State Health Care Innovation Plan Foundational Building Blocks: Prevention Enhancement Recommendations

01

Build a culture of robust quality and price transparency

- Prevention Framework Partnership provides recommendations for prevention performance measures
- Price and quality data will be available at a ACH level
- ACH will be held accountable for improvement
- Performance management system should encompass an overall eye to improving the health of the population with a focus on underrepresented populations and geography
- PCMH recognition will be standardized

02

Activate and engage individuals and families in their health and health care

- Assure materials and engagement strategies are culturally appropriate
- Build and support a statewide health literacy campaign
- Utilize flexible payment methods through contracting, legislative/budget, and/or waiver request , and creative investment funding mechanisms
- PCMH recognition will be standardized
- 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.

03

Regionalize transformation efforts

- Once regions are established Executive Management Advisory Council agency members commit to aligning (where possible) their regional services and programs
- Local needs and priorities from the Community Health Improvement Plan must be tied to the risk bearing entity contracts

04

Create Accountable Communities of Health

- Utilize flexible payment methods through contracting, legislative/budget, and/or waiver request , and creative investment funding mechanisms
- Required to address priority Prevention Framework items in addition to locally selected priorities
- Local needs and priorities from the Community Health Improvement Plan must be tied to the risk bearing entity contracts
- Amplify a Health in All Policies approach across State agencies and within communities

- EMAC utilizes data to align resources
- Include measure(s) relevant to prevention of ACEs (e.g. proportion of children who meet developmental milestones of kindergarten readiness in all domains (physical, social-emotional, cognitive, language, literacy, and math)
- Within Washington's developing clinical data repository, it should prioritize the inclusion of an e-referral system which can connect provider based systems with social supports and vice versa, enabling clinical-community linkages

05

Leverage and align state data capabilities

- Create a Washington Transformation Support Regional Extension Service (or Innovation Center)
- The RES at the state level will serve as a backbone support structure for additional transformation efforts beyond clinical. It could provide:
  - 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
- The Community Health Teams hosted at the ACH (acting as the spoke of the RES) will prioritize population health improvements

06

Provide practice transformation support

- Utilize flexible payment methods through contracting, legislative/budget, and/or waiver request , and creative investment funding mechanisms
- 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.

07

Increase workforce capacity and flexibility