## Appendix C

# Washington State Public/Private Transformation Action Strategy

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# Planning for the Future of Health Care in Washington State

## Triple Aim Goals for Delivery System Transformation in Washington State

**By 2019, Washington State will be among the best five states in the U.S. in:**

**Washington State will have high quality healthcare.**

- Effective primary prevention and screening for preventable conditions
- Effective management of chronic conditions, including chronic physical health conditions and behavioral health conditions
- Quality of care for the most common acute conditions
- Avoiding unwarranted variation in healthcare quality and disparities in quality by race, ethnicity, gender, age, disabilities, language, geography, income, health conditions, and other factors

**Washington State will have affordable healthcare.**

- Total risk-adjusted per capita cost of care for commercially insured individuals, Medicaid recipients and Medicare beneficiaries
- Lowest 5-year growth rate in the total risk-adjusted per capita cost of health care
- Risk-adjusted per capita spending on
  - Treatment of preventable health conditions
  - Chronic conditions
  - Episodes for major acute procedures

**Washington State will have a healthy population.**

- Health of its residents for all major demographic and income groups
- Avoiding disparities in health status by race, ethnicity, gender, age, disabilities, language, geography, income, and other factors

## Key Objectives for Healthcare Delivery System Transformation:

1. Improve health and reduce the incidence of chronic conditions and major acute conditions through effective prevention and screening.
2. Effectively manage chronic conditions, including both physical and behavioral health conditions, particularly for complex patients.
3. Use the lowest cost, highest quality care for acute, non-emergency conditions.

## *Potential* Measures of Progress on the Objectives

*These are suggested as potential measures for consideration. Other potential measures exist. The goal is to have the list be of a manageable size, to focus on system outcomes, to use nationally available measures where available, to consider the cost of data collection compared to the value of the information, and to include measures that are possible given data availability from multiple sources.*

| Prevention and Screening | Chronic Conditions | Acute Conditions |
|---|---|---|
| 1. Proportion of adults with a healthy weight<br>2. Proportion of adults with healthy blood pressure<br>3. Proportion of children with a healthy weight<br>4. Proportion of the state population<br>▪ That is tobacco-free<br>▪ With no substance abuse<br>▪ Current on evidence-based immunizations<br>▪ Screened for serious infectious disease (HIV, Hepatitis C)<br>▪ Screened for behavioral health issues<br>▪ Assessed for oral health problems<br>▪ Current on evidence-based cancer screening<br>▪ With a designated primary care provider<br>5. Infant mortality rate<br>6. Incidence rates of newly diagnosed advanced stage cancer<br>7. Death rates from cervical, breast, colon and lung cancer<br>8. Death rate from drug and alcohol abuse<br>9. Death rate from suicide<br>10. Projected life expectancy and quality of life<br>11. Per capita spending on treatment of preventable conditions | 1. Proportion of individuals with one or more chronic conditions whose healthcare is being well managed<br>2. Proportion of individuals with a chronic condition who have a medical/healthcare home<br>3. Proportion of individuals with depression, mental illness, or chemical dependency participating in a treatment program<br>4. Rates of avoidable emergency room usage for individuals with chronic conditions<br>5. Rates of avoidable hospitalizations for individuals with chronic conditions<br>6. Rates of avoidable hospital readmissions for individuals with chronic conditions<br>7. Ratings by individuals of their experience with the care they have received<br>8. Use of palliative care vs. treatment at end of life<br>9. Ratings by individuals with chronic conditions of their health and ability to function<br>10. Activation (patient engagement) level of individuals with chronic conditions<br>11. Total cost of care for individuals with chronic conditions, risk adjusted | 1. Rates of ER usage for non-urgent conditions<br>2. Proportion of generic drugs prescribed (when generic alternatives exist)<br>3. Proportion of initial births delivered vaginally<br>4. Proportion of babies born full term and at normal birth weight<br>5. Rates of high-tech diagnostic imaging, particularly for conditions such as low back pain<br>6. Proportion of patients<br>▪ Reporting good outcomes from procedures<br>▪ Who die following major procedures<br>7. Proportion of providers with published episode prices for common procedures<br>8. Total spending (by purchaser and by patient) per episode on common procedures, risk adjusted<br>9. Variation in total risk-adjusted spending by provider organization (cost of care) per episode on common procedures<br>10. Per capita rates of procedures, risk adjusted, for procedures where evidence exists that there is overuse nationally<br>11. Per capita spending on most common acute conditions, risk adjusted |

## Four-Part Strategy to Achieve Each of the Three Objectives

*NOTE: All four parts of the strategy – redesigned delivery systems, restructured payment systems, restructured benefit designs, and education efforts – must all be implemented together, in complementary ways, in order for any of them to be successful in achieving the objectives.*

| Strategy | Vision/Guiding Principles |
|---|---|
| **A**<br><br>**Redesign healthcare delivery to improve access, reduce cost, improve quality, and improve patient experience** | • **STRENGTHEN PRIMARY CARE:** High quality, affordable, patient-centered primary care is the foundation of accountable care; it will be accessible to all residents and will play a central role in coordinating care for individuals and encouraging the use of high-value treatment options.<br>• **DELIVER HIGH-QUALITY, EFFICIENT PATIENT AND FAMILY-CENTERED CARE:** All healthcare providers will seek to deliver high quality, evidence-based care as efficiently as possible in ways that are culturally and linguistically appropriate, convenient, and responsive to patient and family needs. Unwarranted variation in care across providers and delivery of unnecessary care will be reduced or eliminated, starting with the Bree Collaborative's areas of focus<br>• **PROVIDE ACCESS TO HIGH VALUE SERVICES FOR ALL INDIVIDUALS:** Individuals in all parts of the state and from all demographic and income groups will be able to access high-value primary care, specialty care, dental care, behavioral health care, and community support services they need to maintain and improve their health.<br>• **COORDINATE ALL ASPECTS OF EACH PATIENT'S CARE:** All providers involved in a patient's care, including primary care, specialty care, dental care, mental health care, and chemical dependency care providers, will work as a team to improve quality, reduce waste and duplication, and improve patient experience and outcomes. Organizational structures such as Accountable Care Organizations will support the ability of different providers to coordinate care and to accept bundled and global payments. Providers will have access to timely, complete, accurate information on their patients' needs and services with appropriate protections for patient privacy. |
| **B**<br><br>**Restructure healthcare payment systems to support and reward providers who deliver high-value healthcare** | • **PROVIDE SUFFICIENT, FLEXIBLE PAYMENT TO ENABLE DELIVERY OF HIGH QUALITY, EFFICIENT, COORDINATED, PATIENT-CENTERED CARE:** Providers who are delivering care as efficiently as possible will receive adequate payment to cover the costs of quality care with the flexibility to continue innovating to improve quality and control costs.<br>• **EXPECT PROVIDERS TO TAKE ACCOUNTABILITY FOR COST, QUALITY, AND PATIENT EXPERIENCE OF CARE:** Providers will take accountability for controlling the total cost of care for their patients, and providers will not be paid for unnecessary care, inefficient care, medical errors, or avoidable complications. Providers will not be expected to ration care to patients or take *insurance* risk (i.e., being required to care for sicker individuals without sufficient resources), but providers will be expected to accept *performance* risk (i.e., to deliver high quality, cost-effective care).<br>• **ALIGN PAYMENT SYSTEMS AND BENEFIT DESIGNS:** The incentives for individuals under their health insurance benefit designs will be aligned with the incentives for providers under payment systems so that patients and providers can work together to improve quality and control costs. |

## Four-Part Strategy to Achieve Each of the Three Objectives, *continued*

| Strategy | Vision/Guiding Principles |
|---|---|
| **C**<br><br>**Restructure healthcare benefit design to enable and encourage individuals to improve their health and use high-value healthcare services** | • **ENCOURAGE INDIVIDUAL RESPONSIBILITY FOR MAINTAINING AND IMPROVING HEALTH:** Individuals will be responsible for maintaining a healthy lifestyle and obtaining appropriate preventive care when they have access to preventive care services and the resources needed to support health.<br>• **ENCOURAGE USE OF PRIMARY CARE:** All individuals who have access to primary care will choose and use a primary care provider to help them maintain and improve their health, to help them choose other providers and services wisely when health care is needed, and to coordinate healthcare services from multiple providers.<br>• **REQUIRE DESIGNATION OF ACCOUNTABLE PROVIDERS FOR NON-EMERGENCY CARE:** All individuals will designate in advance the provider or provider organization they expect to take accountability for coordinating the care they need for a non-emergency health condition or set of conditions.<br>• **SUPPORT VALUE-BASED CHOICES ABOUT NON-EMERGENCY CARE:** Individuals will be responsible for paying more if they choose a higher-cost service or provider of care for non-emergency needs when a lower-cost, high-quality service or provider is available to them. Cost-sharing for high-value services such as preventive care and medications to control chronic conditions will be reduced or eliminated.<br>• **PROVIDE ASSISTANCE WITH NON-MEDICAL NEEDS THAT AFFECT HEALTHCARE:** Individuals who have challenges in obtaining or using healthcare services due to lack of income, language barriers, lack of social supports, lack of transportation, etc. will have access to services to help them overcome these barriers. |
| **D**<br><br>**Educate and encourage state residents to improve their health and use high-value healthcare services** | • **EDUCATE AND ASSIST INDIVIDUALS TO IMPROVE HEALTH, PLAN FOR FUTURE HEALTHCARE NEEDS, AND CHOOSE HEALTHCARE SERVICES WISELY:** Employers, schools, social services agencies, media, and communities will organize programs designed to educate and assist employees, students, service clients, and residents about ways to improve their health, to provide them with resources and self-help tools to improve their health, and to educate them as to how to use information on quality and cost to make wise choices about healthcare providers and services. Individuals will be encouraged to plan for end-of-life decision-making while they are still healthy.<br>• **GIVE PEOPLE ACCESS TO THEIR OWN HEALTH CARE RECORDS:** Individuals will have easy access to complete and understandable information about the healthcare services they have received, ideally in an electronic format, in order to help them and their healthcare providers identify gaps in their care and avoid duplication of services.<br>• **GIVE PEOPLE ACCESS TO INFORMATION ON THE QUALITY AND COST OF HEALTHCARE PROVIDERS AND SERVICES:** Individuals will have easy access to accurate, current, comparable, and understandable information about the quality and cost of healthcare providers and will have access to assistance in using the information to make decisions about care. |

## Action Guides for Implementation – Aligning the Strategies

The principles and actions listed on the following pages represent one desirable approach to health care delivery, payment, and benefit reform. Alternative approaches that achieve better outcomes at a lower cost will be encouraged, **but in all cases, alignment of care delivery, payment, and benefit design is KEY to successful transformation.**

**OBJECTIVE: Improve health and reduce the incidence of chronic conditions and major acute conditions through effective prevention and screening.**

| How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN | How PAYMENT TO PROVIDERS Will Support This Type Of Care | How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care |
|---|---|---|
| Primary care practices will proactively monitor patients to ensure they are receiving evidence-based preventive services and screening when appropriate and in ways that are culturally appropriate for the patients and to identify any barriers the patients are facing in obtaining those services. Through health information exchange, primary care practices will have access to information on the preventive care services that patients receive from providers other than their primary care practice. Unwarranted variation and unnecessary care will be eliminated. Data will be analyzed and used to support continuous improvement. | Primary care practices will receive non-visit based payments to cover the costs of outreach to individuals to encourage evidence-based preventive services, screening, and counseling. Practices that are effective in achieving high rates of evidence-based preventive care for their patients will be rewarded financially. | Individuals will choose a primary care practice to help them maintain and improve their health and ensure they receive evidence-based primary prevention services. Individuals will not be required to obtain all preventive services from their primary care practice -- they may obtain them from other qualified providers, including non-medical organizations. |
| Primary prevention services and screenings will be designed to be as culturally appropriate, convenient, and affordable as possible for people to use, including through non-medical providers. Outreach and follow-up by phone, email, or visit will support patient efforts to live a healthy life. | Higher payments will not be made to higher cost providers for preventive services and screenings when lower cost options are available, but higher payments may be appropriate for services in communities with poor access and/or many high-risk patients. | Individuals will receive information on the most affordable, accessible opportunities for evidence-based screening and preventive services. Patients will have low or no-cost sharing for evidence-based preventive services and screenings and will receive assistance in obtaining services if they are not easily accessible. |
| Providers will work in partnership with employers to improve access to preventive care and to promote employee wellness. Partnerships will be created among healthcare providers, community organizations, and public health agencies to reduce disparities in the rates at which residents receive preventive services and screenings and to remove barriers to healthy living. Primary care practices will partner with others in the community to support special outreach to encourage individuals with health risk factors, minorities, and residents of rural areas to obtain evidence-based preventive services and screenings. | Additional payments will be made to support outreach to and access for high-risk residents, residents of under-served communities and rural areas, and individuals who have high rates of utilization of services for preventable conditions; payments will be flexible enough to support innovative, culturally-appropriate, community-based approaches. | Barriers that individuals face in accessing evidence-based prevention and screening will be identified and addressed. |

*NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.*

**OBJECTIVE: Improve health and reduce the incidence of chronic conditions and major acute conditions through effective prevention and screening,** *continued*

| How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN | How PAYMENT TO PROVIDERS Will Support This Type Of Care | How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care |
|---|---|---|
| All providers (not just PCPs) will encourage individuals to obtain necessary preventive services and screenings. | Payments to support outreach to patients for preventive services, screenings, and counseling will be shared among the providers which have the greatest ability to successfully reach and encourage patients to obtain services. | Employers and other purchasers will educate and incentivize their employees and members in culturally and linguistically appropriate ways about obtaining necessary preventive care and screenings and about maintaining and improving health, e.g., through wellness programs, recognition, lower insurance premiums, etc.<br>Community-wide culturally and linguistically appropriate education will encourage all citizens to obtain appropriate preventive health services. Education will stress the impacts on health, quality of life and expenses when evidence-based prevention and screening is not used. |
| | Mechanisms for investing in primary prevention services will be studied and, if appropriate, implemented. | |

*NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.*

**OBJECTIVE: Effectively manage chronic conditions, including both physical and behavioral health conditions, particularly for complex patients**

| How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN | How PAYMENT TO PROVIDERS Will Support This Type Of Care | How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care |
|---|---|---|
| Primary care practices will design treatments and support programs to meet the health needs of individuals with chronic conditions and customize care based on social needs. | Primary care practices will receive adequate payment to diagnose and develop an effective plan of care for individuals with chronic conditions. | Individuals with chronic conditions will choose and use a primary care provider to help them coordinate their care. |
| Primary care practices will develop a culturally appropriate plan of care for each patient with chronic conditions, including an Action Plan developed jointly with the patient for intervening early when problems arise, and will proactively monitor patients' care and health status in order to avoid the need for higher-cost services (e.g., hospitalizations). | Primary care practices will receive adequate non-visit based payment to deliver effective care management services to patients with chronic conditions, and payments will be risk-adjusted to allow services to be appropriately targeted to higher-risk patients. Practices will analyze data to ensure that their patients are receiving the most effective services. | Individuals will learn how to manage their chronic conditions effectively and take the steps recommended in their Action Plan (developed jointly with their primary care provider) to get help early when problems arise. |
| Primary care practices will use team-based approaches with physicians, nurses, pharmacists, diabetes educators, nutrition specialists, dentists, behavioral health specialists, etc., where appropriate to deliver care efficiently and customized to patient needs. | Payments to primary care will be flexible to allow non-physician care where appropriate to deliver care efficiently and customized to patient needs. | Patients will have lower cost-sharing for any additional services that are defined in a treatment plan developed with their primary care provider as being needed to help manage their chronic conditions. |
| Primary care practices will recommend and assist with arranging for community-based, non-medical services for individuals who need them to successfully manage chronic conditions. | Payments to primary care will be flexible to allow payment for community-based, non-medical services where necessary. | Community agencies will develop support services for individuals facing non-medical barriers to maintaining and improving health. |
| Primary care practices will involve non-primary care specialists when necessary or appropriate to assist in planning and managing care for complex patients. | Specialists will be paid to consult and coordinate with primary care practices without requiring an office visit by the patient if an office visit is not necessary. | Patients will have lower cost-sharing for consultations or office visits with specialists recommended by their primary care provider to assist in managing their chronic conditions. |
| A primary care practice or other provider will coordinate the services of multiple specialists and other providers (such as hospitals and long-term care facilities) for patients with complex conditions who need to use many providers. Patients will not receive duplicate or uncoordinated services from multiple providers. | Primary care practices and specialty practices will receive adequate payment to support the time and work involved in coordination of care and proactive outreach to patients. | Individuals will pay less if they use providers who agree to coordinate care with their PCP (or other care coordinator). |

*NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.*

**OBJECTIVE: Effectively manage chronic conditions, including both physical and behavioral health conditions, particularly for complex patients,** *continued*

| How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN | How PAYMENT TO PROVIDERS Will Support This Type Of Care | How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care |
|---|---|---|
| Primary care practices and behavioral health providers will coordinate their services for patients with chronic physical health and behavioral health conditions, and providers will move toward integrated care models that address both physical and behavioral health needs of patients. | Primary care practices and behavioral health providers will receive flexible, adequate payment to support the work involved in coordinating the care of patients with complex medical and behavioral health needs. | Individuals will pay less if they use a primary care practice and behavioral health provider who coordinate care (when this option is available). |
| Where appropriate, care management and coordination responsibility for patients with chronic conditions may be shared with or transferred to a non-primary care specialist by a primary care practice. | Specialists will be able to receive care management payments equivalent to those received by PCPs if the specialists accept accountability for care management/ coordination for patients with chronic conditions. | Individuals with chronic conditions will have the flexibility to choose a specialist as their primary care provider if the specialist has the necessary training and resources to provide effective primary care and is willing to accept responsibility for care management and coordination. |
| All of the providers involved with a patient's care will work together to take responsibility for controlling and reducing the overall cost of care related to their patient's chronic conditions. Unwarranted variation and unnecessary services will be eliminated. Data will be analyzed and used to support continuous improvement. | Payment amounts will be higher for providers with better outcomes and lower overall costs after adjusting for differences in patient acuity and risk factors. | Individuals will pay less if they choose a primary care provider who has higher quality and lower costs if there are choices of providers available. |

*NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.*

**OBJECTIVE: Use the lowest cost, highest quality care for acute, non-emergency conditions**

| How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN | How PAYMENT TO PROVIDERS Will Support This Type Of Care | How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care |
|---|---|---|
| Provider organizations will assist individuals in gaining access to evidence-based, culturally and linguistically appropriate information and advice (preferably from a neutral source, i.e., an individual or organization which will not perform a procedure or benefit financially from whether a patient does or does not receive a procedure) to help the patient choose which types of testing and treatment are appropriate for acute, non-emergency conditions. | Healthcare providers will be paid for time spent in shared decision-making processes with patients about care decisions. | Individuals will have financial incentives to seek information and advice on the most appropriate and cost-effective treatments and providers for an acute condition. Purchasers, health plans, and healthcare providers will all encourage individuals to engage in shared decision-making processes with healthcare providers before choosing specific services to address a non-emergency healthcare condition. |
| Efficient systems will be developed in each community for diagnosing and treating minor acute conditions to avoid unnecessary treatments in an emergency room. This may include a combination of services delivered by primary care practices or urgent care centers. | Payments to primary care providers will be sufficient to support after-hours access for individuals and flexible enough to allow phone calls and emails with individuals instead of office visits. Primary care providers will be paid more if their patients have low rates of using emergency rooms for minor acute care. | Individuals with minor acute conditions will have lower cost-sharing if a provider that delivers quality services at a lower total cost is available and used by the individual to deliver care. |
| Provider organizations delivering acute procedures or services will take responsibility for coordinating all of the services the patient receives during a full episode of care (e.g., including post-acute care), for avoiding errors and complications, and for eliminating inefficiencies and unnecessary services. | Provider organizations that care for patients with acute conditions will receive a single payment or budget to cover the costs of all services in a single episode of care for treating the acute condition, including the costs of treating any errors or preventable complications that may occur, unless they are receiving a single payment or budget to manage all of the care for the patient for a defined period of time, including care for non-emergency acute conditions. The payment amount will be higher for patients with more health problems or more severe health problems. | Individuals with an acute (non-emergency) condition will be expected to designate a provider organization that will take accountability for both the quality and cost of caring for the acute condition. Individuals can either (a) select a specific provider organization in advance to deliver all of the care they need for any condition if and when it arises, or (2) select a provider for each acute condition as it arises. Patients will only be required to pay a single cost-sharing amount for all of the care they receive from a provider for care of an acute condition, rather than cost-sharing on each individual service. Individuals will be educated about the advantages of receiving care from a provider which offers a warranty (i.e., does not charge extra for preventable complications) or from a provider which accepts an episode or global payment and agrees to coordinate all services. |

*NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.*

**OBJECTIVE: Use the lowest cost, highest quality care for acute, non-emergency conditions,** *continued*

| How Care Will Be Delivered/ DELIVERY SYSTEM DESIGN | How PAYMENT TO PROVIDERS Will Support This Type Of Care | How BENEFIT DESIGNS AND EDUCATIONAL EFFORTS Will Encourage Individuals To Use This Type Of Care |
|---|---|---|
| Provider organizations will redesign care so it is delivered at the lowest cost possible consistent with high quality and appropriate safety for the patient. Unwarranted variation and unnecessary care will be eliminated. Data on quality, cost, and patient experience and outcomes will be analyzed and used to support continuous improvement. | Provider organizations will publish the total episode price they will charge a self-pay patient who has a particular acute condition or who needs a specific procedure or treatment. Purchasers/payers and providers will negotiate to establish fair prices for insured individuals. Unwarranted variation in prices will be reduced or eliminated. | Individuals will have access to comparable, current, easy-to-understand information from a neutral source on the quality and cost of different provider organizations which offer the types of care patients need. Purchasers and payers will seek to give individuals choices of multiple provider organizations for care wherever possible, but the patient will pay significantly less if they use a provider organization with lower costs and equal or higher quality. |

*NOTE: In each row, the elements in all three columns – delivery system design, payment systems, benefit designs, and education efforts – must all be implemented together in order for any of them to be successful.*

## Overarching Strategies to Encourage and Support Delivery System Transformation

These strategies are intended to inform the State of Washington about the tools and levers that can be utilized to support and accelerate delivery system transformation.

| Strategy | Vision/Guiding Principles |
|---|---|
| **E**<br><br>**Measure progress across the state to identify successes and opportunities for improvement** | • **CREATE A COST-EFFECTIVE STATEWIDE MECHANISM TO MEASURE PROGRESS ON OBJECTIVES**: Statewide data will be collected from multiple sources and made accessible to stakeholders for measurement and analysis of the status and progress on goals and objectives and to support continuous improvement and elimination of unwarranted variation by providers. The data collection mechanism(s) will be chosen with consideration for the cost and time involved in data collection, the benefits to be achieved from measurement, and the impacts of changes in payment systems, HIT, and modes of care delivery, drawing on the experiences of other states.<br><br>• **USE COMMON, HIGH-VALUE, CONSENSUS MEASURES OF OBJECTIVES, DRAWING ON MEASURES FROM NATIONALLY-ENDORSED SOURCES WHERE POSSIBLE**: Key stakeholders will agree on and use the most important measures of quality, cost, and patient experience. Measures will be selected considering the needs of different stakeholders and different parts of the state, considering the costs of data collection and the likely impact of improvement on the measures, and choosing nationally endorsed measures to the maximum extent possible. Measures of progress in improving care delivery, payment systems, benefit designs, and patient engagement will also be selected or developed.<br><br>• **IDENTIFY SUCCESSFUL PROGRAMS AND PRIORITIZE OPPORTUNITIES TO IMPROVE COST AND QUALITY**: Analyses will be conducted and publicly shared to (1) identify and celebrate providers and health systems that are delivering efficient, high-quality care and (2) identify unnecessary variations in care and other opportunities to improve quality of care for individuals and/or reduce costs of care for purchasers and patients.<br><br>• **IDENTIFY AND ADDRESS DISPARITIES**: Wherever possible with the data available, cost and quality measures will be analyzed in detail by demography, income, health status, and geography to identify both disparities in care and successful efforts to reduce disparities.<br><br>• **PROTECT PATIENT PRIVACY AND PREVENT MISUSE OF DATA**: All data with patient-specific information will be stored and used in ways that protect patient privacy, and potentially harmful uses of data will be controlled or prohibited. |

## Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

| Strategy | Vision/Guiding Principles |
|---|---|
| **F**<br><br>**Encourage innovation and market-based approaches that support progress on goals** | • **MAKE THE QUALITY AND COST OF PROVIDERS AND SERVICES TRANSPARENT FOR ALL STAKEHOLDERS USING COMMON MEASURES**: Patients, purchasers, providers, and payers will have access to accurate, current, comparable, actionable information about the quality and cost of all providers and services using a common set of high-value measures.<br><br>• **MAXIMIZE THE USE OF MARKET-BASED APPROACHES TO ENCOURAGE DELIVERY OF INNOVATIVE, HIGH-VALUE CARE:** Purchasers and patients will select and use providers who innovate to deliver the highest-quality, lowest-cost care as determined using common, transparent measures, with support from appropriate payment systems, benefit designs, and accessible data. Delivery systems, payment systems, and benefit systems will be adapted to the unique needs of different geographic areas and low-income individuals. Payment and choices for patients will increasingly be based on larger bundles of coordinated care, with costs and quality compared using standard measures.<br><br>• **USE GOVERNMENTAL POWERS WHERE NECESSARY TO ENSURE AN EFFECTIVE HEALTHCARE MARKETPLACE**: State regulations and programs will be used to ensure transparency of information on quality and cost, to correct anti-competitive behaviors and protect consumers, to facilitate successful participation of Medicaid beneficiaries and state employees in the healthcare marketplace, to encourage and remove barriers to integration of physical and behavioral health services, and to remove regulatory barriers to changing the delivery of care in ways that would improve access, improve quality, or reduce costs. The state will serve as a leader among purchasers by requiring use of new payment models and benefit designs for state financed health benefits.<br><br>• **SUPPORT VOLUNTARY MECHANISMS FOR COORDINATION AND COLLABORATION**: Both public and private sector leaders will encourage and support voluntary mechanisms for coordination and collaboration in order to facilitate progress in key areas, including: guidelines to reduce unwarranted variation in high value care, alignment on payment systems, benefit structures, health information exchange, infrastructure sharing (particularly for smaller practices), and sharing of best practices. |

## Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

| Strategy | Vision/Guiding Principles |
|---|---|
| **G**<br><br>**Help rural areas, small providers, and providers with unique needs to transform their care delivery systems** | • **BUILD ON NATURALLY OCCURRING CONVENERS IN RURAL AREAS TO SUPPORT COLLABORATION, ALIGNMENT, AND TRANSFORMATION.** Many rural communities have organizations that are serving, could serve, or have served in the past in roles that support collaboration among stakeholders, provide technical assistance to providers, etc., including public health departments, hospitals, Area Agencies on Aging, regional health collaboratives, etc.<br><br>• **HELP SMALL AND RURAL PROVIDERS OBTAIN TECHNICAL ASSISTANCE IN TRANSFORMING CARE.** Small and rural providers will face unique challenges in transforming care, and they could obtain technical assistance more cost-effectively through joint efforts, learning collaboratives, etc. For example, a "Primary Care Extension Service" could be created to work with small and rural primary care provider organizations to help them redesign care and adapt to new payment and delivery models.<br><br>• **PROVIDE STABILITY AND PREDICTABLITY OF TOTAL REVENUES FOR SMALL AND RURAL PROVIDERS WHILE THEY WORK TO REDESIGN CARE DELIVERY SYSTEMS.** It is very difficult for small providers with limited reserves to take time away from their day-to-day operations to redesign care or to make upfront investments in new care delivery methods that could cause them short-term losses in revenues. Protections against large swings in revenue could give them the "breathing room" needed to innovate.<br><br>• **PROVIDE LOANS AND TRANSITIONAL FINANCING TO HELP SMALL PROVIDERS MAKE INVESTMENTS IN BETTER DATA SYSTEMS.** Even where there is a clear business case for the return on investments in new systems, small providers will likely need help in obtaining upfront capital.<br><br>• **ASSIST THE HEALTHCARE WORKFORCE TO RETRAIN AND OBTAIN WORK IN NEW HEALTHCARE ROLES.** A shift to more primary care, preventive care, and outpatient care and away from inpatient care will require the healthcare workforce to have different sets of skills and to work in different settings and potentially for different organizations. Facilitating this transition will help speed implementation of healthcare improvements.<br><br>• **DEVELOP METHODS OF PAYING FOR MEDICAL EDUCATION, RESEARCH, AND CARE FOR THE UNINSURED THAT DO NOT PENALIZE PROVIDERS THAT SUPPORT SUCH FUNCTIONS.** As greater attention is focused on the cost of care, purchasers and patients could avoid using teaching hospitals and hospitals which serve large numbers of the uninsured unless their higher costs can be supported in ways other than the prices of their services to insured patients. This may require a focus on federal policy change. |

## Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

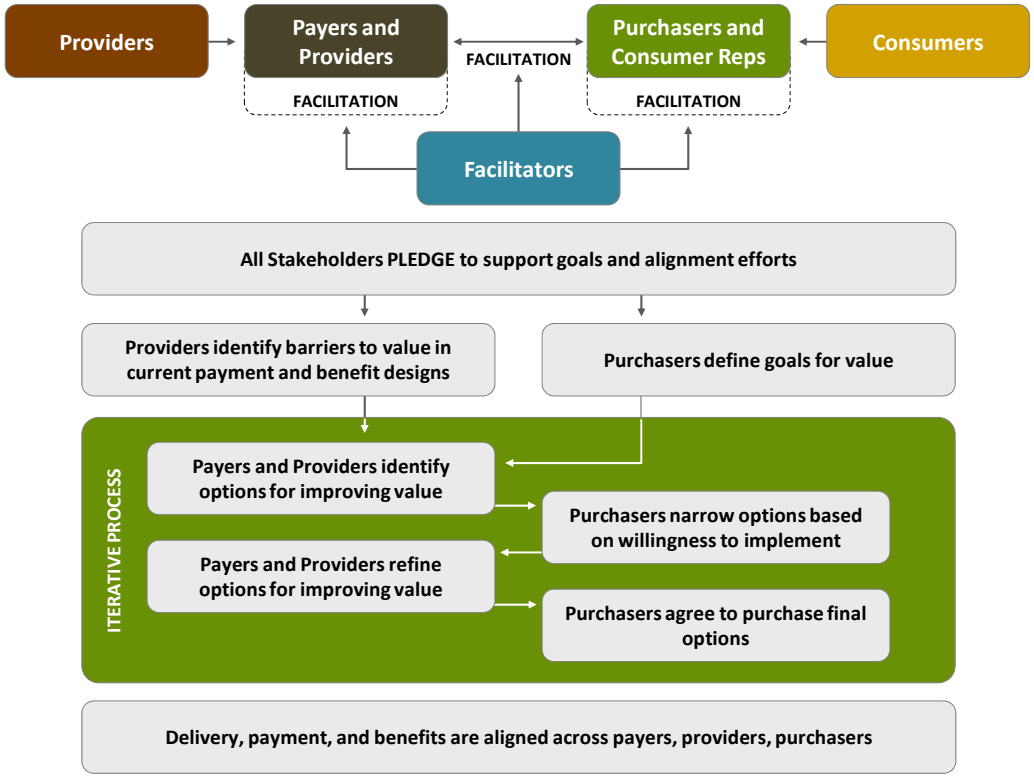
| Strategy | Vision/Guiding Principles |
|---|---|
| **H**<br><br>**Align the efforts of all stakeholders in implementing the strategies** | • **USE A NEUTRAL FACILITATOR TO SUPPORT DISCUSSION AND ALIGNMENT AMONG PAYERS AND WITH OTHER COMPETING STAKEHOLDERS.** Payers see benefits to aligning but will not align on their own without a neutral entity to convene and facilitate alignment. The state should recognize one or more facilitators to perform this function.<br><br>• **USE STATE ACTION EXEMPTION POWERS TO CREATE ANTI-TRUST SAFE HARBORS IF STAKEHOLDERS SEE ANTI-TRUST ISSUES AS A BARRIER TO ALIGNMENT PROCESSES.** Assess this early and take action if needed. Creating anti-trust safe harbors can take time.<br><br>• **ASK EACH STAKEHOLDER TO COMMIT TO THE ALIGNMENT PROCESS, DEFINING WHAT IT IS PREPARED TO CONTRIBUTE TO IMPLEMENTATION AND WHAT IT NEEDS FROM OTHER STAKEHOLDERS IN ORDER TO DO SO.** Differences in the "gives and gets" defined by each stakeholder will need to be discussed and aligned through facilitated discussion. (Please see Appendix D for *sample* commitment statements for purchasers, payers and providers.)<br><br>• **EXPECT INDIVIDUALS *WITH AUTHORITY TO MAKE DECISIONS* TO REPRESENT EACH STAKEHOLDER IN THE ALIGNMENT PROCESS.** This is a time for organizations to commit the time and energy of staff that have both good ideas to offer AND have the authority to make commitments on behalf of their organization. To be most effective, the alignment process needs to be an active participatory process that results in decisions in a timely manner.<br><br>• **ASK PURCHASERS TO INITIATE THE ALIGNMENT PROCESS BY DEFINING GOALS AND A WILLINGNESS TO SUPPORT CHANGES IN PAYMENT SYSTEMS AND BENEFIT DESIGNS.** Providers and payers need to know the goals that their customers – purchasers – are seeking to achieve and the kinds of changes they will and will not support as demonstrated by their own commitments *and actions*.<br><br>• **AVOID TRYING TO ALIGN PAYMENT SYSTEMS WITHOUT INVOLVEMENT AND SUPPORT FROM BOTH PAYERS AND PROVIDERS.** Payment systems must support delivery system changes and vice versa. Facilitation is needed to enable payers and providers to develop mutually reinforcing strategies that achieve the Triple Aim goals.<br><br>• **ASK PROVIDERS TO IDENTIFY AND PRIORITIZE THE BARRIERS TO CARE DELIVERY IMPROVEMENT CAUSED BY PAYMENT SYSTEMS AND BENEFIT DESIGNS.** Alignment among payers is most feasible where there is an economic rationale for alignment; providers must be able to show the costs of non-alignment and the potential savings or improvements through alignment. |

## Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

| Strategy | Vision/Guiding Principles |
|---|---|
| **H**<br><br>**Align the efforts of all stakeholders in implementing the strategies,** *continued* | • **INVOLVE CONSUMERS IN SETTING GOALS FOR HEALTHCARE IMPROVEMENT AND IN DESIGNING CHANGES IN DELIVERY SYSTEMS AND BENEFIT STRUCTURES.** Patient-centered health care must be guided, at least in part, by patients' perspective of the care experience, including the quality and financial outcomes that have a direct impact on patient well-being.<br><br>• **BUILD ON THE SUCCESSFUL ALIGNMENT EFFORTS OF THE WASHINGTON HEALTH ALLIANCE (FORMERLY THE PUGET SOUND HEALTH ALLIANCE), THE BREE COLLABORATIVE, THE FOUNDATION FOR HEALTHCARE QUALITY, QUALIS HEALTH AND OTHER COLLABORATIVES AND QUALITY IMPROVEMENT ORGANIZATIONS.** Washington State enjoys the benefits of several organizations that have made important contributions – each in their own way – to aligning the efforts of purchasers, providers and/or payers in improving health and healthcare. The State Innovation Plan maximizes leverage of these various activities. |

## Aligning Stakeholder Efforts to Achieve the Triple Aim

Aligning stakeholder interests is an iterative process, wherein each step has the potential impact of shaping the next step, and this level of understanding of "gives and gets" represents an important underpinning of facilitated agreement.



## Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

| Strategy | Action Step | Responsibility |
|---|---|---|
| **Getting started and sustaining progress** | 1. Ask all key stakeholders – major purchasers, providers, payers, and consumer/patient representatives – to commit to implementing the strategy defined in this plan and to achieving its objectives.<br>• Each stakeholder should define what it is prepared to contribute to implementation and what it needs from other stakeholders in order to do so.<br>• Purchasers should be asked to make their commitments first, since they will drive the rest of the market.<br>• The largest organizations in other stakeholder groups in each market (e.g., population centers) should be asked to commit next.<br>• Eventually, all organizations should be asked to make commitments.<br>• All organizations and parts of the state should be included, including the military and tribal health systems. | State government will finalize the commitment documents and request commitments from stakeholders<br>There will need to be a process in place to follow-up with needed explanation and dialogue to achieve widespread response to commitment documents |
| | 2. Appoint facilitators and begin convening the stakeholders who have made commitments for aligned action to implement the strategies in the plan | State government will identify one or more private and/or regional community entities to serve as facilitators of stakeholder discussion and alignment<br>Each stakeholder should appoint a high-level decision-maker to participate |
| | 3. Obtain and/or make data available to measure variations in care, compare performance to benchmarks, and to measure progress against goals | State government will identify one or more neutral and trusted entities to assemble and make data available to stakeholders.<br>State government may need to take legislative or regulatory action to ensure transparency of information on quality and cost, ensuring that all major data suppliers participate equitably |
| | 4. Affirm an initial goal for reduction in healthcare spending that is ambitious but feasible based on available data | State government will solicit input from stakeholders and finalize the goal |

## Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

| Strategy | Action Step | Responsibility |
|---|---|---|
| **Getting started and sustaining progress,** *continued* | **5.** Call on all stakeholders to identify actionable opportunities for achieving the goal. | State government will issue the call for opportunities |
| | 6. Prioritize opportunities within each of the three objectives that would enable the goal to be achieved. Criteria for prioritization include:<br>• Potential for savings for all payers<br>• Existence of opportunity statewide rather than in selected communities<br>• Opportunities are actionable | Some opportunities are explicitly called out in the State Health Innovation Plan for more immediate action by the state as first mover; analyses commissioned by state government may include further rating/ranking of opportunities<br>State government will solicit input from stakeholders to develop final priorities not explicitly included in the State Health Innovation Plan |
| | 7. Identify barriers to implementing the priority activities and develop a coordinated strategy for overcoming them. Use existing models of effective care delivery, payment systems, benefit designs, etc. to facilitate solutions (e.g., Wagner Chronic Care model) | Facilitators would convene stakeholders to identify barriers and solutions |
| | 8. Implement the elements of the strategy | State government asks for more detailed commitments from individual stakeholders to implement relevant aspects of the strategy, e.g.:<br>• Purchasers: changing benefit designs for employees or members; choosing health plans that implement payment and benefit changes<br>• Payers: implementing payment and benefit changes<br>• Providers: changing care delivery processes<br>• State and media: educating the public about needed consumer, patient support |

## Overarching Strategies to Encourage and Support Delivery System Transformation, *continued*

| Strategy | Action Step | Responsibility |
|---|---|---|
| **Getting started and sustaining progress,** *continued* | 9. Measure and report on progress quarterly<br>• in implementing planned solutions<br>• in achieving the identified opportunities | State government surveys stakeholders as to implementation progress and issue status reports<br>State government commissions regular analyses of progress on targeted opportunities and issue progress reports<br>Stakeholders have access to timely data to measure their own progress |
| | 10. Call on all stakeholders to identify actionable opportunities for achieving the goal. | Coordinated action by all stakeholders |
| | Repeat the process of soliciting and prioritizing actionable opportunities and developing strategies for implementing them. | State government with input by all stakeholders |