventive services and health promotion in community settings, where appropriate, to support greater reach, engagement, and cost-effectiveness. • Build and support a statewide health literacy campaign • Build payment pathways for prevention-oriented health outreach and engagement activities, utilizing flexible payment methods through contracting, legislative/budget, and/or waiver request • PCMH and or PMHH recognition will be standardized across WA state. (not sure if we are making this a requirement) • Shared decision making aids should be in alignment with the focus areas of the Prevention Framework; decision aids prioritized to mental illness, CVD, diabetes, etc. **Recognize and act on social determinants and allow flexibility for local policy makers to act* **Connect individuals and primary care providers to community resources so everyone is aligned, engaged, and participating in plan* Supporting the ability for individuals and families to make the easy choice the healthy choice by supporting communities in developing healthy social and physical environments

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3	**Regionalize Transformation** 1. Health care is local 2. 7 to 9 designated regional service areas 3. Accountable Communities of Health (ACHs) 4. Transformation Support Regional Extension Service-Agents 5. Multiple Accountable Risk Bearing Entities (ARBEs)	• Once regions are established Executive, Management Advisory Council agency members commit to aligning (where possible) their regional services and programs • The regional risk bearing entities should utilize information from the Regional Health Improvement Plan to inform the benefit design of the regional contracts. • Use regional approach to better elevate effective local best practices
4	**Accountable Communities of Health** 1. Locally governed public-private collaborative 2. Partner in Medicaid purchasing 3. Develop a region-wide health assessment and regional health improvement plan 4. Drive accountability for results 5. Act as a forum for harmonizing payment models, performance measures and investments 6. Health coordination and workforce development	• Utilize flexible payment methods through contracting, legislative/budget, and/or waiver request to support the financing of community prevention and clinical/community linkages. Create innovative social investment tools to finance prevention strategies with longer-term return on investment. • Incentivize the implementation of the Prevention Framework's priorities via the ACH structure, in addition to locally-driven priorities as expressed in regional health improvement plans. • State, tribal, regional and local entities integrate health criteria into decision making, where appropriate, across multiple sectors

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5	**Leveraging State Data** 1. Partnering with University of Washington and local public health to develop data toolbox 2. Improving the state's data pool and analytic capability 3. Mapping of data by census tract to illustrate prevalence, hot spots, and regional trends	• EMAC utilizes data to align resources, state-wide data discussions and better coordinate efforts • Include measure(s) relevant to the prevention framework priority areas, including measures of relevant community attributes and policies. • Within Washington's developing clinical data repository, it should prioritize the inclusion of an the capability to seamlessly transition care and services among a variety of providers across the spectrum of social support and health services, enabling clinical community linkages • Assure mechanisms for aggregating data from individual cases so that the data can be used to promote population-level policy and system change • Adopt non-medical risk factors mechanism for clinical systems to asses, and refer to non-medical support **Efforts include integration of public health data and data systems (i.e. BRFSS)* • Fund BRFSS sufficiently to enable better tracking of population health outcomes • Strengthen the capacity of local health jurisdictions to make use of integrated data sets for assessment, surveillance, evaluation, and planning.

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6	**Practice Transformation Support** 1. Transformation Support Regional Extension Service will serve as a convener 2. 'Hub' will host supports and resources around practice transformation 3. 'Spokes' will provide regional data and serve as test sites	• Create a Washington Transformation Support Regional Extension Service (or Innovation Center) to expand the extension system beyond clinical transformation • The RES at the state level will serve as a backbone support structure for additional transformation efforts beyond clinical: ***Learning Collaboratives* ***Peer-to-peer networks* ***Population health* • CHNA, community based policies: ***Technical assistance and support* ***Interpret and deploy* • Data and analytics: ***Resources and best practices* ***PCMH recognition support and tech assistance* ***Academic learning clearinghouses* • The Community Health Teams hosted at the ACH (acting as the spoke of the RES) will prioritize population health improvements **Transformation support and efforts should connect with experts on prevention initiatives (AHA, ACF, etc.)*

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7	**Workforce Capacity** 1. Incentivize current workforce to learn new skills 2. Community Health Workers Team-based and coordinated care 3. Telehealth and telemonitoring	• Utilize flexible payment methods through contracting, legislative/budget, and/or waiver request to better enable different types of providers and non-traditional health workers • CHW will be an essential part of the community health team • Prioritize development of definition of a CHW, their scope of work, training standards, and financing models. This includes defining CHW qualifications that will allow Washington to take advantage of the new Center for Medicaid Services ruling allowing non-licensed providers to bill Medicaid **Utilize CHT and CHW to expand community linkage between clinical and non-clinical setting* **Capacity building and assessment efforts should also address workforce shortages* • Increased training and understanding of population health should be included in academic medical schools

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