State of Washington
Washington State Health Care Authority

Washington State Health Care Authority

State Medicaid HIT Plan (SMHP)

January, 2017

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EXECUTIVE SUMMARY

Since its creation in the late 1980s and affirmed with recent legislation, the Health Care Authority (HCA) has played a central role in the Governor's health health reform efforts. HCA is currently leading several initiatives designed to transform the health care delivery and payment system.

HCA is providing statewide leadership in health information exchange (HIE) and playing a central and prominent role in bringing the clinical health management infrastructure and tools to state agencies that can benefit the larger care community as well. The use of information technology and health information exchange will play a vital role in making these efforts a reality. HCA manages two programs to advance the use of health information technology to improve care:

- **Electronic Health Record (EHR) Incentive Program** which provides financial incentives to healthcare providers for using EHR technology to positively impact patient care.

- **Health Information Exchange** to increase the utilization of the state HIE to make complete and current patient level clinical data available to decision makers at the point of care.

Medicaid EHR Incentive Program

HCA began accepting attestations from providers for adopting, implementing or upgrading to electronic health record technology in June of 2011 and has issued over 9,800 payments to eligible professionals and hospitals totaling more than 279$M (as of February, 2016). Provider outreach resulted in participation of providers across many specialties and a steady increase in first time payments that remains higher than the national average.

Fig. 1: Percentage of All WA MDs, NPs, and PAs that Demonstated Meaningful Use of a Certified Health IT, April 2015 and received a CMS EHR Incentive Program Payment.

		% of All MD/Dos, NPs, and PAs				% of MD/DOs		% of NPs		% of Pas	
Region	**Total MD/Dos NPs, Pas**	**Dec-12**	**Dec-13**	**Dec-14**	**April-15**	**Total/MD Dos**	**Apr-15 %**	**Total NPs**	**Apr-15 %**	**Total PA's**	**Apr-15 %**
Washington	16,857	17%	34%	48%	52%	13,426	61%	1906	26%	1528	2.7%

http:/dashboard.healthit.gov/quickstats/PDFs/Health-IT-Quick-Stat-Health-Care-Professional-EHR-Incentive-Payment-Scorecard.pdf

While the adoption of certified EHR systems is critical to building the capabilities to exchange data, further efforts to assist providers in health information exchange are necessary. HCA will continue to refine and enhance our stakeholder engagement strategy to reach out to underrepresented specialty groups. Please refer to Section C of this report for details of future planned activities.

Health Information Technology Progress

Health information technology within an enterprise has made great strides in the healthcare industry. With federal incentive payments to help offset the costs, many new providers and practices adopted, implemented, or upgraded to certified EHR technology & have begun meaningful using this technology to improve care coordination, and population health outcomes . With a business case and a fairly mature market, HIT within an enterprise has taken a strong foothold in the healthcare industry leaving few practices trying to get by solely on paper.

Some pockets of providers still struggle in these early stages of health IT adoption and meaningful use as it requires time and effort to make complex changes to their business processes and some specialties lack EHR tools that meet their needs. Providers who have adopted, implemented and upgraded to new certified technology have been focused on getting data into their new system and adapting their business processes.

The move into Stages One & Stage Two of Meaningful Use (MU) still offers many challenges:

> **Disruption to practices** – Each new round of MU requires an upgrade to an existing EHR, which means disruption in operations and workflow. Resources to help medium and small sized practices work through these disruptions are not readily available.

It's not just the technology – Using EHR technology meaningfully means changing the culture of the practice so that it is more focused on and able to deliver population-based health care. This means changing workflows and processes.

Cost – There is generally a financial investment necessary for each EHR system upgrade needed to meet CMS requirements for each stage of meaningful use. Providers may not have adequately anticipated these costs or planned for them.

Usability – As the MU requirements get more complex, the EHR vendors are increasingly challenged to meet them in the time provided. Some vendors may not keep pace and drop out of the market, requiring providers with their solutions to essentially start over. Poor EHR system design and improper use can cause EHR related errors that jeopardize the integretig of the information.

Data Quality – Data quality was not historically an issue in ambulatory care settings as providers generally did not use data at a population level. Creating and enforcing data standards is new and will mean cultural changes and extensive education in the practices.

Interoperability – While interoperability of patient health information is advancing in small steps across the industry, challenges remain. Expense of building point to point interfaces to share data with other enterprises with different EHR vendors can consume recources. Variablilites in systems and how they have been implemented creates challenges.

Health Information Exchange

The adoption of Health Information Exchange (HIE) between enterprises still faces many challenges yet there are a wide variety of HIE activities currently accomplished which include:

- Browser based access to applications
- Direct EHR-to-EHR exchange
- Repository-based HIE's
- Hub based HIE's and clearinghouses
- Faxes and document exchange

The patient benefits of HIE are clear, real time clinical data to support better decision making and reducing redundant or unnecessary testing and avoidance of medication complications contribute to better population health. Providers who have never had access to this type of information outside of their practice have to be convinced of the value and access to such data must be easy. Data privacy, access, and consent concerns also serve as a barrier to open exchange particularly among the behavioral health provider community.

The Path Forward

Over the next 1 to 5 years, HCA envisions the following advances in the Health IT landscape:

Interoperable Electronic Health Record Technology: A critical mass of Washington provider organizations operate with highly functional and interoperable EHR systems.

Adoption of Standardized HIE Transactions: Washington providers broadly adopt industry standard data sets for health information exchange.

Utilization of Health Information Exchange: HCA and a critical mass of care partners share clinical information across organizational boundaries for use at the point of care**.**

Longitudinal Clinical Data Sets: Health care plans and providers contribute clinical data sets electronically to populate a longitudinal Medicaid health record.

Multi-Payer Partnerships: Payer Community comes together to bring necessary infrastructure to broader community to support new care delivery and payment models.

HCA is fully committed to advancing the technical infrastructure to meet the needs for real time clinical data for Medicaid program management and the tool sets needed to realize the opportunities presented in the Health Care Innovation Plan which include:

Aligned multi-payer strategies: Engage multiple public and private payers in new payment and service delivery models with common outcomes measures.

Physical-behavioral health integration: Identify transformation opportunities to support integrated medical, behavioral health, and long-term supports and service delivery.

Prevention: Identify upstream strategies to keep communities and individuals healthy by addressing social determinants of health, health promotion and community health supports.

Healthy beginnings: Identify strategies from pre-conception to age 3 to ensure a healthy start for Washington state children.

Appropriate adult care: Speed identification and adoption of effective strategies aimed at overuse, misuse and underuse of care.

Care transitions/coordination: Identify cross-cutting strategies, focused primarily on necessary infrastructure to improve coordination of care and transitions between settings.

Transparent and accountable plan and provider performance: Identify strategies to improve and make visible health plan and provider performance through metrics, accreditation and public reporting.

HCA is also committed to advancing meaningful use of health information technology and increased usage of health information exchange. Our SMHP includes the following elements:

Standards and Interoperability: Identify strategies to advances the adoption and implementation of national HIT standard transactions and data sets.

Meaningful Use: Identify strategies to advance the adoption and meaningful use of certified electronic health record system. Helping Incentive recepients with certified technology integrate and exchange health data and utilizing the data in a meaningful way.

Achieving our vision requires the types of improved efficiencies that become possible with the collection, integration and sharing of clinical information across organizations. The availability and use of integrated health information serves as the foundation to enable the state's innovation plan and overall objectives of better health, better care and lower costs.

Our desire is to move to a more robust and widely available technology framework that supports the secure electronic collection and exchange of clinical health information. This enable new methods to measure health outcomes and clinical health management and paying for value not volume.

High Level Goals

1. Play a more central, prominent role in bringing infrastructure and tools to Medicaid that can benefit the larger care community in a structured way.
2. Drive broad utilization of integrated clinical and administrative information to inform policy, program and care decisions.
3. Drive broad adoption of standardized HIE transactions and increased use of health information exchange between organizations.
4. Support the adoption and meaningful use of certified Electronic Health Record (EHR) technology among Medicaid providers.

New Capabilities

Adoption of electronic health records and capabilities for HIE must be complimented with the following tools and capabilities that collect, compile, manage and interpret large quantities of clinical data and present evidence based information to support care decisions:

Record Locator: Query and locate patient records within multiple provider systems to enable health care community to contribute data electronically to patient's health record.

Clinical Data Collection and Aggregation Tools: Collect clinical, behavior health and social services data coming from different systems and parse into patient specific records.

Clinical Data Repository (CDR): Consolidate data from a variety of clinical sources to populate a longitudinal view of a patient's health record. Data types may include lab results, pharmacy data, radiology reports and images, pathology reports, hospital admission and discharge data, diagnosis, and discharge summaries.

Case Management and Decision Support Tools: Outline clinical care pathways, tasks and clinical interventions for health management and disease prevention. Monitor at-risk patient populations and identify preventative actions needed at the point of care.

Reminders, Notifications and Alerts: Send a wide range of messages automatically from a system to a clinician at the point of care that are important, urgent and/or time sensitive.

Clinical Portal: Presents complete and up to date longitudinal patient information and to authorized users using role-based privacy levels to protect patient privacy.

Analytic Tools: Provide high level dashboard reporting on provider performance, patient health and population health trends and make data available to analytical data stores.

Patient Portal: Present longitudinal health record and educational materials that enable individuals to self-manage their health, their family's health or others they care for.

High Priority Initiatives

HCA's vision includes a set of high priority initiatives that include new solutions, processes and policies to help address patient population care issues that cut across organizational boundaries:

1. Bring needed infrastructure and tools that meet Medicaid enterprise needs for clinical health information as a payer and can benefit the larger care community.
2. Integrate behavioral health encounter, diagnosis and medication data with physical health data into a comprehensive, longitudinal clinical record.
3. Outline evidence based clinical care pathways, tasks and interventions for management of complex conditions and disease prevention.
4. Acquire tools that can monitor individuals with complex conditions as they move through the health care system.
5. Drive broad utilization of health information exchange & adoption of standardized transactions.
6. Bring clinical data sets from EHR systems into a Clinical Data Repository and state data analytic stores for Medicaid program evaluation.
7. Support adoption & meaningful use of certified electronic health record (EHR) technology among Medicaid providers.

HCA will implement the initiatives in a phased approach over the next 5 years as outlined in Section E. Implemenation of this plan brings with it broad changes to state agencies and health

care partners in how we collect, share and use clinical data for program, policy and care decisions.

Funding the Effort

HCA has asked the Managed Care Organizations (MCO's) to collaborate with peers, HCA and the State HIE to conduct a multi-year statewide Performance Improvement Project (PIP) to provide a clinical Data Repository (CDR) service that will focus on collecting, integrating and providing authroicaed access to medical, behavioral health and social service data currently stored in provider EHR systems and other state and locat data sources across the health care delivery system.

The CDR will serve as a shared asset to connect and leverage the power of information and federal, state and private investements in EHR technology. The CDR will enable communications among care providers and provide access to data sets that are not broadly available in clinicians, care teams, communities and purchasers.

As of 2015, all state MCO's have entered into contracts which require the funding of this effort as performance improvement projects through a purchased service model with a per member per month with quarterly payments to the state HIE for each Apple Health enrollee assigned to the plan.

This approach allows HCA and the MCO's to share the cost of the investment for all Managed Care covered clients.

Guiding Principles to gain provider engagement

To see the full value from community care coordination and HIE initiatives, the majority of health care organizations must agree to share health information. The following principles will guide our stakeholder engagement strategies and activities:

1. Acquire technical solutions that work in the providers preferred environment and work flow.
2. Consolidate and leverage existing standards built into certified EHR systems, connections and routing for health information exchange.
3. Adopt national standard transactions and data sets and apply file translation to accelerate exchange.
4. Leverage data available in provider EHR systems for quality reporting where possible.
5. Demonstrate that patients will continue to move between delivery systems and reinforce the need for sharing of patient information to improve care.
6. Leverage policy where possible to advance adoption through contracting mechanisms.

7. Seek early adopters who serve multiple managed care organizations and have highly functional systems.
8. Lead project from a clinical perspective with the primary use of shared data to informa decisions at the point of care.
9. In 2016, HCA required providers who meet all of the three of the following criteria to participate in the CDR:
    a. Is your organization part of a Managed Care Organization network of providers who serve Apple Health lives?
    b. Does your organization have an Electronic Health Record (EHR/EMR) instead of paper records?
    c. Have already purchased 2014 certified EHR systems.

SECTION A: WASHINGTON STATE'S "AS-IS" HIT LANDSCAPE

In Section A, the Washington State Health Care Authority (HCA) describes the current "as is" landscape for Health Information Technology (HIT) and Health Information Exchange (HIE). This description focuses on the Medicaid program and describes the status of the adoption of Electronic Health Records (EHR) and HIE by the Medicaid program and its partners in the provider community.

The Health Care Authority is committed to supporting the use of health information technology and Health Information Exchange and has outlined where the state and providers are in the adoption process.

A.1 GOVERNANCE AND PROGRAM LEADERSHIP

The Health Care Authority

The HCA is a cabinet-level agency responsible for managing and purchasing health benefits for more than 1.6 million Washingtonians, including state and public employees and low-income individuals. The HCA has long been a source of public policy innovation and entrepreneurism.

Since its creation in the late 1980s and affirmed with recent legislation, the HCA has played a central role in the Governor's health improvement and health reform efforts. The agency oversees a mix of health care programs and provides leadership and coordination for numerous state and federal legislative and grant initiatives.

With a consolidation of the HCA and the Medicaid Purchasing Administration (formerly part of the Department of Social and Health Services (DSHS) in 2011) the HIT and HIE programs were consolidated into a single unit to further integrate and coordinate the work of the two groups.

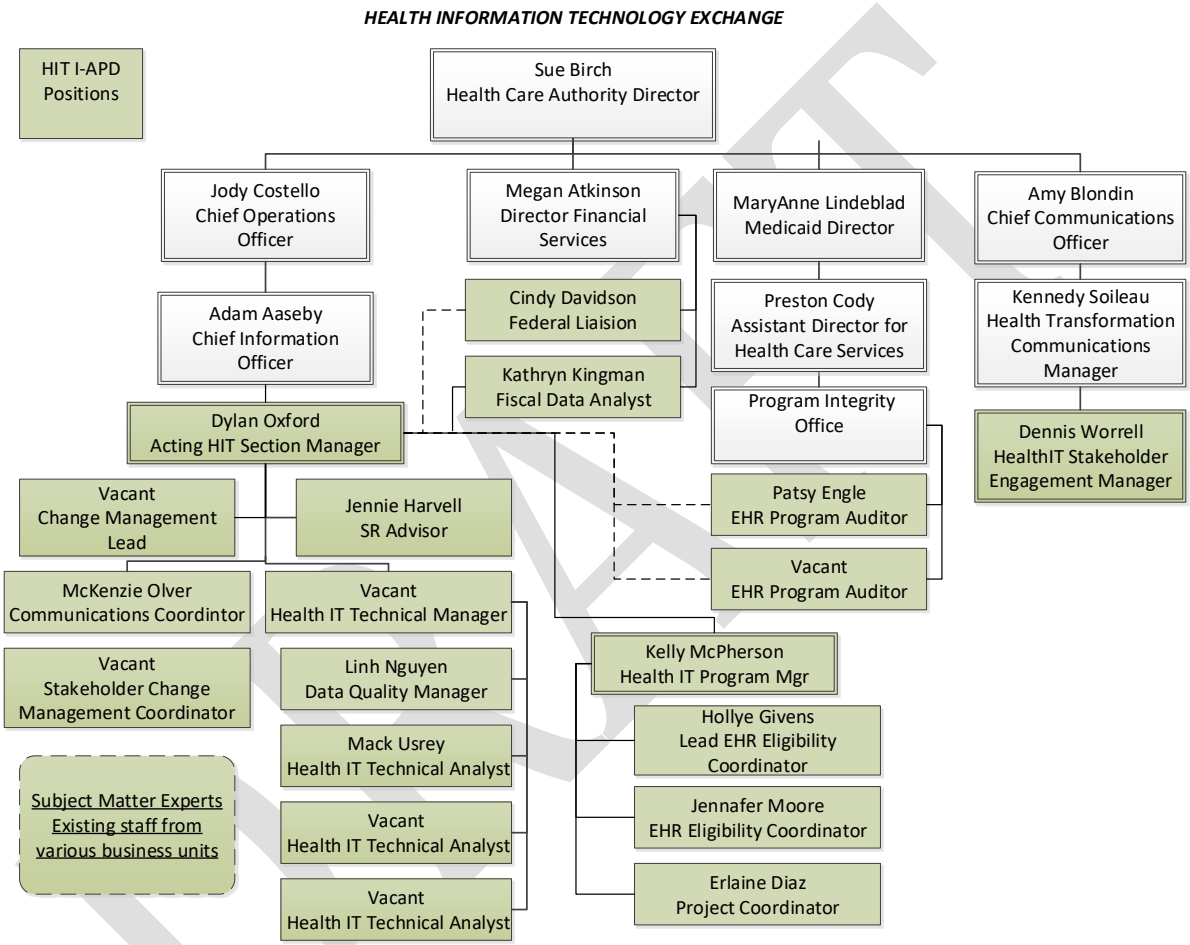
The Health IT team is led by the Health IT Coordinator under the direction of the HCA CIO, who oversees technology projects.

The following organization chart illustrates the staffing relationships at the program level. Shaded positions reflect those covered with HIT funding under HITECH:

Fig. A-1: HIT/HIE Organization Chart

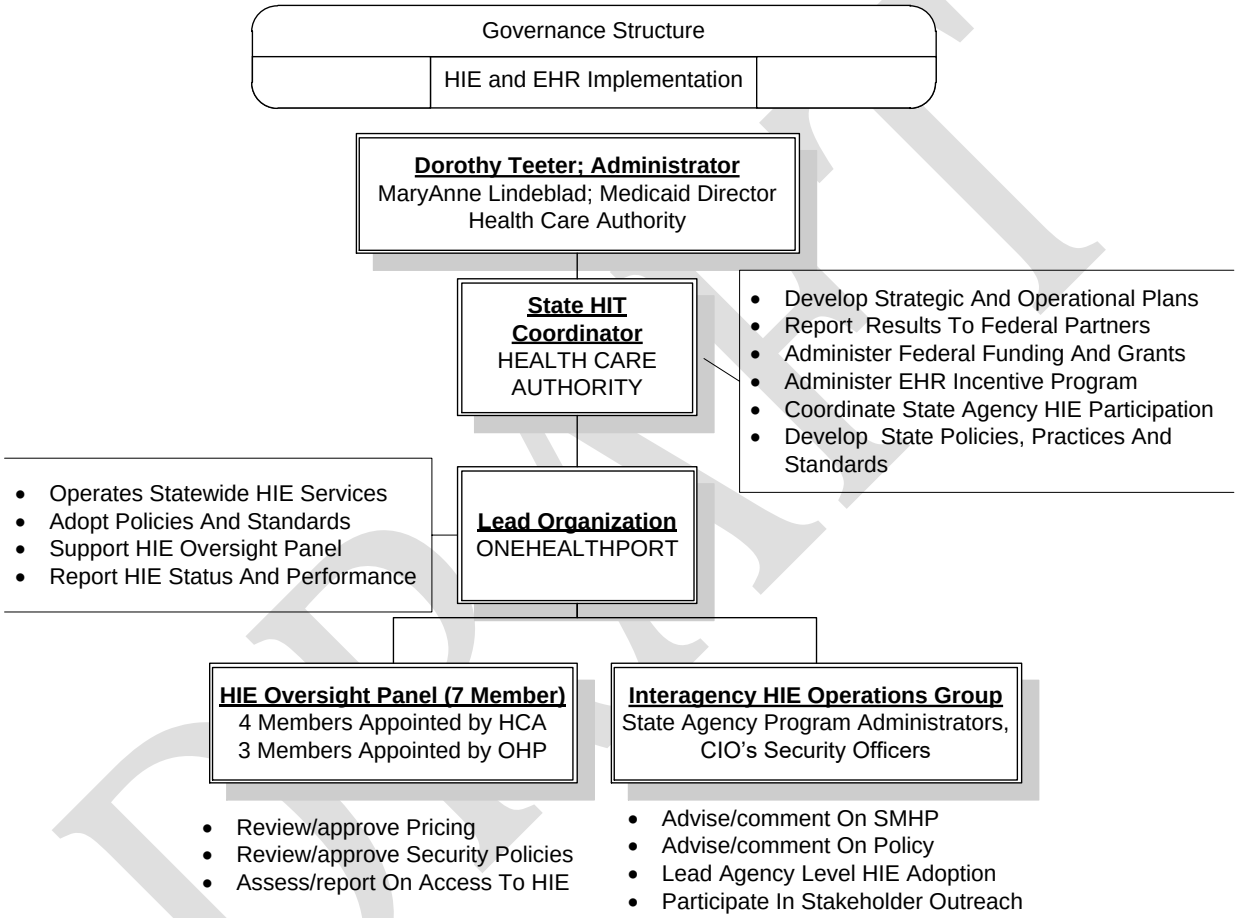
Washington State Health Care Authority

Enterprise Technology Services / Health Information Technologies
REV 12/07/2017



Washington State has a formal governance model and has developed the key partnerships necessary for managing a statewide collaborative HIE. The state appointed HIT Coordinator works closely with the Lead Organization, OneHealthPort, and stakeholders to bring the HIE service to trading partners and continue to monitor and evaluate additional services needed by the healthcare community.

Fig. A-2: WA State's Collaborative HIE Governance



A.2 Medicaid EHR Program Participation in Washington State

A.2.1 EHR Adoption by Provider Community

A series of outreach and stakeholder engagement activities have been executed to help move providers from a lack of awareness, to awareness, to understanding, to participation in the EHR Incentive Program and finally becoming Meaningful Users of the data collected. HCA began accepting attestations from providers for adopting, implementing or upgrading to electronic health record (EHR) technology in June of 2011.

Fig. A-3: Medicaid EHR Payments as of February 8, 2016

	YR	Total Unique Providers	Money Paid
EP	1	5713	120,792,112.00
EH	1	88	63,781,127.00
EP	2	2405	20,317,848.00
EH	2	75	34,025,917.00
EP	3	1209	10,262,335.00
EH	3	51	20,117,381.00
EP	4	303	2,572,667.00
EH	4	25	7,832,668.00

HCA has experienced steady participation. We see the highest levels of activity following broad stakeholder outreach events and year end attestation deadlines in February and November. Returning provider metrics are depicted in the following chart as of February, 2016.

Fig. A-4: Returning Provider Metric Report as of February, 2016

Incentive Program Type	Provider Type	Medicaid EP/Hospital Type	Program Year	Provider Count (Pay Year 1)	Provider Count (Pay Year 2)	% Pay Year 2 / Pay Year 1	Provider Count (Pay Year 3)	% Pay Year 3 / Pay Year 2	Provider Count (Pay Year 4)
MEDICAID	EP	Certified Nurse - Midwife	2011	44					
MEDICAID	EP	Certified Nurse - Midwife	2012	45	15	34.09%			
MEDICAID	EP	Certified Nurse - Midwife	2013	24	31	68.89%	12	80.00%	
MEDICAID	EP	Certified Nurse - Midwife	2014	16	28	116.67%	29	93.55%	7
MEDICAID	EP	Certified Nurse - Midwife	2015	19	47	293.75%	33	117.86%	34
MEDICAID	EP	Dentist	2011	131					
MEDICAID	EP	Dentist	2012	114	29	22.14%			
MEDICAID	EP	Dentist	2013	148	49	42.98%	22	75.86%	
MEDICAID	EP	Dentist	2014	115	22	14.86%	30	61.22%	11
MEDICAID	EP	Dentist	2015	122	351	305.22%	42	190.91%	39
MEDICAID	EP	Nurse Practitioner	2011	376					
MEDICAID	EP	Nurse Practitioner	2012	408	173	46.01%			
MEDICAID	EP	Nurse Practitioner	2013	255	185	45.34%	126	72.83%	
MEDICAID	EP	Nurse Practitioner	2014	196	140	54.90%	113	61.08%	57
MEDICAID	EP	Nurse Practitioner	2015	255	630	321.43%	239	170.71%	176
MEDICAID	EP	Physician	2011	1170					
MEDICAID	EP	Physician	2012	1367	480	41.03%			
MEDICAID	EP	Physician	2013	907	719	52.60%	369	76.88%	
MEDICAID	EP	Physician	2014	387	693	76.41%	518	72.04%	227
MEDICAID	EP	Physician	2015	324	1736	448.58%	813	117.32%	635
MEDICAID	EP	Physicians Assistant practicing in FQHC or RHC led by a PA	2011	46					
MEDICAID	EP	Physicians Assistant practicing in FQHC or RHC led by a PA	2012	62	21	45.65%			
MEDICAID	EP	Physicians Assistant practicing in FQHC or RHC led by a PA	2013	12	22	35.48%	15	71.43%	
MEDICAID	EP	Physicians Assistant practicing in FQHC or RHC led by a PA	2014	9	5	41.67%	10	45.45%	6
MEDICAID	EP	Physicians Assistant practicing in FQHC or RHC led by a PA	2015	22	34	377.78%	19	380.00%	17

MEDICAID	EH	Acute Care Hospitals	2011	3					
MEDICAID	EH	Acute Care Hospitals	2012	1	1	33.33%			
MEDICAID	EH	Acute Care Hospitals	2013	0	0	0.00%	0	0.00%	
MEDICAID	EH	Acute Care Hospitals	2014	1	0		0		
MEDICAID	EH	Acute Care Hospitals	2015	0	3	300.00%	0		0
MEDICAID	EH	Children's Hospitals	2011	1					
MEDICAID	EH	Children's Hospitals	2012	1	1	100.00%			
MEDICAID	EH	Children's Hospitals	2013	1	0	0.00%	1	100.00%	
MEDICAID	EH	Children's Hospitals	2014	0	1	100.00%	0		1
MEDICAID	EH	Children's Hospitals	2015	0	1		1	100.00%	0
DUALLY_ELIGIBLE	EH	Acute Care Hospitals	2011	49					
DUALLY_ELIGIBLE	EH	Acute Care Hospitals	2012	25	30	61.22%			
DUALLY_ELIGIBLE	EH	Acute Care Hospitals	2013	6	27	108.00%	28	93.33%	
DUALLY_ELIGIBLE	EH	Acute Care Hospitals	2014	0	13	216.67%	22	81.48%	24
DUALLY_ELIGIBLE	EH	Acute Care Hospitals	2015	1	10		22	169.23%	26

Provider engagement activities and high touch outreach to all types of eligible professionals has resulted in broad participation of providers across many specialties.

Provider Type	Payment Year	Count
Certified_Nurse_Midwife	1	125
Certified_Nurse_Midwife	2	73
Certified_Nurse_Midwife	3	41
Certified_Nurse_Midwife	4	7
Dentist	1	500
Dentist	2	95
Dentist	3	50
Dentist	4	11
Doctor_of_Optometry	1	3
Nurse_Practitioner	1	1231
Nurse_Practitioner	2	491
Nurse_Practitioner	3	233
Nurse_Practitioner	4	56
Physician	1	3796
Physician	2	1701

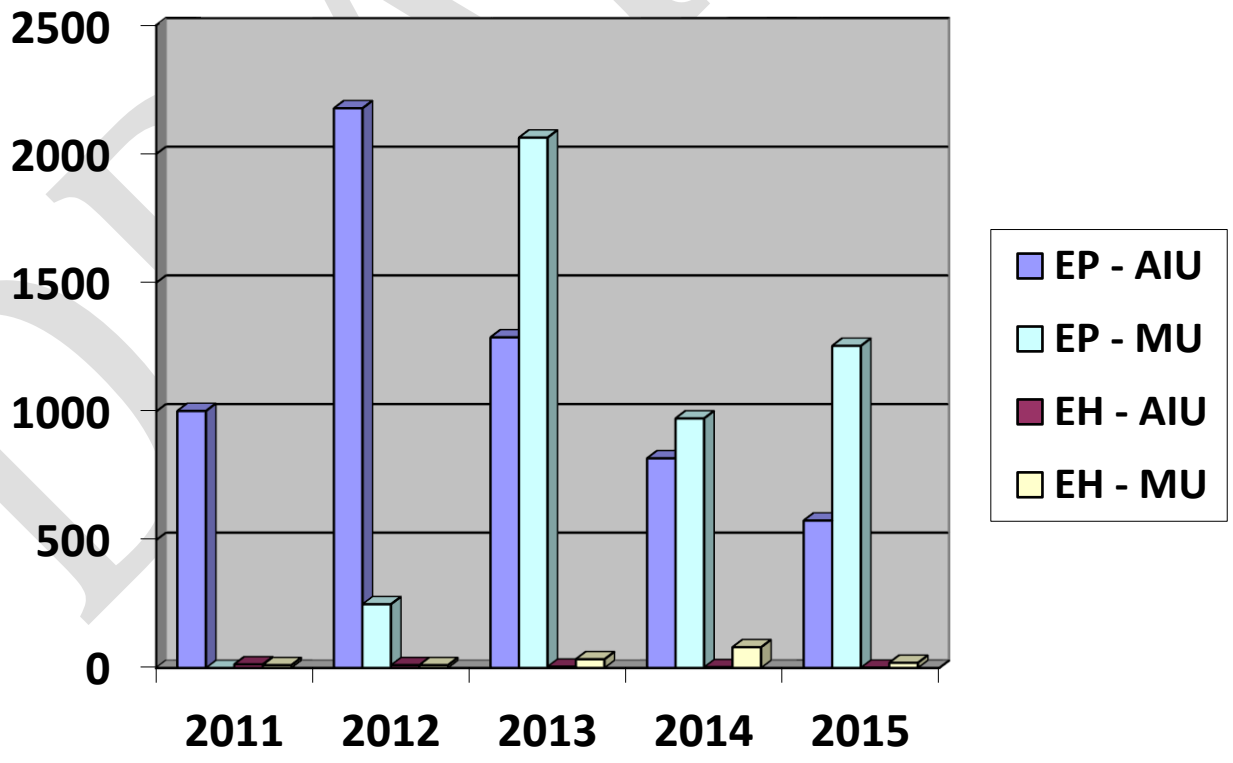
Physician	3	862
Physician	4	223
Physicians_Assistant_practicing_in_FQHC_or_RHC_led_by_a_PA	1	87
Physicians_Assistant_practicing_in_FQHC_or_RHC_led_by_a_PA	2	47
Physicians_Assistant_practicing_in_FQHC_or_RHC_led_by_a_PA	3	23
Physicians_Assistant_practicing_in_FQHC_or_RHC_led_by_a_PA	4	6

Fig. A-5: EHR Payments by Provider Specialty Feb, 2016

HCA monitors the continued participation of Medicaid providers as they move through the stages of participation and Meaningful Use. The table above depicts payment by program year:

489 total EHR

Fig. A-6: Medicaid EHR Payments by Program Year (Through February, 2016)



HCA will continue specific outreach to identify challenges and barriers for advancing in the program. Appendix C.1 Stage 2 Meaningful Use and Acceleration 2.0 has been updated with an outreach plan for 2016 where additional details are available.

Washington providers who have sought EHR incentive payments have adopted a broad range of technology. Five vendors make up 67% of the market coverage as of Feb, 2016.

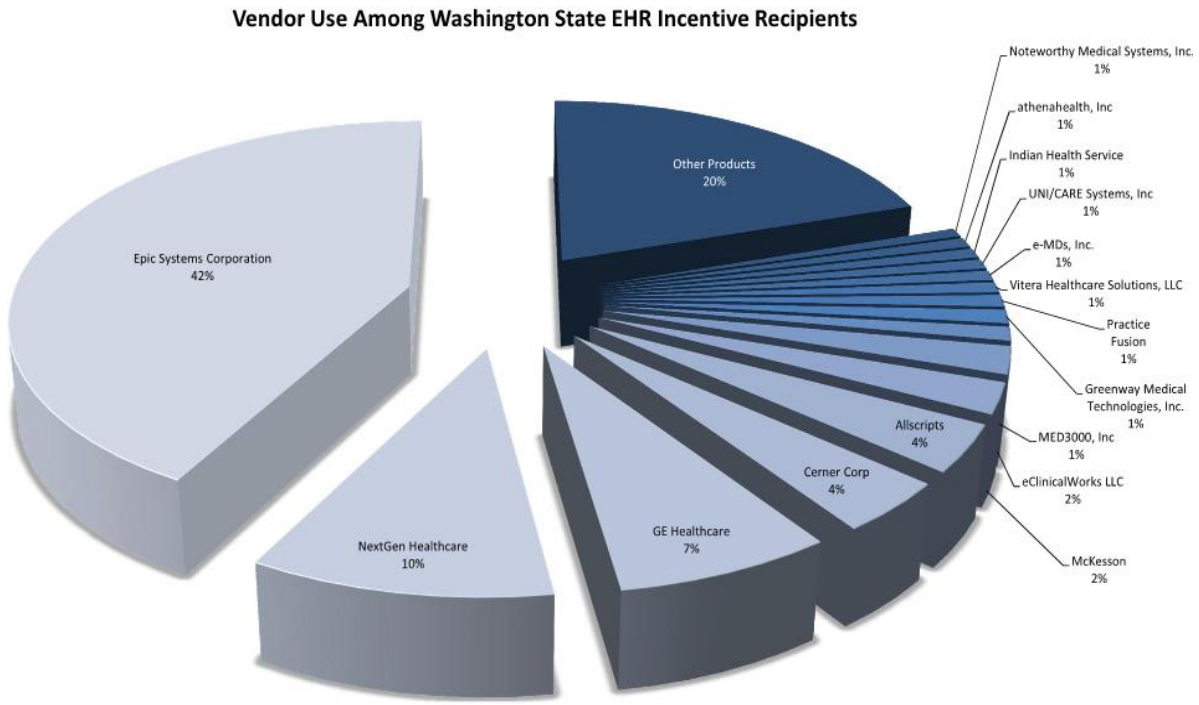


Fig. A-7: EHR System Market Share October 2016

Indian Health Services and Tribal Activity

All but one of Washington's 29 Tribes currently contracts with the Medicaid program to provide medical or behavioral health care to their members and others.

- 2 Tribes have federally operated IHS clinics (Yakama and Colville)
- 27 Tribes operate their own programs under P.L. 93-638 contract or compact
- 22 offer dental care in addition to medical services
- 24 offer mental health services in addition to medical services

- 27 provide chemical dependency treatment in addition to medical services
- 12 offer pharmacy services in addition to medical services
- 2 offer chiropractic services in addition to medical services

Washington also has two IHS funded urban Indian health programs. They primarily provide medical care, dental care and behavioral health services. They are paid for services provided to Medicaid enrollees as Federally Qualified Health Centers.

Tribes and geographic areas are depicted below:

Fig. A-8: Washington Tribes

Fig. A-9: Tribal EHR Status as of August 2014

AIU	MU	Tribe	EHR
4 out 23 providers		Chehalis Tribe	RPMS
Y	Y	Colville Confederated Tribes	**RPMS**
Y	Y	Cowlitz	**RPMS**
		Hoh Tribe	NA
		Jamestown Sklallam	NextGen, moving to EPIC
Y		Kalispel Tribe of Indians	**Centricity**
Y		Lower Elwha Klallam Tribe	**RPMS**
Y		Lummi	**RPMS**
Y		Makah	**RPMS**
Y		Muckleshoot Tribe	**RPMS**
Y	Y	Native Health Services	**RPMS**
Y		Nisqually Indian Tribe	**RPMS**
Y		Nooksack Indian Tribe	**RPMS**
Y	Y	Port Gamble S'Klallam Tribe	**NextGen**
Y		Puyallup Tribe	**NextGen**
		Quileute Tribe	RPMS
Y		Quinault Indian Nation	**RPMS**
		Samish Indian Nation	NA
Y		Sauk-Suiattle Tribe	**RPMS**
Y	Y	Seattle Indian Health Board (SIHB)	**Allscripts**
Y		Shoalwater Bay	**RPMS**
Y		Skokomish Indian Tribe	**RPMS**
Y		Snoqualmie Tribe	**RPMS**
Y	Y	Spokane Tribe	**RPMS**
Y		Squaxin Island Tribe	**RPMS**
		Stillaguamish Tribe of Indians	None
		Suquamish Tribe	None
Y	Y	Swinomish Indian Community	**RPMS**
Y		Tulalip Tribe	**RPMS**
		Upper Skagit Indian Tribe	MacPractice
Y	Y	Yakama Indian Nation	**RPMS**

Seventy-five (75) percent of providers affiliated with a tribal clinic or health center have received an EHR incentive payment. These providers represent 25 Tribal clinics in Washington. While most have received readiness assistance through the NPAIHB Regional Extension Center, 11 individual providers received support from WIREC. In 2014-15 we began specific outreach by providing the HCA tribal liason with EHR information packs for distribution at on-site visits. Additional activities in 2016 will be specifically aimed at tribal participation as part of the 2016 outreach plan (Appendix C.3).

A.3 HIT/HIE IMPLEMENTATION IN WASHINGTON STATE

While the adoption of certified EHR systems is critical to building the capabilities to exchange data, further efforts to assist providers in practice transformation and health information exchange are necessary.

The Washington State Deparment of Social and Health Services (DSHS) has entered into a contract with Cerner to provider an EHR system for the State Hospitals and is currently exploring the feasibility of qualifying for incentice payments. The Deparment of Corrections (DOC) is also in an exploratory phase for obtaining and implementing an electronic health record system for correctional institutions.

The following organizations has partnered with Medicaid and the Health Care Authority in implementing the HITECH Act and have provided their perspectives on the current state of HIT and MU, HIE and health care system trends, payment models and population health:

OneHealthPort (OHP): In response to both the Federal grant opportunity and State law, HCA designated OneHealthPort as the lead HIE organization for Washington. In this role, OHP led the development of the state HIE infrastructure and has attracted private and public sector trading partners to invest and participate in HIE.

Qualis Health REC, Washington & Idaho Regional Extension Center (WIREC): Supported over 4,000 eligible professionals in their pursuit of Meaningful Use.

A.3.1 Health Information Technology Adoption and MU Within an Enterprise

Health information technology within an enterprise has made great strides in the healthcare industry. Prior to EHR incentive payments, hospitals and larger practices were already exploring and implementing new technologies to streamline processes and enhance patient care. Federal incentive payments have helped drive providers to meet Meaningful Use requirements.

As of January 2015, Washington had issued over 9,000 payments to eligible professionals and hospitals totaling more than 279$M. With a business case and a fairly mature market, HIT within an enterprise has taken a strong foothold in the healthcare industry leaving few practices trying to get by solely on paper.

Some pockets of providers still struggle in these early stages of health IT adoption and meaningful use. Health IT requires financial and human resource investments and time and effort to make complex changes to their operational business processes.

Not all EHR products fit the clinical needs for behavioral health, dental and pediatric providers and more work will need to be done to identify and overcome barriers in these areas. Primary care practices have received a significant amount of support from the regional extension centers. Specialty practices could benefit from additional outreach and support.

Stage One and Stage Two of Meaningful Use (MU) Challenges
Providers who have adopted, implemented and upgraded to new certified technology have been focused on getting data into their new system and adapting their business processes. The move from Stage One of Meaningful Use and into Stage Two (MU) offers many challenges:

- **Disruption to practices** – Each new round of MU will require an upgrade to an existing EHR, which means disruption in operations and workflow. Resources to help practices understand what to expect and how to work through these disruptions are not readily available and this has not been the role of the EHR vendor community.

- **It's not just the technology** – Health IT has tremendous potential to transform how health care is delivered. Stage two of Meaningful Use focuses on exchanging and using information to improve the care of individual patients. Using EHR technology meaningfully means changing the culture of the practice so that it is more focused on and able to deliver population-based health care. This means changing roles for many members of the staff, changing expectations, changing workflows and processes.

- **Cost** – There is generally a financial investment necessary for each EHR system upgrade needed to meet CMS requirements for each stage of meaningful use. Providers may not have adequately anticipated these costs or planned for them. The intent with multiple year incentive payments is that investments can be offset over a period of time as requirements for meaningful use increase.

- **Usability** – As the MU requirements get more complex, the EHR vendors are increasingly challenged to meet them in the time provided. Some vendors may not continue to keep pace and drop out of the market. This would require providers with their solutions to essentially start over. Feedback from the provider community also suggests that certified products allow

them to check boxes for meaningful use requirements, but are not consistently meeting expectations for reporting.

- **Data Quality** – Until relatively recently, data quality was not an issue in ambulatory care settings as they generally did not use data at a population level. Creating and enforcing data standards is new to the field and will mean cultural changes and extensive education in the practices.

A.3.2 Health Information Exchange Between Multiple Enterprises

All partners agree that the adoption of Health Information Exchange (HIE) between enterprises has not reached critical mass and still faces many challenges. Health Information Exchange is not yet viewed as a critical business need when compared with the number of demands facing health care organizations. Providers are challenged to meet basic MU requirements, ICD-10 and other efforts at the same time.

As new payment models emerge and Stage 2 meaningful use is implemented which requires the sharing of data outside of organizational walls, we intend to leverage the standards present in Certified EHR systems.

Although we haven't reached critical mass, there are a wide variety of HIE activities at the corporate, community/regional, and state level. No single HIE solution is going to meet all needs and the challenge for the state and health care delivery system will be to knit all the technical solutions and platforms together.

Some of the ways Health Information Exchange is currently accomplished include:

- Browser based access to applications
- Secure email exchange
- Direct EHR-to-EHR exchange
- Repository-based HIE's where information is deposited and withdrawn
- Hub based HIE's and clearinghouses
- Faxes and document exchanges

The HIE market in the state is characterized by five trends:

- Most HIE is accomplished through proprietary approaches that don't scale well. This challenges organizations participating in multiple arrangements requiring information exchange.
- At the national level an ambitious standards based path toward interoperability is being laid out. This model is in the early stages of implementation with some vendors further along than others though in theory all certified vendors will get there eventually.
- There is a large block of Epic EHR's installed in the state. Epic theoretically offers simplified access to other Epic systems and some basic connections to non-Epic systems. The ease of Epic connectivity to non-Epic systems is currently being explored.
- Many EHR owners have difficulty getting data in and out of their systems for exchange purposes. Standard methods are supposed to exist but are not present in all cases.
- There are a few organizations dedicated to HIE's including OneHealthPort. All of these HIEs are in the early stages of development and it is not clear what model(s) will prevail.

The patient benefits of HIE are clear, real time clinical data to support better decision making and reducing redundant or unnecessary testing and avoidance of medication complications contribute to better population health. Providers who have never had access to this type of information outside of their practice have to be convinced of the value and access to such data must be easy. Additionally, the business case must be made to Administrators and Chief Financial Officers.

Two issues affecting this area are the fact that HIE is not required at this time and is in fact dis-incentivized in a fee-for-service environment. If it is easier and faster to order a new test than it is to find results of a test done in another setting, and if the clinic makes money when doing a test, then there is no driver to implement HIE.

The second issue is the growth of Integrated Delivery Networks (IDNs) who may believe that enabling the electronic sharing of patient data outside their network will place them at a competitive disadvantage. They promote their networks as systems where patients can receive all the care they need and where all of their data is easily accessible. When financial success is critical to sustainability, we need to move away from payment models that support these barriers.

Among smaller practices, few are advanced enough to consider sharing robust clinical information with other entities. One-off interfaces with various entities will become an issue as larger scale interoperability is required. Necessary resources and expertise may not be available at an affordable cost to these practices. We will see a greater need for support of Health

Information Exchange in 2015 when meaningful use Stage 2 requirements are effective and more measures are collected requiring interoperability.

OneHealthPort transaction volumes have continued to grow. In 2014 the Washington State Department of Health linked qualification for several Meaningful Use public health reporting objectives for eligible hospitals and providers with use of the State Health Information Exchange Program. This requirement helped drive participation in the market and nearly all hospitals in the state are now sending transactions through the State HIE. Total transactions through State HIE grantee-funded or supported/enabled mechanisms were 2,403,112 in 2012, 27,361,764 in 2013 and 16,022,280 in 2014. The drop in transaction count between 2013 and 2014 reflects the end of an initiative in 2013 to "catch up" and report historical end-stage renal dialysis quality data reporting to CMS. Transactions in 2014 for quality data reporting have assumed a normal trend and increases in transaction activity are now beginning to include clinical information sharing between health care entities.

A.3.3 Health Care System Trends, Payment Models and Population Health

Health Information Exchange will be very important for pay for reporting/performance models in the future but the current standard in Washington is fee-for-service and managed care.

Until there are concrete, visible efforts to change payment models, any efforts at full scale health care transformation will be limited. The current health care delivery system has been optimized for fee-for-service. Every element – how a patient makes an appointment, how referrals are made, the admission and discharge processes from hospitals maximizes fee-for-service revenue. Trying to insert care coordination and population based health care into this environment can cause disruption and frustration on the part of providers and patients.

Although there have been payment pilots focused on small populations or single payers, these will not be sufficient to drive change on a larger scale. Healthcare organizations cannot afford to make major changes in the ways they operate for just a subset of their patients. They need to be able to deliver the same level of care for all patients, regardless of who the payer is.

Two healthcare systems are currently Accountable Care Organizations (ACO's) (through the Medicare Shared Savings Program) in Washington. While managing clinical outcomes for population health is an important aspect of becoming an ACO, many providers have difficulty generating accurate data out of the health IT systems and if they are able to do so, may not have the capacity to utilize the date for focused quality improvement projects. ACO's require sophisticated clinical

reporting capability both for external reporting of outcomes and for internal reporting to manage outcomes.

EHR's are certified to limited reportable data sets specific to meaningful use measures and usability remains a factor in the near term.

A.4 PUBLIC HEALTH

Washington is one of the first two States to receive The Public Health Accreditation Board's (PHAB) national accreditation for all public health departments. To receive accreditation, a health department must undergo a rigorous, multi-faceted, peer-reviewed assessment process to ensure it meets or exceeds a set of public health quality standards and measures. Public health departments play a critical role in protecting and improving the health of people and communities. Across the nation, health departments provide a range of services aimed at promoting healthy behaviors; preventing diseases and injuries; ensuring access to safe food, water, clean air, and life-saving immunizations; and preparing for/responding to health emergencies.

Department of Health is actively working on readiness for all public health meaningful use measures to be connected to the HIE and coordinating other registries in the Department's jurisdiction. Providers wanting to meet the Meaningful Use requirements need to be able to demonstrate connectivity with the Department of Health (DOH):

For Stage 1:

1) Washington State Immunization Information System (WAIIS)
2) Electronic Laboratory Reporting (ELR) notifiable lab/case system (PHRED/PHIMS)
3) Syndromic surveillance system (PHEEDS project)

For Stage 2:

1) Washington State Immunization Information System (WAIIS)
2) Electronic Laboratory Reporting (ELR) notifiable lab/case system (PHRED/PHIMS)
3) Syndromic surveillance system (PHEEDS project)
4) Washington State Cancer Registry (WSCR). Cancer Case Reporting
5) Approved specialized registry- Prescription Drug Monitoring Program (PDMP)
6) Other potential registries under consideration

A.4.1 State Immunization Registry Interoperability

The State has a fully functional immunization state-sponsored registry, Washington State Immunization Information System (WAIIS), with child and adult immunization records, that has advanced to include bidirectional interfaces on a pilot basis. The Registry is a candidate for use through the statewide HIE, rather than point-to-point as is the current approach.

The registry has HL7 capabilities with over 100 one-way HL7 interfaces which support nearly 600 medical facilities, and about 20 bidirectional interfaces. EHRs are more ready to export data than to import it, according to the experience of WAIIS staff. As such, the data flow tends to be "one-way." There are over 70 million vaccination records in this registry.

Washington State's statewide immunization registry is widely adopted. Over 95% of about 1,200 practice sites administering immunizations to children are enrolled and contribute data on a regular basis. Many family practice clinics also are enrolled, and the registry contains millions of vaccination records for individuals of all ages. In addition, about 260 public school districts and 40 private schools are enrolled, along with 66 Head Start agencies, 13 health plans, DSHS Foster Care Health, the Department of Corrections, and the Health Care Authority/Medicaid.

Currently, the WAIIS system has HL7 real-time or HL7 batch one-way data exchange with over 100 practice sites using 21 different EHR products including 2 proprietary products. Two products (about 20 practices) have bidirectional exchange with the registry. Providers can upload data continuously via a web app using HL7 messages. The registry has a waiting list of providers eager to connect their EHRs with the system. The main barriers are the cost to providers of an EHR interface, and limited staff resources on the WAIIS team. The Hub to be offered by the Statewide HIE should accelerate progress in this area.

Enhancing the Interoperability of Electronic Health Records (EHR) with the Washington State Immunization Information System (WAIIS) (CDC) - This project improved the completeness of immunization histories in the IIS available to clinicians and public health, improved the timeliness of immunization data submission to the IIS, improved the quality of IIS coverage assessments, and improved the data available to other public health systems. WAIIS has improved capacity and upgrade from HL7 2.3.1 to 2.5.1 through a cooperative agreement from CDC that partially funded this improvement.

The purpose of the state proposed HIE solution, a statewide Hub, is to support and enable secure exchange of HL7, X12 and other similar transactions. In developing the concept for the Hub, OneHealthPort had extensive discussions with stakeholders about specific use cases for the Hub. Immunization reporting to the state registry was one of the identified priority use cases for the State HIE Hub. This use case could assist providers in meeting the following Meaningful Use

requirement: "23. Demonstrate the capability to submit electronic data to immunization registries and actual submission where required and accepted, by performing at least one test of transmission to immunization registries."

The immunization registry has also developed privacy contracting approaches. Washington has considerable experience with HIE contracting, including a number of contracts that informed the Data Use and Reciprocal Support Agreement (DURSA). Other well-known contract strategies in Washington include the WAIIS agreement for access to and use of immunization information.

A.4.2 Public Health Reporting Interoperability

The interoperability capabilities of the Electronic Laboratory Reporting (ELR) notifiable lab/case system (PHRED/PHIMS) is in a rapid state of enhancement, thanks to investment from CMS 90-10 funds. At this time, all electronic connections with these information systems are point-to-point. There are a number of Medicaid provider facilities that have expressed interest in reporting to the state's public health reporting information system (PHRED) via the Health Information Exchange (HIE).

DOH is moving to an HIE model because of the labor intensive process to manage all the point-to-point connections. Currently DOH uses a variety of standards, including ICD9 and 10, LOINC, SNOMED and HL7 version 2 messaging standards up to and including version 2.4. They predominantly use Microsoft BizTalk and Orion Rhapsody as data transformation engines.

PHRED – Public Health Reporting of Electronic Data. This system provides a mechanism for the provider community to send laboratory results, and other information about notifiable conditions/reportable lab results to DOH and local health departments. The system upgrade currently underway will enable support of HL7 v2 messaging standards through v2.7, including v2.5.1 for Meaningful Use.

WELRS – Washington Electronic Laboratory Reporting System. WELRS is the next generation ELR reporting system for DOH and is replacing PHRED. In the future support may be needed to connect this reporting system to the HIE.

PHIMS – Public Health Issue Management System. This is the case management tool that supports public health investigation and intervention, but that does not currently "talk to" PHRED. Public health investigators must manually enter into PHIMS information from a laboratory report received by PHRED. One objective of the current enhancement is to enable PHIMS to accept lab reports electronically from PHRED, making it easier and faster for public

health practitioners to initiate appropriate public health action, including notification to CDC. The ultimate goal is improved population health.

WDRS – Washington Disease Reporting System. The next generation disease reporting system currently at DOH is WDRS and is replacing PHIMS. Future support may be needed to connect this reporting system to the HIE. This will become pivotal in meaningful use stage 3 when case reporting is a requirement.

A.4.3 Public Health Syndromic Surveillance Interoperability

Public Health Emerging Event Detection System (PHEEDS) is our syndromic surveillance program area. Washington has been conducting syndromic surveillance at the local level since 1999, and is one of the most experienced states in the country.

Washington State DOH has been conducting syndromic surveillance since 2003. Over 40 hospitals across the state contribute de-identified clinical information to the state's syndromic surveillance system. Epidemiologists use the system to identify events of potential public health importance and to monitor population-level trends in clinical syndromes such as influenza-like illness.

The majority of hospitals participating in Washington's syndromic surveillance system submit text files containing information about emergency department visits on a daily basis. Subsets of hospitals send files containing data about both inpatient admissions and emergency department visits; these data are sent in batch files every 15 minutes using HL7 version 2.5. Syndromic surveillance data are loaded into a database as well as a syndromic surveillance web application called ESSENCE. Both of these systems need to be updated in the next year to accommodate HL7 2.5.1 messages that conform to the 2014 syndromic surveillance messaging standards named by the Office of the National Coordinator for Meaningful Use. The department is also planning to contribute Washington's syndromic surveillance data to Bio Sense 2.0, the national syndromic surveillance program.

All syndromic surveillance data are currently received through point-to-point connections between the department and each hospital or healthcare system. With Meaningful Use, DOH anticipates that the syndromic surveillance system will expand to receive data from nearly all of Washington's hospitals along with many urgent care centers and clinics. The department is preparing to receive syndromic surveillance data through the HIE in order to reduce the burden of maintaining point-to-point connections with the expanding number of healthcare partners.

A.4.4 Washington State Cancer Registry (WSCR) Cancer Case Reporting

The Washington State Cancer Registry (WSCR). Cancer is a reportable condition in Washington State. WSCR processes data for over 34,000 new cases annually and maintains over 600,000 cases

in its database. The number of facilities diagnosing and treating cancer is expanding rapidly and WSCR continues to enhance its ability to receive and process cancer case records electronically. The Washington State Cancer Registry has recently implemented the software and tools necessary to validate and process CDA messages, and designated staff to handle work related to Meaningful Use. WSCR is using the state's HIE to receive information from Eligible Providers.

A.4.5 Approved Specialized Registry

- Prescription Drug Monitoring Program (PDMP or PMP): The PMP system has implemented an HIE connection. Authorized providers can query the system via the HIE to receive controlled substance dispensing information on their patients. The connection allows providers (including those in Medicaid's network) to seamlessly access this information through connected EHR systems. The data can help providers with: identifying duplicative prescribing, dangerous drug interactions, addiction, as well as monitoring treatment contracts and coordinating care. The system receives on average over 900,000 records for dispensed controlled substances per month.

A.4.6 Other Potential Registries in Washington

The following systems used by public health for population health management are being explored for potential integration with the statewide HIE.

- NBS – Newborn screening dried blood spot reporting via HIE. NBS lab results are currently reported using paper-based reports and mailed to providers. This project will enable NBS to deliver results electronically (HL7) to providers through the HIE. The state lab does this testing by law on every live birth. Used to detect metabolic disorders in infants.

- Early Hearing loss Detection, Diagnosis and Intervention (EHDDI): The EHDDI case management system is linked with the NBS tracking and surveillance system. Data Exchange with Audiologists and Providers via HIE: Receive & and send hearing loss screening and diagnostic data between the Neometrics system & audiologists / hospitals using the HIE. This project would initially focus on data exchanges with hospitals that are already connected to the HIE via the HIE-NBS project.

- Universal Developmental Screening – There has been a ground swell of activity across the state promoting universal developmental screening for all children birth to six years of age. As more and more health care, educators and child care providers implement developmental screening the need for a data system to compile the findings and coordinate care has emerged. HIE is viewed as an ideal mechanism to foster information exchange among these service providers.

- Critical Congenital Heart Disease (CCHD) **–** WA DOH runs a CCHD registry and is exploring receiving this information directly via the HIE.

- Health Statistics Unit – There are approximately 500 births a day, 89,000 per year, in Washington State. This is a database that hospitals/providers use today to enter birth data. This could be a place to start MPI events for children going forward. May also want to link the HIE with the Social Security System as hospitals currently facilitate the movement of newborn information (with parental permission) to SSA to obtain Social Security Numbers.

- Birth Defects surveillance System Reporting to the BDSS System Via the HIE Receive birth defects data from birthing hospitals via the HIE. Future need to connect providers for three new birth conditions manifested in later age & detected by providers (past birth).

- The Comprehensive Hospital Abstract Reporting System (CHARS) has hospital inpatient (ICD9) coded admission to discharge information (derived from billing systems). The database is used to collect public information such as the age, sex, zip code and billed charges of the patient, as well as the codes for their diagnosis and procedures among other items.

- CHAT – The Comprehensive Healthcare Analytics Tool is an application used by public health to manage population health.

- HAI – Hospital Acquired Infection reporting. Currently this is a manual upload. Today an FTE is needed by the provider to extract and format the information for CHARS and HAI manual upload. Need to explore HIE opportunity to pick this up out of information streams.

- WHAVE – List of emergency responders that can be tapped by the Fire, Police, and other responder/rescue agencies in the event of an emergency. Single database for provider credentialing being put in place under SSB5346 may provide some additional possibilities for maintaining accuracy in WHAVE emergency provider lists.

- Professional Licensing Information Dissemination to Agencies with Contracts Use the HIE to more efficiently send electronic licensing information from the Integrated Licensing Regulatory System (ILRS) to agencies with whom DOH holds contracts.

- Family Planning Potential for Receiving Client Visit Data via the HIE: Ahlers & Associates Family Planning System receives client visit data from LHJs, Planned Parenthood clinics, & free standing clinics. There may be a potential for clinics & Ahlers (until replaced) to connect to the HIE to share the data. The office will discontinue the region-wide funding & expects each grantee to deal with their own data system.

- The Breast Cervical and Colon Health Program (BCCHP) uses the online Medical Information Tracking (Med-IT®) health screening information database, developed by OxBow Data Management Systems LLC, for cancer screening surveillance and fiscal management for BCCHP clients. Med-IT is a complete and real-time system that features automatic eligibility computation, real-time data editing checks, performance indicator tracking, HIPAA (Health Information Portability and Accountability Act) safeguards, graphic data visualization, integrated budgeting and billing tools, built-in system administration, and multiple report options. Potential HIE considerations include using Med-IT with providers (both in and out of BCCHP network) to develop a statewide cancer screening surveillance registry. This new opportunity could assist overloaded Medicaid providers with a cancer surveillance option for their clients, and be used to generate provider specific screening summary reports, follow up reports, case management logs, and client reminders .
- Trauma program is interested in using the HIE for reporting of ED and Trauma center data
- Electronic Childhood Blood Lead Surveillance System already uses ELR but could expand to use other case information from Medicaid patients
- Electronic Test Order and Results Reporting (ETOR). Implementing ETOR at the Public Health Laboratory (PHL) by establishing connections between the PHL and submitters through the HIE. This could expedite STD and HIV testing done for Medicaid Clinics.
- STD Surveillance Network (SSuN). The Washington State Department of Health (DOH) is testing the applicability of a regional Health Information Exchange (HIE) operated by Inland Northwest Health Services (INHS) for reporting sexually transmitted disease (STD) data to public health agencies. This approach streamlines the reporting process for both health care providers and public health agencies and potentially improves timeliness and completeness of reporting. There is potential to expand this to the statewide level.

A.5 HIE AND EHR INTERDEPENDENCES WITH MMIS (ALSO KNOWN AS PROVIDERONE)

Washington Medicaid's enterprise MMIS, which includes ProviderOne, is a significant part of HCA's enterprise system. ProviderOne stores claims data about Medicaid clients for HCA and CMS use. The to be section describes in great detail future plans for integration of more real time clinical data which will be made available through health information exchange through the state HIE.

The following IT, fiscal and communications systems are leveraged in support of Health IT program implementation:

MMIS Enterprise Components

- **Provider One** – This is the core system for Washington Medicaid that includes the master provider file, client demographics, a Data Warehouse, Internet Portals, Fiscal Systems, Document Management (including letter generation), and Call Center solutions. All of ProviderOne's aforementioned components are used to support the EHR Incentive Program in the short and long term perspective.

- **FADS** – This is Medicaid's new Fraud and Abuse Detection System. It is used in support of the program integrity and audit processes described in this document.

- ***e*MIPP** – This is the Medicaid Incentive Payment Program application. This is the core system that tracks and manages provider registration, eligibility, attestation, reviews, approvals, and payments for the EHR incentive program. This includes an interface with the National Level Repository (NLR) hosted by CMS.

- **Washington State HIE CDR Service** – This is the State of Washington's Health Information Exchange that is expected to provide capabilities for collecting and providing Meaningful Use data from providers to support CMS' Meaningful Use data and report requirements.

Fiscal Systems

- **AFRS** – This is the state's Agency Financial Recording System. AFRS interfaces with ProviderOne and supports accounting processes. It is used to support provider payment processing for the EHR Incentive Program.

- **OFIN** – This is the financials system that is part of Provider One. It is used to support the Account Payable processes in generating provider incentive payment checks and performing payment reconciliations.

Communication Systems

- **Listserv** – This is an email list management product where all provider email addresses are stored and managed. This solution is also capable of managing email subscriptions, designing and managing email campaigns, delivering the provider email communication in bulk, and tracking the email campaign's effectiveness statistics.

Email System – The standard email system is hosted by the State of Washington. Medicaid is a subscriber to the state's email solution. This email system is part of the overall long term solution to provide the product to support and administer the Medicaid Incentive Payment Program users with email alerts and notifications to ensure communication of relevant status and action items. This is also the mechanism for the HealthIT.wa.gov inbox used by providers to interact directly with the EHR eligibility coordinators who review and process all attestations.

- **Provider Website** – Washington Medicaid currently uses a web-based provider website to post provider related communications. This will continue to be used for general and global provider communication.

A.6 STAKEHOLDER ACTIVITIES

PROVIDER SCAN

Provider Environmental scanning is one of the essential components of the EHR analysis. Monitoring, forecasting and environmental assessment complete the analysis. HCA carefully monitors the EHR environment for detecting signs of opportunities and difficulties that may influence the current and future status of EHR adoption. In December 2015, HCA queried the Washington State ProviderOne Medicaid Payment system with the requested data below:

NPI = Active

Business Status = Active

EHR Indicator = No

Claim Billed in last 6 months = Yes

Provider Type =

Email address =

Name =

Phone Number=

License Type =

Returned report showed:

Dental	684
ARNP	2193
MD and OP	12,377
Naturopathic MD	91
Podiatrist	179
Psychiatrist	1

After identifying over 15k Providers that could potentially qualify for the EHR Incentive program, our eligibility coordinators conducted extensive outreach letting these providers know they may qualify for Incentive Payments and that 2016 is the last year they could start the EHR Incentive program.

Washington Medicaid believes that the existing strategic approach has proven successful in garnering solid external stakeholder engagement in the EHR Incentive payment program as evidenced with our registration and attestation statistics. Washington will continue the existing comprehensive stakeholder engagement strategy that includes multiple avenues of communication strategies, educational events, outreach activities and other tactics to partner with providers. Please refer to Section C of this report for details of future planned activities.

SECTION B: WASHINGTON STATE'S "TO-BE" LANDSCAPE

B.1 IDENTIFYING MEDICAID ENTERPRISE HEALTH IT NEEDS

Washington has invested a significant amount of effort to ensure both the current and future Health IT (HIT) needs for the Medicaid enterprise are fully identified as outlined below:

2013: Participated in agency innovation planning activities to analyze enterprise HIT capabilities needed to improve quality, care coordination, and patient outcomes.

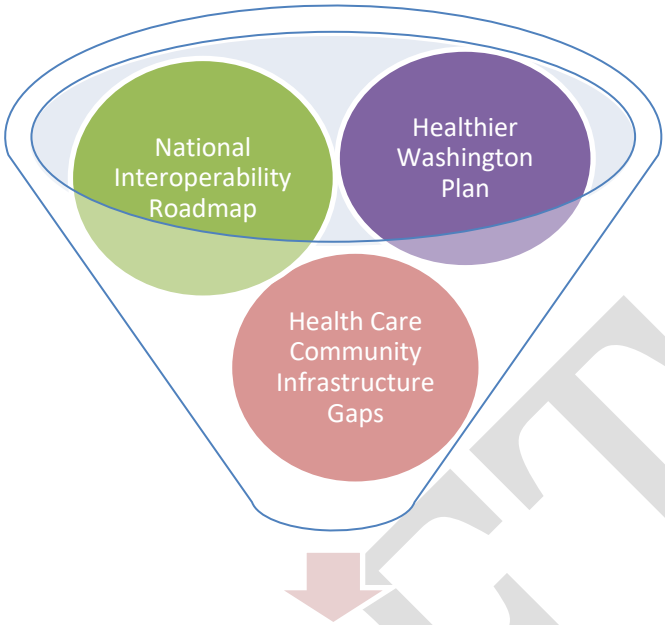
2013: Reviewed MITA maturity models to identify business processes dependent on the availability and use of clinical data to advance the maturity of the Medicaid enterprise.

2014: Consulted with Managed Care Organizations to understand their plans for use of clinical data and HIE, barriers to achieving their vision and how HCA could address challenges.

2015: Analyzed *Healthier Washington Plan* to ensure tools are in place to advance the collection, sharing and use of health information to support interoperability, analytics, and measurement.

2015: Analyzed the *Shared Nationwide Interoperability Roadmap* to identify critical actions Washington will take to advance interoperability and HIE adoption.

2016:



B.2 THE FUTURE HEALTH IT LANDSCAPE

Over the next one to five years, HCA envisions the following advances in the Health IT landscape:

Interoperable EHR Technology: A critical mass of Washington provider organizations operate highly functional electronic health record systems. Behavioral health providers will acquire EHR capabilities and contribute patient level data to an integrated data repository.

Interoperable HIE Services: Affordable services for the collection, integration, sharing and use of clinical health information from different EHR systems are in place to support decisions at the point of care and across the care community.

Utilization of Health Information Exchange: A critical mass of health care partners participate in the state HIE to contribute patient level data to populate a longitudinal health history that reflects care across time and organizational boundaries**.**

Adoption of Standardized HIE Transactions: Washington providers will broadly adopt standards for sharing clinical summaries (CCD-A), transition of care (ToC) documents, and Admit, Discharge, Transfer (ADT) transactions.

Multi-Payer Partnerships: Payers and health care systems will come together to bring necessary infrastructure to the broader community to support new care delivery.

Automated Quality Reporting: The necessary clinical and operational data will be integrated to systematically measure performance and enable pay for performance models.

Advanced Data Analytics: More robust data sets will be available to support population health management and clinical research.

B.3 VISION FOR THE MEDICAID ENTERPRISE AND TRANSFORMATION PLANNING

Washington remains focused on transforming the current health care delivery and payment system to support a future environment where integrated systems result in:

- Healthier people and communities – multi-sector linked services achieve better health
- Quality health care at the right place and time – care focuses on the whole person
- Lower costs with better health – payments reward quality, not volume

HCA is committed to leverage current investments to advance the collection, sharing, meaningful use of health information technology, and increased usage of health information exchange to enable the following strategies outlined in the Healthier Washington Plan:

- Integrate behavioral and physical health services;
- Build Accountable Communities of Health (ACHs);
- Support clinical practice transformation;
- Promote people's involvement in their health decisions;
- Develop value based payment strategies; and
- Consistently measure performance to improve quality and lower costs.

B.4 ENABLING HEALTH CARE INNOVATION USING INTEGRATED HEALTH INFORMATION

Achieving our vision requires the types of improved efficiencies that become possible with the collection, integration, sharing and use of clinical and cost information electronically across organizations. The availability and use of integrated health information serves as the foundation to enable the state's transformation initiatives and overarching objectives of better health, better care, and lower costs.

Adoption of electronic health records and capabilities for health information exchange must be complimented with advanced tool sets to support the integration of data from disparate systems made available to all authorized members of the care team.

Provider organizations have made significant investments in certified EHR technology and have gained experience getting data into these systems for use across their enterprise. Collectively, not as much progress has been made in getting data out of these systems to share with members of the care team outside of their own enterprise.

Providers have expressed significant challenges in achieving broad scale levels of exchange:

- Variability of systems, forms, assessment tools, and care plans – not sufficiently standardized;
- EHR systems are still evolving;
- There has been slow EHR adoption in small clinics and Behavioral Health settings;
- Providers lack capacity for developing additional infrastructure and face competing priority projects; and
- There is not a shared understanding of what is legally defensible in terms of sharing personal health information through an HIE.

As a critical first step, Medicaid, in partnership with the broader health care community, can:

- Address the variability between EHR systems;
- Advance the use of standards; and
- Promote the implementation of tools to fill the gaps.

As part of our 5 year plan, HCA is advancing Washington's Medicaid enterprise capabilities to collect, share, and use integrated physical and behavioral health information from delivery system EHR's. HCA believes this level of clinical data sharing through an HIE is an essential foundational element for the strategies outlined in Healthier Washington, and is necessary to improve and mature our Medicaid business processes as outlined under MITA. To address this gap, Medicaid will establish a clinical data repository as part of the state HIE.

This repository will be a module of the MMIS, separately procured using a Software as a Service (SaaS) model. This module will collect medical, oral, and behavioral health data from disparate and different systems to develop an integrated, longitudinal health care record for Medicaid clients. Integrated patient level data will be made available to authorized care providers, and aggregate data will be provided as needed for program management.

The solution offered by the state HIE will:

- Develop a master patient record that integrates health information and follows the Apple Health consumer across settings over time regardless of plan, care setting, or provider;
- Create a longitudinal record that describes care and needs, including physical, behavioral health, and social services;
- Provide a consistent set of high value data to source the record, not what a single clinician, clinic, or plan might determine relevant;
- Provide on demand access to shared care plans and summaries for patients with complex and chronic conditions;
- Provide access to information by authorized care providers using tools that meet providers where they are – whether they have fully functional EHR systems or need access through a clinical portal; and
- Provide actionable data to identify gaps in care and predictive data to identify who is likely to need care;
- Address the variability among EHR systems to share information with Medicaid and use more real time data to drive program decisions; and
- Address Medicaid's emerging needs for patient level and population level health data.

Our high level strategies to ensure the CDR is adopted and used include:

- High touch leadership to leadership meetings with large delivery systems to invite them to join us early and begin contributing data;
- Driving adoption of clinical data sharing through our Medicaid purchasing efforts and existing authorities through contracts with Managed Care Organization;
- Collecting and integrating clinical information into MITA business processes and emerging processes to support pay for performance; and
- Providing early value to providers to move toward automated performance monitoring by adding Medicaid claim and encounter data to clinical data.

B.5 HIGH LEVEL HEALTH IT GOALS

The following high level goals work together to ensure we have the infrastructure, tools, and business processes in place to address Medicaid's needs:

1. ***Meet emerging needs for integrated high value data sets that go beyond current claims and encounter data for organizations going at risk for performance and new organizational arrangements that require capabilities outside traditional enterprise HIT resources.***
   How: Partner with Managed Care Organizations to establish and maintain an integrated health record available as Apple Health consumers move from one plan to another. Use a cost sharing model that is sustainable.
2. ***Drive broad adoption of standardized HIE transactions and increased use of health information exchange between organizations.***
   How: Require Managed Care organizations to require subcontracted providers with EHR systems send a care summary using a standard CCD-A from their EHR to the clinical data repository each time an Apple Health consumer is seen.
3. ***Drive broad utilization of integrated clinical and administrative information to advance Medicaid business processes and better inform policy, program, and care decisions.***
   How: Develop a shared understanding and formal AG opinion of the states interpretation of what is legally defensible under HIPAA, CFR 42.2, and other state pricacy laws.
4. ***Support the adoption and meaningful use of certified EHR technology among Medicaid providers, with a focus to expand adoption among behavioral health providers.***
   How: Leverage SIM Grant to assess what is needed and determine if a community solution that behavioral health care providers could subscribe to would advance capabilities at the pace needed.

B.6 NEW CORE TECHNICAL CAPABILITIES NEEDED

Our strategies require tools that collect, compile, manage, and interpret large quantities of clinical data, and can present evidence based information to support decisions at the point of care.

The following specific capabilities are needed to achieve our goals, advance [1]MITA maturity levels, and prepare to realize new opportunities presented in the Medicaid Innovation Plan:

Record Locator: Query and locate patient records within multiple provider systems to find and collect health care data electronically into Medicaid patient's clinical health record.

Clinical Data Collection and Aggregation Tools: Collect and evaluate clinical, behavior health, and social services data coming from different systems.Parse data into patient specific records to provide a comprehensive picture of the patient's situation and needs. Map data vocabulary sets from different systems to describe lab results, problems, allergies, medication, and other clinical content to ensure consistent data sets.

Clinical Data Warehouse (CDW): Consolidate data from a variety of clinical sources to populate a longitudinal view of a patient's health record.

Clinical Portal: Presents complete and up to date longitudinal patient information to authorized users using role-based privacy levels to protect patient privacy.

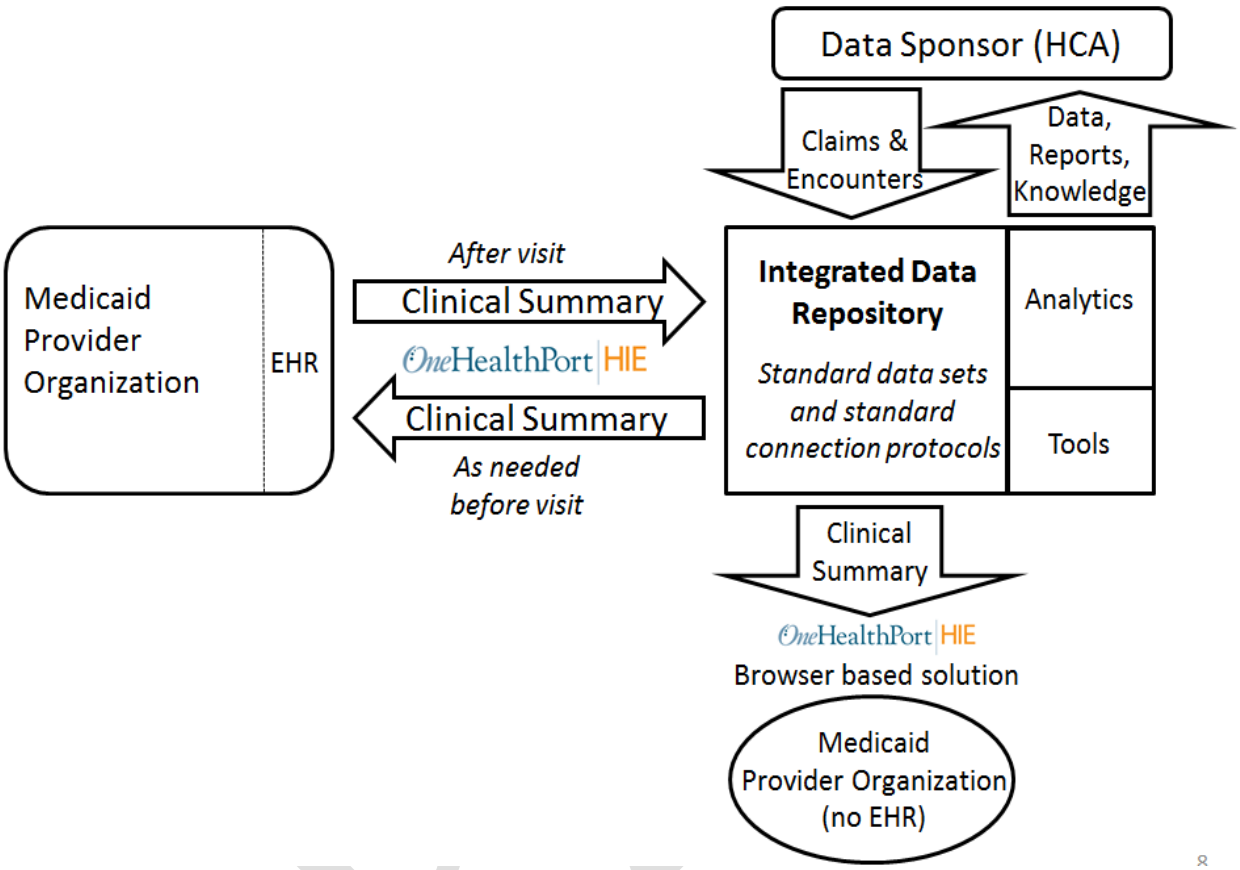
Analytic Tools: Provide dashboard reporting on provider performance, patient health, and population health trends.Make data available to analytical data stores for advanced analytics.

B.7 HEALTH CARE AUTHORITY CONCEPTUAL DATA INFRASTRUCTURE

As Washington moves away from a largely fee-for-service reimbursement system to an outcomes-based payment system, there are emerging needs for new data sets to measure care outcomes. In addition, improved health, better care and lower costs requires Washington to close the gaps between primary care and physical and behavioral health care. Effectively integrating mental health, substance abuse, and primary health care services produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs.

[1] The MITA Maturity Model shows improvement of the Medicaid business over time. Level 4 maturity requires immediate access to clinical data. Level 5 requires national data sharing and interoperability.

To implement the specific goals and objectives of HIT / HIE, the conceptual Washington's data flow is depicted below:



B.8 Medicaid Business Process Integration

Washington's MMIS contains Medicaid claims and encounter data, but does not currently collect clinical summary data. The future state architecture will allow the state to bring more real time clinical data into our MMIS Enterprise for advanced analytics. Washington will review current business proceses within the MITA framework to determine which processes and staff need access to this new data.

Washington is seeking flexible data integration platforms and analytic tools that can leverage these data sets for more complex data analytics and business intelligence. A team of staff funded under the SIM grant are leading these effots to advance Analytics, Interoperability, and Measurement.

B.9 FUNDING MODEL

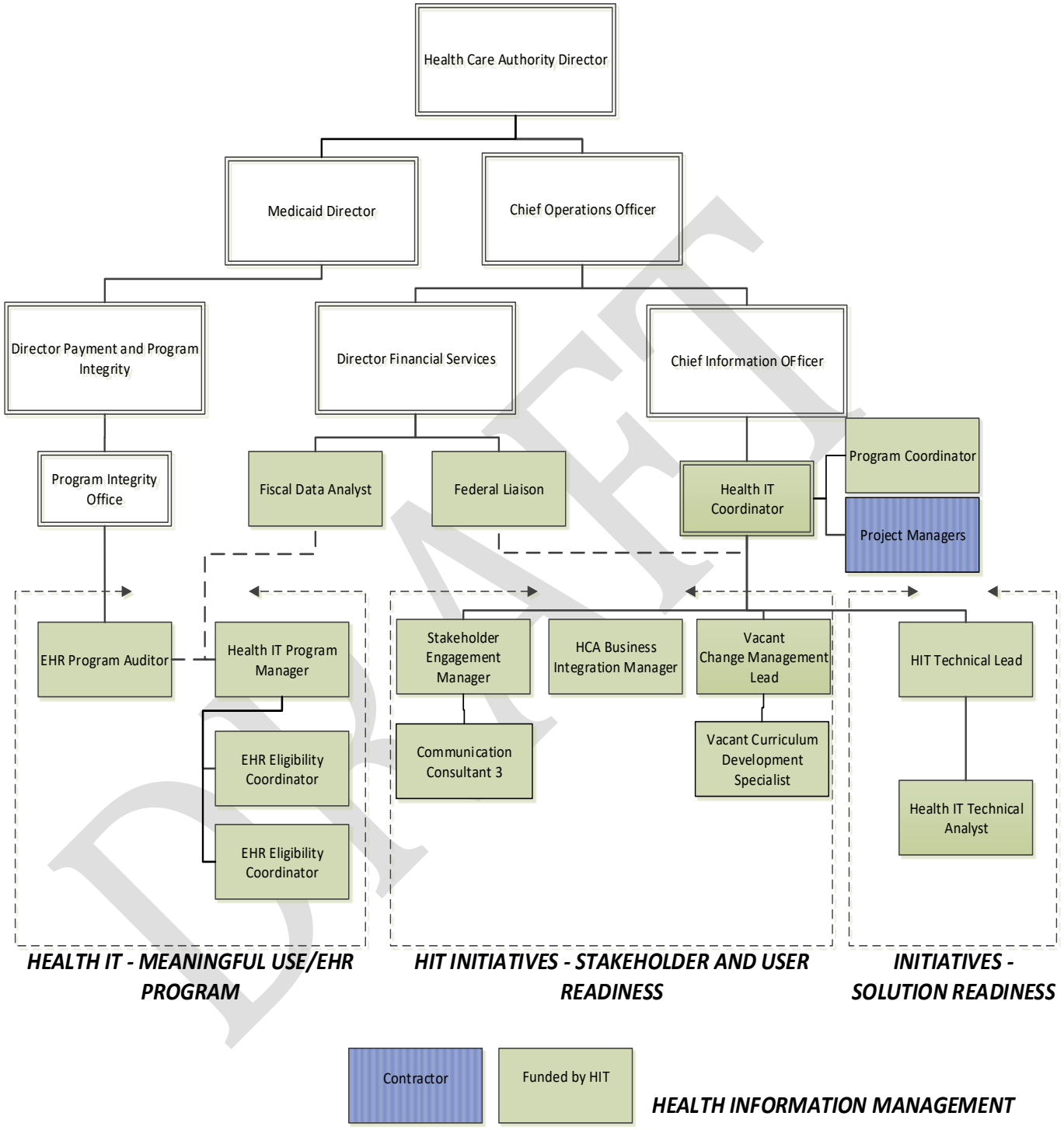
Washington has developed a multi-year Performance Improvement Project with our contrated Managed Care Plans that outlines a shared cost model to support the clinical data repository. The state is completing the set up of the repository and paying for the software as a service with federal funding participation. The annual costs for maintaining each record is paid for by the Managed Care Plan for all enrollees.

This approach provides Medicaid with the access to clinical information, and results in lower entry costs and predictable annual expenses. It also brings the solutions to the entire community and brings data together on a much broader scale. As part of our OAPD for the MMIS, we have included funding to cover Medicaid's investment for the managed care population.

In developing the shared cost model, the following principles were applied:

- Costs are allocated using a methodology that identifies Medicaid's pro-rated share. Cost allocation will involve the timely and assured financial participation of all parties so that Medicaid funds are not the sole contributor.
- Costs are predictable and integrated into the Medicaid business enterprise.
- Costs are shared among organizations who also benefit from access to the data in a way that leads to a permanent and sustainable model.
- Leverage investments already made in state HIE and provider organization EHR systems.

B.10 STAFFING MODEL –



Staff Roles and Responsibilities

Health IT Coordinator
Overall strategic planning and oversight for operationalizing Health Information Management into Medicaid Enterprise activities. This includes serving as the project director for all Health IT projects and working across the HCA with other state agencies serving Medicaid covered individuals to implement change.

Program Coordinator
Supports HIT program activities and project activities related to the State HIT and Link4Health Clinical Data Repository Project

Change Management Lead
Identify the impacts of planned HIT initiatives to current Medicaid business processes across state government. Develop and implement strategies to support the adoption of new processes.

Stakeholder Engagement & Communication Manager
Manage statewide stakeholder outreach, relationships and activities (public and private), develop and implement deliverables, development & implementation of strategies and associated timelines, provide regular progressive updates to agency leadership on these responsibilities. Manage daily communication and stakeholder efforts. Supervise communication staff.

Health IT Program Manager
Manage key stakeholders, deliverable completion, timelines and tasks, development and implementation of HIT program and federal reporting and planning activities.
Manage daily operations of EHR program and eMIPP system updates. Supervise Eligibility staff.

Business Integration Manager
Manage the formulation, implementation, and execution of an agency wide, long-range change management strategy for the collection and utilization of integrated clinical and administrative information to inform state Apple Health policy, program and care decisions. Interpret and analyze impacts on agency systems, business processes and staff and make decisions regarding strategy changes in a fluid environment. Provide expert level consultation with HCA leaders and groups to ensure that stakeholders are prepared and ready for the changes critical to the success of each affected program. Provide agency leadership to oversee business process re-engineering, transition planning and staff training needed to accomplish the desired organizational changes.

EHR Program Eligibility Coordinators (2 positions)
Conduct in depth analysis to validate EHR Program Eligibility, including certified EHR and Meaningful use, and provide technical support to providers regarding the EHR Program

EHR Program Auditor

Establish program integrity policies and procedures for EHR Incentive Program. Perform post payment review for approved EHR Incentive payments.

Health IT Technical Lead
Conduct the strategic leadership and planning for technical elements of the Health IT Projects and initiatives. Identify needed changes to the Medicaid Enterprise architecture and manage the deliverables and staff conducting the technical design, development and implementation. Manage expansion of MMIS to include new clinical data sets, repository, interfaces and tools.

Health IT Technical Analyst
Support the Health IT Technical Lead to conduct the hands on technical analysis and development of technical elements to support Health IT initiatives as they move from planning into design, development and implementation.

Curriculum Development Specialist
Design, create and deploy internal and external development tools and methods for Health Information Technology work and initiatives for internal staff and external stakeholders

Communication Consultant 3
Support Health IT unit communication activities, write and edit documents, website updates, newsletter compilation and distribution.

Federal Liaison and other Fiscal SMEs (.4 FTE)
Manage all interactions with CMS and provide leadership on federal funding. Provide expertise in development of fiscal processes including payment calculations.

Subject Matter Experts - Existing HCA State Staff from various business areas (2 – 2.5 FTE)
Provide expertise to the project team to facilitate program integration.

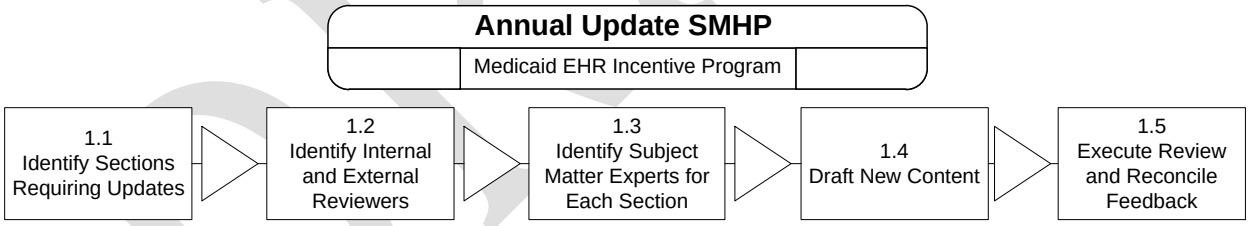
SECTION C: ADMINISTRATION / OVERSIGHT OF EHR INCENTIVE PAYMENT PROGRAM

Washington Medicaid shares in the vision of CMS and sees this program as an opportunity to improve health care quality, safety, and efficiency through the promotion of health information technology (HIT) and the electronic exchange of health information.

Following CMS guidelines, Washington Medicaid has developed a comprehensive plan for implementation and ongoing administration of the EHR Incentive Payment Program. It was the goal of Washington Medicaid to integrate the Program throughout the organization, so that it seamlessly fits within current processes and procedures where possible. Washington does not intend to propose any changes to the Meaningful Use definition.

The Washington SMHP was initially approved prior to the implementation of the EHR program. It remains a living document outlining our current and future HIT/E goals and strategies as well as the administration of the EHR Incentive Payment Program and related audit strategies. The original was compiled by Qualis Health in 2011. The updates have now moved internally and are done collaboratively within HCA and with HIT/E partners. The August 2013 update is more extensive than most updates as we have redefined our timelines and roadmap and are creating an updated picture of the HIT/E landscape. Additional updates are done as needed when new functionality is released and/or screen changes are made to eMIPP application.

Fig. C-1: Process for SMHP Updates



C.1 GUIDING PRINCIPLES FOR PROGRAM ADMINISTRATION

Implementation has occurred and ongoing administration of the Electronic Health Record program is now a routine function within HCA. The program is directly managed by the Health IT Program Manager, The Meaningful Use Business Manager and two Eligibility Coordinators. The organizational structure is outlined in Section A.

Washington Medicaid defined a set of principles to guide investment decisions relating to the State Medicaid HIT Plan and EHR Incentive Payment Program and Medicaid's involvement with the Statewide HIE and other emergent initiatives. Specifically, Medicaid sought a framework to assist in answering three questions about EHR/HIE implementation:

1. To what, if any, extent should Medicaid expand the list of Meaningful Use requirements?
2. In what, if any, other capabilities referenced in the Medicaid Director's Letter should Medicaid consider investing?
3. How does Medicaid engage with the HIE infrastructure in Washington State?

The following principles have been established for guiding Medicaid initiatives and investments related to the SMHP/EHR Incentive Program and Medicaid's involvement with the Statewide HIE.

The initiative/investment must:

1. Be Within Guidelines - Fall within current or anticipated EHR Program Guidelines and Requirements.
2. Increase Program Participation - Maximize the number of providers meaningfully using EHRs and serving Medicaid beneficiaries (e.g., more providers pursuing fewer requirements is a better outcome than fewer providers pursuing more requirements).
3. Avoid risk to EHR Incentive Program Implementation – Focus resources on the delivery of the basics to meet the incentive program. (e.g. Medicaid will not expand program in year one.)
4. Promote Efficient Electronic Exchange - Minimize the cost and complexity of information exchange for Medicaid and its trading partners (e.g., Medicaid will use the state HIE as its single point of connection for trading partners interested in accessing its data.)
5. Improve Health Outcomes - Maximize the health and/or minimize the cost of care for the Medicaid population (e.g. reduce use of unnecessary/ineffective services).

C.1.1 Program Implementation and Administrative Goals

The broad goals for the federal program include enhanced care coordination and patient safety, improved efficiencies, electronic information sharing across providers, payers and state lines, and data sharing using state health information exchange. Achieving these goals will improve health outcomes, facilitate access, simplify care, reduce costs of healthcare nationwide, and improve the quality of care for millions of Americans.

The State's Health Innovations for Washington closely aligns with these national goals and are outlined in Section B.5 of this SMHP. To support these goals, HCA administers the EHR Incentive Program using the following guiding principles:

- Adopt the Meaningful Use definition as outlined in the CMS rule. We do not intend to propose any changes to the definition as permissible per rule-making.

- Maximize the number of providers meaningfully using EHRs (e.g., more providers pursuing fewer requirements is a better outcome than fewer providers pursuing more requirements)

- Promote statewide health IT activities that ensure providers are supported in their pursuit of "adopt, implement and upgrade" and Meaningful Use of EHR technology.

- Wherever possible, capitalize on existing processes within the State for payment, appeals and audit to enable efficient program operations and eliminate duplication.

- Invest time up front in pre-payment validation to avoid a "pay and chase" approach.

- Communicate effectively the program goals, vision and required information to ensure that the program is understood by all parties involved in implementation and ongoing administration.

- Promote the program to ensure that the goal of improving quality, safety and efficiency is achieved throughout the State of Washington.

- Ensure accountability of State and Federal funds through development and implementation of appropriate checks and balances.

- Wherever possible, automate manual processes as soon as possible after implementation of the program.

- Collaborate with stakeholders and other partners to contribute to the development and promotion of the Washington HIT program.

- Wherever possible, bring tools to the broader community to include those not eligible for EHR incentives but necessary to support the critical mass of providers needed for adequate health information exchange.

C.2 Partners and Communications

C.2.1 Partners

In addition to partnering with CMS and ONC at a national level Washington's EHR program partners with the following organizations for ongoing Incentive management. More detail on some of these partnerships can be found in other sections of the SMHP. This section is list of formal partners and their statements of work.

Electronic Health Record Incentive Program

Washington State's Medicaid EHR Incentive Program is playing an important role in establishing critical health information technology designed to reduce costs, improve care and advance coordination across our healthcare system, leading to better health outcomes and healthier lives.

Health Information Exchange

In 2009 the Washington State Legislature enacted law in support of robust Health Information Exchange. This legislation directed the Health Care Authority (HCA) to designate a private sector organization to lead implementation of Health Information Exchange. OneHealthPort (OHP), an exchange entity originally developed by a consortium of clinics, healthcare facilities and insurers, was selected as the lead organization. Collaborative efforts (OHP –HCA) have focused on provider outreach, education, preparedness and engagement in meaningful data exchange. Joint planning and technology development activities assist in meeting the goal of interoperability and exchange, and offers support to organizations that are new to clinical data exchange and/or lack resources or expertise to execute exchange beyond their own network.

Regional Extension Centers

The Qualis Health Regional Extension Center (formerly WIREC) provides vendor-neutral health IT consulting services related to the successful adoption, implementation, and utilization of electronic health records (EHRs) for improving healthcare. The REC has exceeded 100% of its goal to bring nearly 2,400 eligible doctors and other providers in Idaho and Washington State to meaningful use. Achieving meaningful use has helped these providers qualify for more than $80 million in Medicare and Medicaid incentives. With this milestone, Qualis Health is ninth among 62 RECs nationwide to reach its meaningful use goal, and the first to do so across a large, multi-state region.

Workforce Training and Development

Bellevue College leads Curricula development, student recruitment and retention, equipment acquisition, and community college/university bridge programs and activities that will help optimize state ARRA health IT efforts.

Washington Health Information Industry-Education Council (WHIIEC)

The Health Care Authority convenes and facilitates the Washington Health Information Industry-Education Council (WHIIEC). WHIIEC is a forum for representatives of employers and HIT education/training programs to align educational opportunities with the HIT staffing needs of health care providers, public health agencies, insurers and other employers and provide meaningful career opportunities for graduates.

Public Health

HCA has developed a strong partnership with Department of Health and has assisted them by seeking federal funding participation for work necessary to enable providers to electronically report lab results for Meaningful Use. Deputy Health IT Coordinator has hosted ongoing check in meetings with DOH leadership to keep lines of communication open. Department of Health is moving many one to one interface reporting processes to the HIE.

Additional the Washington State Department of Health has formed the **Electronic Data Exchange Executive Sponsor Group (ESG)** to provide high level decision-making, communication, and oversight for DOH Meaningful Use and HIE projects.

Areas of Focus:

- Approve strategic project selection and prioritize criteria.
- Review all Visibility Documents for MU and HIE projects.
- Provide oversight and alignment of MU and HIE project portfolio
- Serve as escalation path for decision-making and risk management for MU and HIE issues
- Oversee and approve MU and HIE agreements and approaches with OHP and HCA
- Monitor OHP Community Oversight and send attendees as necessary

Membership:

- DOH Deputy Secretary - Leader
- DOH Assistant Secretary and/or Chief Administrator for each division
- DOH Chief Information Officer

Resources:

- Facilitator – DOH HIE Project Manager
- Technical Advisor – Chief PH Informatics Officer, DOH Liaison to HCA
- Ad hoc attendees as needed

Research and Development

A research team at the University of Washington has completed the first year Health Information Exchange (HIE) performance evaluation report on with preface and reaction/postscript by the Health Care Authority and OneHealthPort. For the purposes of the HIE, the primary objective of the evaluation is to support and inform decision-making about how to improve the performance of health information exchange in meeting stakeholders' business needs and strengthen its sustainability.

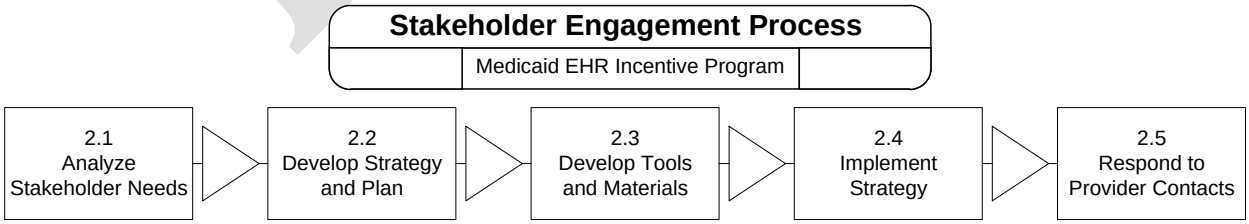
Health Homes Program HIE Pilot

A Medicaid Health Home Program Pilot was implemented under the combined leadership of HCA and the Department of Social and Health Services (DSHS). The required electronic transmittal of Health Action Plans has resulted in a key partnerships and new business processes between approved lead organizations, HCA and OneHealthPort.

C.2.2 Stakeholder Engagement and Communication

A well-researched and ongoing Stakeholder Analysis lays the foundation for successful communications and engagement with providers who may qualify for incentive payments. Stakeholder analysis has been done at the statewide HIE level and a number of individuals and groups have been engaged for some time. The EHR Stakeholder Analysis identifies and defines all groups who are impacted specifically by the implementation of the Medicaid EHR Incentive Payment Program. Ongoing review and updates ensure that stakeholder engagement activities are integrated with other agencies and undertaken in a coordinated manner. The Stakeholder Engagement Manager plans regular Stage 2 Acceleration Challenge partner meetings to collaborate messaging, acts as the state's HealthIT.wa.gov website administrator and editor, writes, publishes and distributes a monthly EHR newsletter to approximately 5,000 internal and external EHR stakeholders and plans and coordinates a quarterly HIE Inter-Agency Leadership meeting with an average of 50 participants. The following visual depicts a cyclical and evolving method where new strategies and plans are in regular development.

Fig. C-2: Stakeholder Engagement Process



The HCA uses a variety of means to maintain communications with EHR eligible providers.

Webinars – Informational and educational webinars will be used to reach and support viewers with EHR information over the internet. Links to CMS and ONC webinars are also provided on the home page of HealthIT.wa.gov website to provide viewers with up-to-date training and information. Provider sub-group focused webinars have been offered and provided in large group meeting formats as well. In 2014 HCA produced and published a webinar specific to AIU and one specific to Meaningful Use.

White papers – from CMS are posted on our website for easy provider access. When complex topics arise or state-specific decisions are reached, an informational white paper may be written and posted

Road show – we experienced great success in the nine roadshows previously done in conjunction with our partners at OHP and WIREC. There was a significant increase in registration and attestation. The HIT team partnered with OHP to partipate with a vendor table at three meetings across the state to do face to face outreach with materials for AUI and Meaningful Use.

High Touch Outreach with Eligible Hospitals – Partnered with OHP to contract for high touch 1:1 outreach to 11 hospitals who had not yet participated in EHR Incentive Program. Educated decision makers about the Medicaid program and AIU and provided support to them through the process. $3.4M of first year AIU payments resulted from this effort.

High Touch Outreach with Eligible Professionals – Discuss Individual follow-up with providers who have registered with CMS and not attested- a direct email follow-up is being conducted to reach providers who have registered with CMS but not attested. The focus of this effort is to identify and resolve any challenges this group of providers face. Four targeted provider sub-groups will receive outreach communications specific to their identified needs. These are: Tribal, Dental, Behavioral Health and Pediatricians.

Use of inbox to manage provider inquiries to closure – This system was implemented and is currently being used. This ticket management system receives all email inquiries and routes them to the EHR inbox. Our EHR support team members retrieve, research and respond to the inquiries via telephone or return email, including pertinent supportive materials and resource links. Once an inquiry has been resolved, the ticket is closed and saved.

Website- A provider-facing website was redesigned to contain current information about the EHR program, training materials, a library of over 100 supportive documents and user guides, links to CMS materials and contacts and information about our partners.

List serve and Newsletter distribution - Our state's current Listserv enrollment to receive EHR and HIT related messages, monthly newsletters and notifications reaches approximately 4,000

viewers. We provide the same messages for distribution through the Washington State Tribal communication channels which reaches approximately 60 tribal health directors for viewing and redistribution. We anticipate statewide distribution to state dental association and regional dental societies will begin in the fall of 2013.

Step by step user guides – have been written for the following: EH AIU eMIPP, EH MU eMIPP, EP AIU eMIPP, and EP MU eMIPP. These include helpful step-by-step screenshots. We have made these available on our website and are distributing during outreach meetings with provider sub-group leadership. We encourage the leadership of these groups to redistribute to their entire membership and provider teams.

One paper correspondence and seven unique system-generated messages inform providers of current status as they proceed through registration and attestation. All system generated correspondence is sent via email to the registered contact- The system generates the following at key times during their processes; registration: Provider Submission Complete Notice, Approval Notice, Rejection Notice, Auto-enrollment Notice, Auto-denial Notice and the B6 Update.

Use of communication campaigns – Multiple communication campaigns are taking place and are planned surrounding HIT/EHR/HIE for our state. All campaigns include leveraging communication channels and working with our partners to accomplish timely, effective, focused outreach to the multi-layer internal and external stakeholder communities. Beginning fall 2013 we will implement an inter-agency/partner communication council to formulate, review and distribute common messaging regarding our state's HIE.

A provider website has been established that contains information about the Electronic Health Records Incentive Program, such as links to CMS fact sheets, a partners list, essential tools and a contact us option that generates a help ticket to the Eligibility Managers. The website was recently updated to include links to webinars, a library of over 100 supportive documents and user guides, updated links to CMS and ONC and copies of EHR specific newsletters.

Additionally, The State of Washington has established a unique listserv (email distribution list) that providers can subscribe to for HIT and EHR Program updates. This will used extensively to ensure that providers have Health IT information needed delivered to them electronically. Washington Medicaid communicates regularly with its audience on a biweekly basis and with more frequency before critical programmatic dates, deadlines, policy changes, and announcements. We also offer monthly distribution of these messages through other communication channels such as the tribal medical providers, the state dental association and the regional dental societies. We anticipate developing similar distribution to the medical, hospital, pediatrics and behavioral health organizations.

As we continue with Stage 2 Meaningful Use and plan for Stage 3 we are we have created a communication/outreach strategy specifically to increase participation and develop targeted strategies for a variety of subgroups including those who have registered, but not attested and specific provider communities. These include tribal liaison and leadership, dental, behavioral health and pediatricians.

Refer to ***Appendix C.3*** - ***Electronic Health Records - 2015 Outreach.***

C.3 ARCHITECTURE AND INTERFACES

A diagram of the eMIPP architecture is provided in figure C.3. The eMIPP application is accessed through its own secure portal and interfaces with ProviderOne to ensure basic provider eligibility for EHR payments.

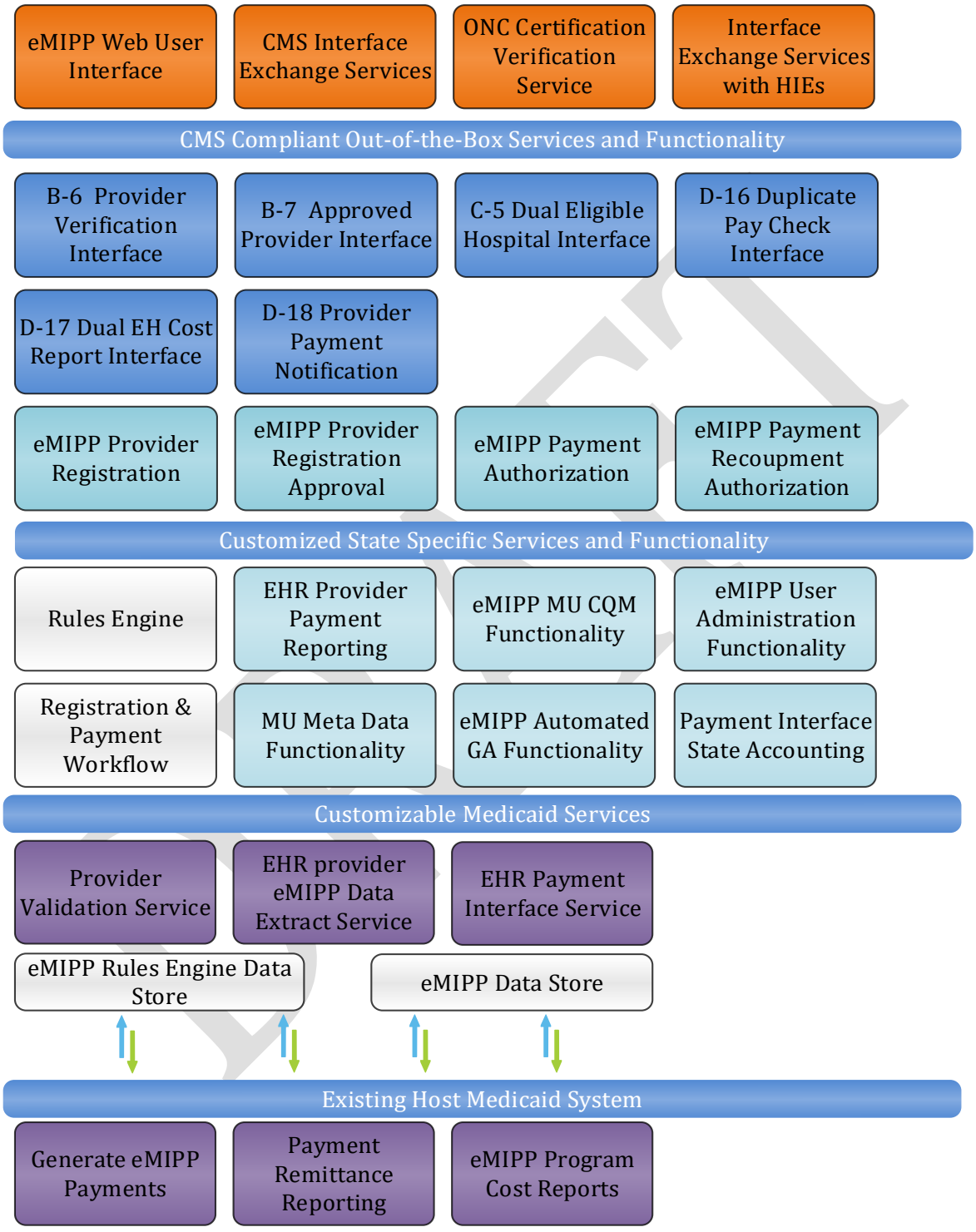


Fig. C-3: eMIPP Functional Architecture

C.4 VERIFICATION AND PAYMENT ACTIVITIES

Washington Medicaid is using the CNSI Medicaid Incentive Payment Program product, eMIPP to enable qualified providers to attest to AIU and Meaningful Use. The system is designed with a one stop attestation process that allows for straightforward entry of information into a windows based system.

A high level visual of the process is shown in figure C.4 depicting the process flow from CMS registration to EHR incentive program payment.

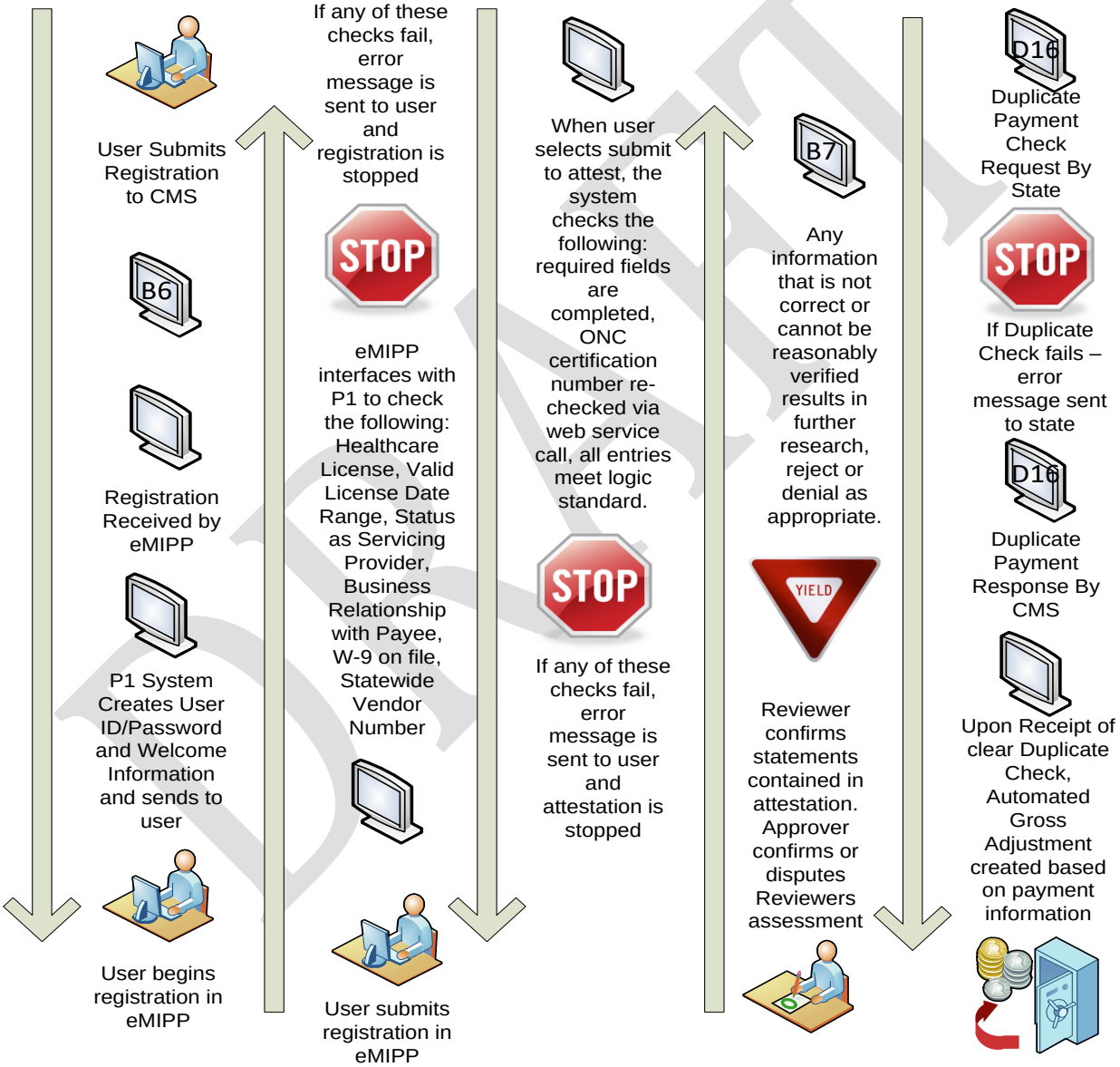


Fig. C-4: Process Flow

C.4.1 Verify Providers have successfully completed steps to Adopt, Implement or Upgrade (AIU) certified EHR technology:

The AIU verification process for the first year of the program includes the submission of attestation and documentation by the EP or EH as follows:

- Provide attestation via eMIPP for certified EHR technology purchase or upgrade (or of binding agreement to purchase or upgrade). Providers will be notified that these documents must be retained for six years and available for audit purposes.
- Submission of document(s) that demonstrated that the EP or EH possesses the Certified EHR system or modules for which they have attested. Documents might include items such as:
    - Signed Contract
    - User Agreement
    - Purchase Order
    - Receipt
    - License Agreement
    - Vendor Letter
- Provide the EHR Certification Number when registering with CMS so that it is sent on the interface to eMIPP.
- Update, as necessary, information contained in their provider record.
- Interface with the NLR to obtain and store information regarding payments received from another State agency or Medicare in their database. (future functionality)

The verification process for the program's first year focuses on accepting attestations for the AIU requirement. At the end of the attestation process providers are required to certify that the information they have provided is true, accurate and complete through the use of electronic signature functionality. Submitted documentation is stored in eMIPP or the ProviderOne provider file depending on method of submission. Additional documentation verifying the information entered into eMIPP to support and administer the Medicaid Incentive Payment Program may be requested from the providers during pre or post payment reviews.

Verification for other EHR Incentive Payment Program requirements rely on attestation by providers and audit of records through the standard audit processes in place in the Medicaid program today. Providers may be asked to send documentation and are advised to maintain copies of all documentation for at least six years for audit purposes.

For the first year of the program, providers attest to the Adoption, Implementation and Upgrading of EHR systems. All attestations and verifications are subject to audit by the process described in Section D of this SMHP document.

C.4.2 Verification providers have achieved Meaningful Use of certified EHR technology in program Year 2.

The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures.

Per CMS guidelines, to qualify for Medicaid incentive payments, Meaningful Use requirements must be met in the following ways:

Eligible professionals and eligible hospitals may qualify for incentive payments if they adopt, implement, upgrade, or demonstrate Meaningful Use in their first year of participation. Washington Medicaid supports payments for AIU during year one. EP's and EH's must successfully demonstrate Meaningful Use for subsequent participation years.

Washington Medicaid follows the CMS guidelines for the core clinical measures required by Eligible Professionals and Eligible Hospitals in the second year of participation. Additional clinical measures may be added in subsequent years. If warranted, Washington will work with CMS and the provider community to implement additional clinical measures that are meaningful to the Medicaid population in our State.

Verification steps for Meaningful Use of certified electronic health record technology for providers in the second year have been enhanced by working with CMS and other States to determine the best solution and process for verification. This solution now includes a supplemental questionnaire and documentation request for several of the Stage 2 measures. Addionally, for providers invoking the Flexibility Rule for program year 2014, they must submit a signed letter by the organization CIO, COO, EHR vendor or equilavent explain how they qualify under the flexibility rule allowances. This letter is reviewed by the Health IT Program Mangager for appropriatness during the prepay process.

C.4.3 Notify Parties of Determination

Providers determined to be ineligible for the EHR Incentive Program are notified via certified mail and e-mail using the addresses collected during the CMS registration process.

C.4.4 Data Collection Processes

Washinton collects data several ways. During prepay validation providers are asked to submit supplemental information via questions in Survey Monkey for several measures depending on the stage of the program. These documents are collected and added to the eMIPP application for

each provider. We also request patient volume reports to ease the reporting burden if a provider is chosen for a post pay audit. We found early in the post pay auditing process that some providers had difficulty recreating these reports years after the attestation process.

We also collect clinical quality measures via attestation or via QRDA III file upload. Few providers are currently using the available QRDA process.

Washington Medicaid is currently developing an approach for alignment of the data collection and analysis project with the collection of other clinical quality measures data, such as Children's Health Insurance Program Reauthorization Act (CHIPRA).

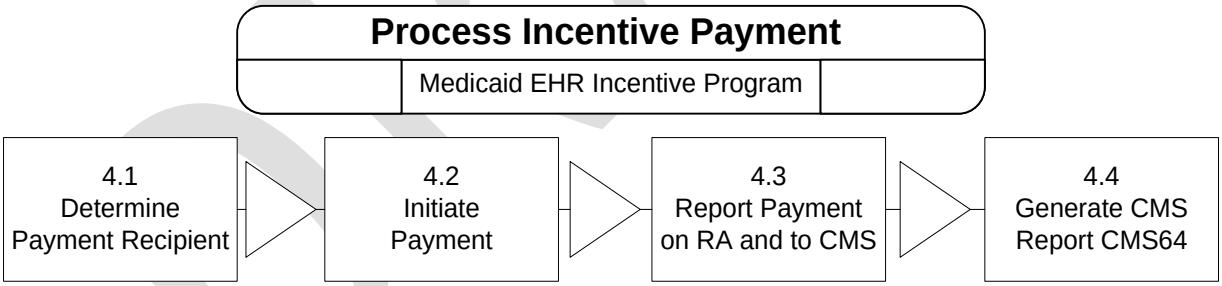
Details of current verification activities and the step by step attestation review process can be found in ***Appendix C.2 – EHR Incentive Program Procedure Manual for Eligible Providers and Eligible Hospitals*.**

C.4.5 Payment and Financial Management Process

The payment process is a critical component of the state's implementation process for the EHR Incentive Program. After processing provider attestations and verifying eligibility, the payment process is the next step.

The following Figure C.4 illustrates the payment process for providers:

Figure C-5: EHR Incentive Program Payment Process



C.4.6 Determine Payment Recipient

CMS rules allow for payments to be made to hospitals, EP's or to entities promoting adoption and Meaningful Use of EHR should an EP's voluntarily decide to reassign their payment.

If a payee designee arrangement is indicated, the Eligibility Coordinators ensure that participation in the payment arrangement is voluntary and additional documentation may be requested as outlined in the eligibility desk manual.

The Tax Identification Number (TIN) is used to identify the providers on IRS Form 1099 and allows IRS reporting when providers have received an EHR Incentive payment from Washington. The NLR Registration transaction to the State includes the EP's Personal TIN and the Payee TIN. The TIN/EP relationship is validated against information within ProviderOne.

C.4.7 Initiate Payment

Washington Medicaid leveraged the existing payment processes within ProviderOne to disburse EHR incentive payments weekly to the providers. Once attestation information is entered in eMIPP and verification has been completed, information is sent to the accounting department for approval.

Information is then coded and entered into the ProviderOne system which interfaces with the state's Agency Financial Recording System (AFRS) for payment. These payments are processed as gross adjustments with a specific code developed to identify EHR payments on the remittance advice.

ProviderOne issues weekly payments. Payments entered by Tuesday are paid on the following Thursday. Washington Medicaid meets or exceeds the guidelines for prompt payment within 45 days.

C.4.8 Process for Disbursement to Servicing Only Providers

To ensure all eligible servicing professionals are payable within the ProviderOne system, eligible professionals that do not bill Washington Medicaid directly on a fee-for-service basis were uploaded and identified with an "EHR flag" identifying them as payable for EHR incentive payments only. They do not have the ability to bill Medicaid, but can attest and receive EHR payments.

C.4.9 Report Payment

After an EHR incentive payment is made through ProviderOne, an interface provides the payment information back to eMIPP. Washington Medicaid reports payment information out of eMIPP to CMS via the NLR interface. Providers see their payments on their remittance advice which identifies the payment based on a unique payment code.

C.4.10 Generate CMS Report CMS64

Washington Medicaid uses existing processes to assure that all Federal funding, both for the 100% incentive payments, as well as the 90% HIT Administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner.

Extensive controls are in place within the accounting system to ensure that funds are never commingled. This is managed through the use of a unique cost objective system which identifies

the funding sources and is the lowest level in the State AFRS accounting system. In order to separately track expenditures, a separate accounting code is used. This code assures that administrative funds related to the EHR incentive program are appropriately budgeted for and reported on as required by CMS.

On a monthly and quarterly basis, there are several steps completed in order to prepare the CMS64 report, including:

- Journal Vouchers are completed for corrections and adjustments
- Transactions are analyzed
- Adjustments are completed

On a monthly basis, the State prepares an approved Letter of Credit (LOC) in order to request estimated funds from the federal government. On a quarterly basis, the certified expenditures are submitted on the CMS64 form. A separate line item is included on the CMS64 showing funds for the EHR Program.

C.5 Changes to Meet CMS Requirements

HCA eMIPP changes for year two were deployed in May 2013 and Meaningful Use Stage 2 updates were deployed in December 2013. Flexibility Rule changes were implemented in October 2014. The following eMIPP updates have been made according to CMS requirements.

Modifications to Stage 1, Year 1 and 2

Change	eMIPP/ProviderOne	Business Process	Provider Tools
Meaningful Use Objectives	Updated eMIPP to require EPs seeking Year 2 payment to meet 20 of 25 Meaningful Use objectives and EH's to meet 19 out of 24 Meaningful Use objectives. All federal Meaningful Use objectives are available in eMIPP.	HCA EHR Eligibility Coordinators manually review the numerators/denominators and exclusions to all required MU objectives. If required measures are not met the attestation is rejected.	Updated Provider step by step attestation guide. Updated white papers.
Clinical Quality Measure (CQM) Data	Updated eMIPP to require that EPs report on 6 CQM, and EHs report on 15 CQM when seeking Year 2 payment. All 44 federal CQM measures are available in eMIPP.	HCA EHR Eligibility Coordinators manually review the reported CQM's to verify all measures are met. If required measures are not met the attestation is rejected.	Updated Provider step by step attestation guide. Updated white papers.
Document Download/Upload	Updated eMIPP to allow providers to upload and download an MU compliance PDF form for attestation.	Eligibility coordinators request supporting documentation during prepayment review.	Updated Provider step by step attestation guide.
NLR and eMIPP cost reporting interfaces	eMIPP interface changes	Automated process	N/A
E-mail welcome letter	eMIPP welcome email updated for Year 2 and beyond.	Automated process	N/A

Report updates	Three reports updated to include Year 2 records.	N/A	N/A
New reports	Two new Cognos reports created.	N/A	N/A
Flexibility Rule Changes	Updated system to allow for 2014 program changes	Added documentation requirements and review steps.	Updated provider guide and documentation

Stage 2 Meaningful Use Implementation

More extensive changes for Stage 2 Meaningful Use were completed in December 2013. Additional business rule, reporting and interface udpates were completed in 2014 to keep eMIPP current. Those changes are outlined below and can be found in the HCA and CNSI contracts.

Change (2013)	**Short Description**
Eligible Encounter Calculations	eMIPP update to allow groups to submit eligible encounters simultaneously for all members of the group.
Meaningful Use Policy Changes	eMIPP/an exclusion does not count towards number of menu set objectives that must be satisfied/2014 onward
Stage 1 MU Criteria Changes effective 2014	Multiple Stage 1 revisions to eMIPP effective 2014 onward.
Stage 2 MU and CQM changes effective 2013 and 2014	Adds 18 functional extensions to eMIPP for MU Stage 1 and 2.
C5 Interface Changes	eMIPP C-5 interface changes to accommodate revisions to Stage 1 and extension to Stage 2.
Electronic CQM Reporting	eMIPP functionality to collect and store eCQM data.

Cognos Report Changes	Modify existing reports.
CMS Audit and Appeal Interfaces	Develop 4 new interfaces with CMS.
Interfaces	Added additional elements to inbound B6 interface and modified relevant system rules.
Change (2014)	
Reports	4 new reports created for Stage 2
MU in year 1	Updates to allow year one attestation to be for AIU OR MU
Business rule	Two new business rules to validate certification id's for relevant year
Interfaces	B6 and C5 interface updates per CMS rules
Patient Volume	Updated threshold, rounding rules and screen for patient volume
eCQM	Implemented rules to cover individual submission rights in a group scenario
Interfaces	Updated B6 and D16 interfaces per CMS rules.
Flexibility Rule	Updated system and processes for program year 2014 changes

Washington does allow the group reporting option for CQM's via the QRDA III. To address the issue of EP's who switch group practices during an EHR reporting period the following examples depict the process for three scenarios.

Not group proxy	EP leaves Clinic A and joins Clinic B. EP's ninety day PV reporting period spans days at both clinics. EP uses all encounter data for the reported period from both clinics. If Clinic A uses EP's encounters in their Group Proxy calculations then EP cannot use those encounters in his encounter data.
Group proxy/AIU	EP leaves Clinic A and joins clinic B. Clinic B is including EP in their Group Proxy. EP's Patient Volume calculation includes only those encounters associated with clinic B. Clinic A cannot use EP in the Group Proxy calculation.

Group Proxy MU	EP leaves clinic A and joins clinic B. Clinic B is including EP in their Group Proxy. EP's Patient Volume calculation includes only those encounters associated with clinic B. Clinic A cannot use EP in the Group Proxy calculation. Meaningful Use data must be obtained from all clinics EP worked at during Meaningful Use Reporting period. If EP worked at clinic A and clinic B during the MU reporting period EP must use all MU data from both clinics for that time period.

Flexibility Rule Implementation

Please see Appendix C.4 for details of the changes made in October 2014 to implement system udpates per the CMS flexibility rule. This was submitted to CMS on 10/31/2014 and subsequently approved on 12/23/2014.

Appendix C-6

Changes to the Washington State Electronic Health Record incentive program

After review of the program and in an effort to increase participation and further the goals of the national interoperability roadmap as well as the initiatives of Healthier Washington; effective with the 2015 program year Washington will begin recognizing all Medicaid providers licensed as Medical doctors with the state Department of Health as eligible for incentive payments.

After careful review of the Department of Health requirements and our state Medicaid plan we have determined that program eligibility should be extended to include Naturopaths who meet other program requirements. These changes have been reviewed and approved by the director of the Washington State Health Care Authority, responsible for administering the program in Washington.

This program change can be completed with a no cost service request to the eMIPP vendor, CNSI.

Our ProviderOne MMIS payment system has 218 active Naturopaths.

By including these providers in the Incentive Program there is the potential of $46,325,000.00 of incentive money for AIU and $18,530,00.00 each additional year for attesting to Meaningful Use for the remainder of the program for this provider community. We will be doing outreach specific to these providers in the coming months to ensure they are aware of the financial incentives and processes for attestations. Every provider we reach increases the opportunity for true interoperability and the long term aim of better health care at lower cost.

Appendix C-7

SECTION E: WASHINGTON HIT ROADMAP

As outlined in section B.5, the following high level goals work together to ensure we have the infrastructure, tools and business processes in place to address Medicaid's needs and opportunities outlined in the Innovation Plan:

1. Play a more central, prominent role in bringing infrastructure and tools to Medicaid that can benefit the larger care community in a structured way.

2. Drive broad utilization of integrated clinical and administrative information to inform policy, program and care decisions.

3. Drive broad adoption of standardized HIE transactions and increased use of health information exchange between organizations.

4. Support the adoption and meaningful use of certified Electronic Health Record (EHR) technology among Medicaid providers.

E.1 HIGH LEVEL INITIATIVES, PERFORMANCE INDICATORS AND BUSINESS VALUE

Washington's to be vision includes a set of seven high priority initiatives to be phased in over the next five years. The initiatives will be helpful in addressing patient population care issues that cut across organizational boundaries which require infrastructure, clinical data sets, care coordination and population management tools for use by Medicaid and the larger care community.

Aligned multi-payer strategies: Initiatives that pay for services based on outcomes and provider performance while addressing patient population care issues that cut across organizational boundaries rely on the timely exchange of clinical health information.

Key Initiative 1.	Key Performance Indicator	High Priority Business Need/Value
Bring needed infrastructure and tools that meet Medicaid enterprise needs for clinical health information as a payer and can benefit the larger care community.	Strategy for Public/Private acquisition of clinical infrastructure and tools by December 31, 2013.	**Record Locator:** Query and locate patient records within multiple provider systems.
	Cost allocation methodology for Medicaid enterprise share of costs developed by December 31, 2013.	**Data Collection:** Obtain data from various systems & parse into patient records.
	Infrastructure and tools for Medicaid's clinical health information needs in place by September 30, 2014.	**Data Aggregation:** Map data to describe lab results, problems, allergies, and medication.
		Case Management: Identify preventative actions and care needed by at-risk patients.
		Clinical Portal: Present longitudinal patient information to authorized users.

Physical-behavioral health integration: Initiatives that rely on integration of physical and behavioral health require data from diverse systems across the care setting.

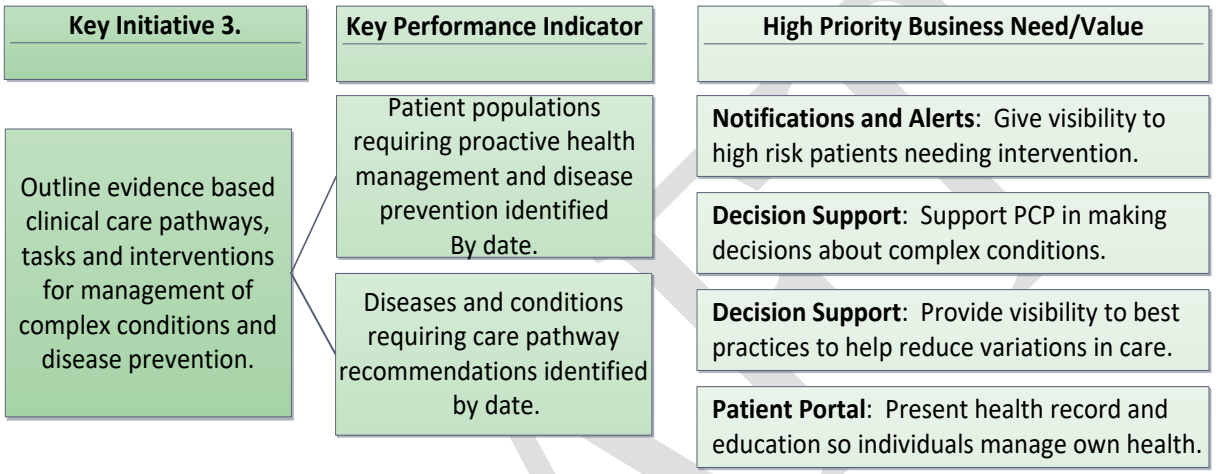
Key Initiative 2.	Key Performance Indicator	High Priority Business Need/Value
Integrate behavioral health encounter, diagnosis and medication data with physical health data into a comprehensive, longitudinal clinical record.	High value CCD data sets defined for HCA by December 31, 2013.	**Data Aggregation:** Integration of all types of health data from diverse systems.
	Use cases outline behavioral health data that will be used and by whom by March 31, 2013.	**Patient Safety:** Access to past imaging studies, medications, allergies & conditions.
	Medicaid policy statements describe how patient privacy is protected by November 30, 2013.	**Medication Reconciliation:** Data to inform script writing and prevent drug interactions.
		Care Coordination: MH provider notified when patients receive treatment.
		Patient Protection: Privacy and security roles and filters that segregate data views .

Prevention: Identify upstream strategies to keep communities and individuals healthy by addressing social determinants of health, health promotion and community health supports.

Healthy beginnings: Identify strategies from pre-conception to age 3 to ensure a healthy start for Washington state children.

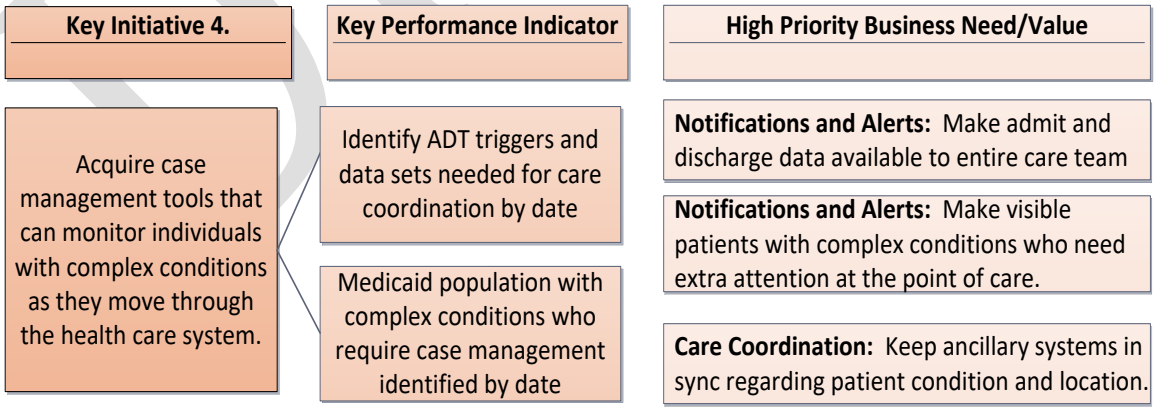
Appropriate adult care: Speed identification and adoption of effective strategies aimed at overuse, misuse and underuse of care.

Initiatives that aim to keep individuals healthy and assure adoption of evidence based care rely on decision support tools, alerts when patients need extra attention and integrated clinical data.



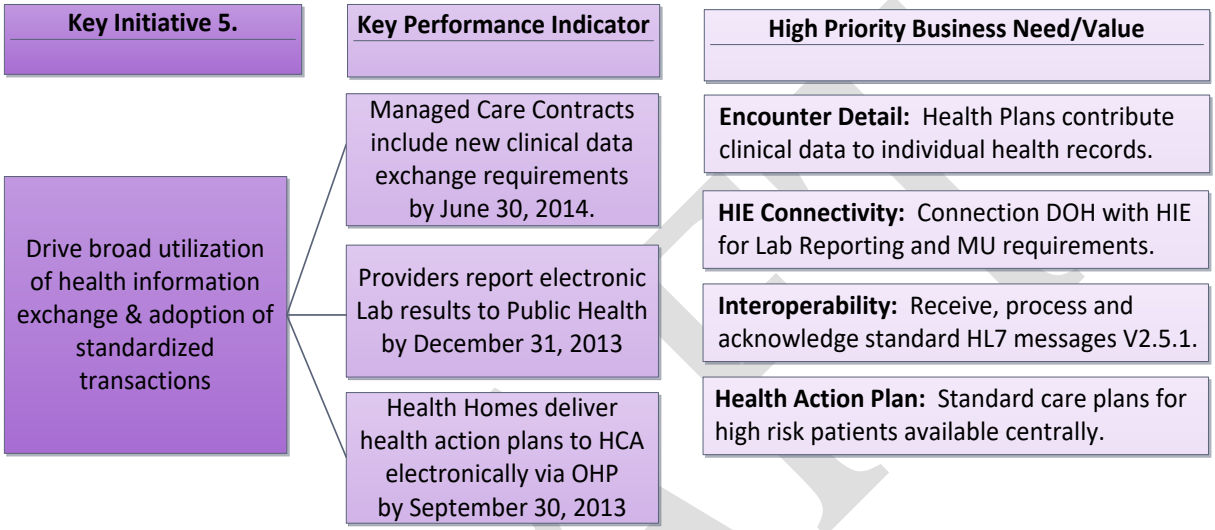
Care transitions/coordination: Identify cross-cutting strategies, focused primarily on necessary infrastructure, to improve coordination of care and transitions between settings, especially for those with multiple or complex conditions.

Initiatives that aim to keep an entire care team informed and enable the improved coordination of care between settings rely on visibility into hospital admission and discharge information.



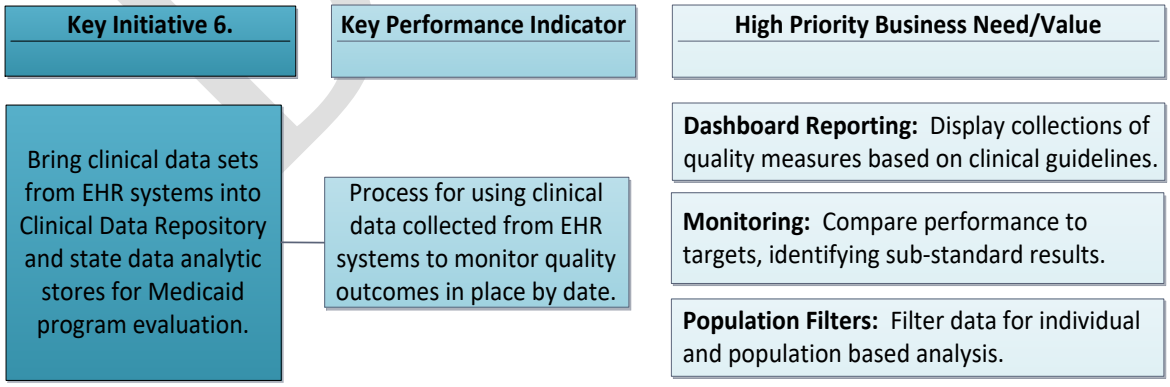
Standards and Interoperability: Identify strategies to advances the, adoption and implementation of national health information technology standards.

Initiatives which aim to share information seamlessly between provider systems with very different uses for health information and different types of products need to broadly adopt standard transactions for data sharing.



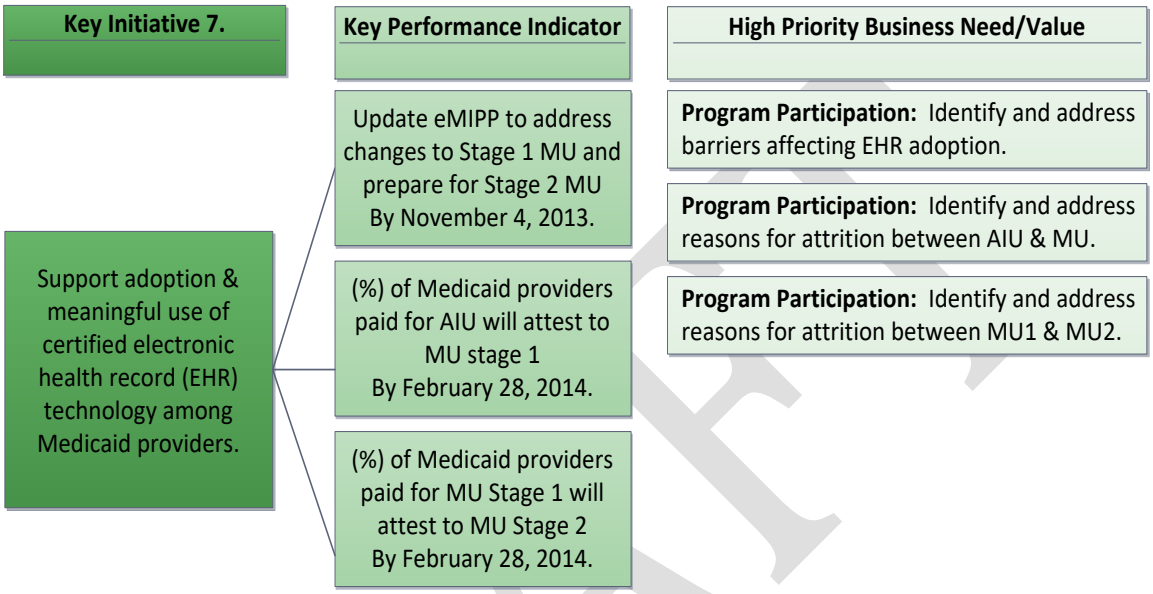
Transparent and accountable plan and provider performance: Identify strategies to improve and make visible health plan and provider performance through metrics & reporting.

Initiatives which aim to measure provider performance relies on timely clinical information currently housed in provider EHR systems. By leveraging a framework that makes integrated clinical and public health data and performance data available to analytical data stores, we may be able to collect this data without creating a heavy administrative burden on providers.



Meaningful Use: Identify strategies to advances the, adoption and meaningful use of electronic health record systems.

Initiatives which aim to share information between diverse provider systems need Providers to broadly adopt and use certified EHR systems that enable electronic exchange of clinical data.



E.2 TIMELINE

HCA intends to phase in development of the "to be" vision and has developed the following high-level timeline to pursue these projects necessary to achieve this vision:

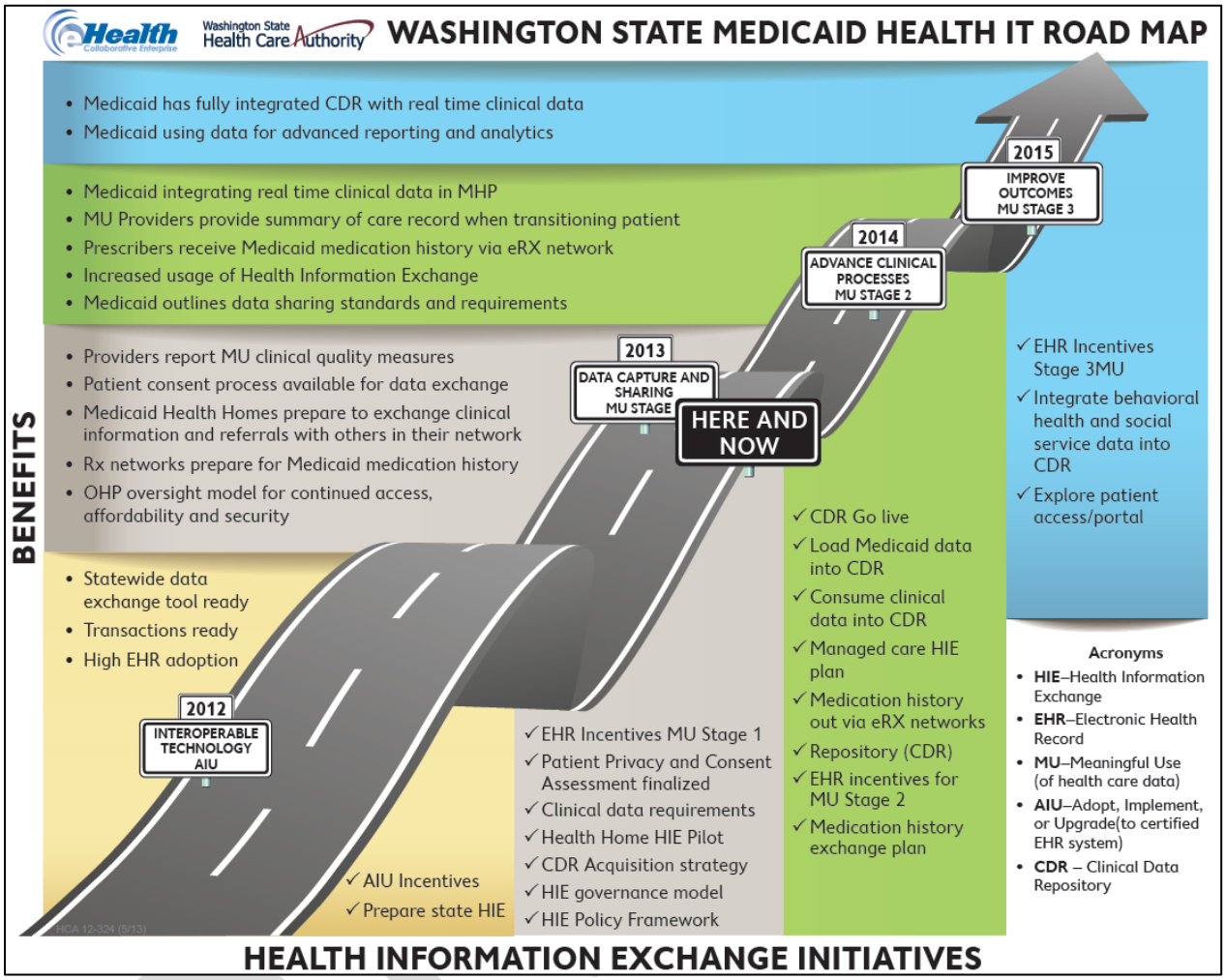
	2013	2014	2015	2016	2017
First Priority Activities					
Gauge interest of other enterprises to collectively acquire health information management platform and tools for Medicaid and larger care community.					
Develop acquisition strategy for a health information management platform and core services and tools.					
Develop cost sharing methodology that accounts for Medicaid covered lives.					
Determine funding streams and seek FFS and state match through APD and supplemental request.					
Develop behavioral health use cases to outline what data will be used and by whom.					
Develop a consent management policy statement for how patient privacy is protected.					

Implement stage 2 meaningful use communication and outreach campaign.					
Collect health action plans from Medicaid health homes and develop data sharing and reporting strategy.					
Second Priority Activities					
Update managed care contract language to specify health information exchange requirements.					
Populate health information management platform with Medicaid clients & claims/medication history.					
Define high value CCD data sets for Medicaid and ADT transaction triggers.					
Update eMIPP application for attestation and eligibility and payment tracking for future stages of meaningful use.					
Identify populations, diseases and conditions that could benefit from care pathway recommendations.					
Develop process for using clinical data collected from EHR systems to monitor quality outcomes					
Collect clinical information from EHR systems using query and response tools and regular CCD updates.					
Develop clinical care pathways, tasks and interventions for complex conditions and disease prevention.					
Third Priority Activities					
Implement process for using clinical data collected from EHR systems to monitor quality outcomes					

E.2.1 VISUAL ROADMAP

The following visual provides some insights into the timing of the planned activities and their alignment with the various stages of meaningful use. The visual roadmap is a living document which will be updated as timelines and activities become more specific.

Fig. E-1: Road Map



E.3 Organizational and Provider Change Management

The initiatives outlined in the SMHP and the HCA's Innovation efforts require Washington State to implement major changes in the way it collects, manages and uses clinical health information. Among the changes are moving from point to point data exchange to using a state HIE, integrating more real time clinical data into analytic efforts and predictive modeling, rolling out new tools to partners in the health care community, adopting new data exchange standards across state agencies.

E.3.1 MANAGING THE CHANGE

Implementation of new platforms and tools will significantly expand our analytica capacity and will provide a flexible and scalable application that can adapt to changes, new data exchange requirements with our provider partners and changes to business practices.

The tools will be shared by a number of state agencies. Size, infrastructure and culture ary greatly among these organizatios. In addition, information channels, relations with providers, administratibve structures and operational practices are unique to each organization.

The initiatives will not create sustainable benefits over time without the effective sponsorship and participation of state agencies. HCA will develop a comprehensive change management strategy that effectively engages business units and program managers from HCA and other affected state agencies.

This change management strategy will include the existing Interagency HIE Operations Group which is made up of program managers at the HCA, Department of Social and Health Services, Labor and Industries, Department of Health and others.

A full time employee will be added to the HIT team to plan, lead, organize and oversee the strategic and tactical planning of all critical non-technical change readiness activities to include:

- HIE Opportunities Inventory – Activities using point to point exchange today
- Business process impact assessment and gap analysis
- Business process re-engineering and transition plans
- Assessment of skills needed for operating in the new environment
- Training strategy for business areas and staff affected by changes

E.3.2 GUIDING PRINCIPLES TO GAIN PROVIDER ENGAGEMENT

To see the full value from community care coordination and HIE initiatives, the majority of health care organizations must agree to share health information. Obtaining such agreements can be difficult during a time of uncertainty about the impact of health care reform.

The following principles will guide our stakeholder engagement strategies and activities:

1. Demonstrate the business case with pilots that link care coordination and health information exchange to local payment reform efforts.

2. Select technical solutions that work in the providers preferred environment and work flow.

3. Consolidate and leverage existing connections and routing for health information exchange.

4. Adopt standards and apply file translation to accelerate exchange.

5. Leverage data available in provider EHR systems for quality reporting where possible.

6. Demonstrate that patients will continue to move between delivery systems and reinforce the need for sharing of patient information to improve care.

E.3.3 STAKEHOLDER ENGAGEMENT AND READINESS ACTIVITIES

As changes are identified and we implement new tools, there will be a need for additional and targeted external stakeholder engagement. The following identifies some new tactics and activities which will be further developed and deployed to support the provider community.

Tactic	Scope	Activities
Focused EHR Stakeholder group outreach - Dental	WSDA and 17 regional Dental Societies	Attendance at Meetings; submit monthly updates for distribution via their established distribution channels
Expand tribal HIT stakeholder relationships through HCA Tribal Liaison	27 Tribes	Attend Monthly Tribal Affairs government to government meetings; submit articles and notices to the HCA Tribal Liaison for distribution to all tribal providers and 27 tribal newspapers as appropriate
Expand relationship with the WA Chapter of the American Academy of Pediatrics		Initial state-level outreach; attend meetings to provide membership with updates; provide Pediatric specific EHR materials and supports; submit articles to the WA Chapter for distribution
EHR Stakeholder group outreach - Behavioral Health	13 Washington State Regional Support Networks	Leveraging existing relationships and communication channels; develop MH specific materials; submit articles to the WA State Dept. of Behavioral Health Recovery and RSNs for distribution