Washington Rural Health Access Preservation (WRHAP) Pilot

Engrossed Substitute House Bill 2450; Section 2(2)(b)(ii)(D); Chapter 31; Laws of 2016
Substitute House Bill 1520; Section 1(2)(b)(iii)(E); Chapter 198, Laws of 2017

December 31, 2021

Legislative summary

This report is the final report for the Washington Rural Health Access Preservation (WRHAP) pilot. The Legislature directed the Health Care Authority (HCA) to share results on the WRHAP pilot through ESHB 2450 (2016); Section 2(2)(b)(ii)(D), and SHB 1520 (2017); Sec 1(2)(b)(iii)(E):

> The department of health, health care authority, and Washington state hospital association will report interim progress to the legislature no later than December 1, 2018, and will report on the results of the pilot no later than six months following the conclusion of the pilot. The reports will describe any policy changes identified during the course of the pilot that would support small critical access hospitals.

Background

In 2015, the Department of Health (DOH) and Washington State Hospital Association (WSHA) formed WRHAP to develop a sustainable, alternative payment model for 13 of Washington's smallest, most isolated and financially distressed critical access hospitals (CAHs). CAHs have struggled to provide access to essential services, including emergency and primary care services because of limited and unsustainable funding.

The Washington State Legislature appropriated $6.1 million in state and federal funds to support the transition of these 13 CAHs into a new payment model. Funds were tied to quality improvement metrics that were implemented over a three-year period, from June 2018 to December 2020.

HCA contracted with WSHA to manage the pilot implementation and provide routine updates on WRHAP progress, with a final report highlighting key activities, program strengths, and recommendations for next steps. Attached is the final program report from WSHA.

In addition to this report (including the one from WSHA), HCA will also provide a final report to the Legislature and Office of Financial Management in spring of 2022. It will provide HCA's formal program evaluation of the WRHAP pilot.

Rural health transformation efforts

WRHAP hospitals successfully implemented evidence-based quality improvements across many areas of care, including patient coordination, care management, and behavioral health integration. The final report includes key recommendations for achieving better access, better care, and lower costs in rural Washington.

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The WRHAP pilot is part of an ongoing focus on rural health transformation, woven into several efforts. Beginning with the State Innovation Model (SIM) grant in 2014, HCA initiated efforts to move from fee-for-service (FFS) to value-based payments and foster the development of robust, health transformation-related programs throughout the state.

One of these robust programs is the Medicaid Transformation Project (MTP), which is Washington State's Section 1115 Medicaid demonstration waiver. MTP began in 2017, with a goal of incentivizing community and clinical linkages and investment to support critical health services.

From 2018 onward, HCA has continued to engage rural providers, payers, associations, Accountable Communities of Health, and others to address the sustainability of rural health systems. HCA has also continued exploring options with Center for Medicare & Medicaid Innovation (CMMI).

In 2020, HCA applied for and received a CMMI grant called the Community Health Access and Rural Transformation (CHART) Model. Like WRHAP, CHART aims to sustain access to high-quality care at lower costs by bringing together rural health systems, health plans, and community stakeholders to design a rural health system that meets the community's needs.

The CHART Model embodies the recommendations learned from WRHAP, most notably a new value-based sustainable funding mechanism across multi-payers that incentivizes improvements in health outcomes and population health.

Conclusion

WRHAP hospitals plan to continue the core activities of the pilot, despite the lack of ongoing funding. Through the CHART Model and other programs that support rural health transformation, our state can continue to support and strengthen CAHs.

Contact

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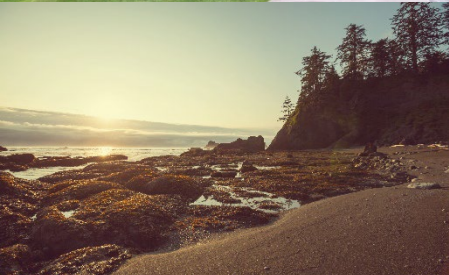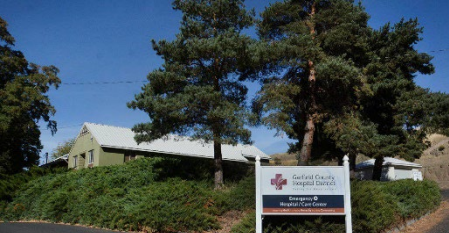
PHASE THREE

Washington Rural Health Access Preservation Program: Final Report

Task 1c. Final Program Data Analysis

Task 2c. Implementation Management

Task 3c. Final Program Recommendations

Washington State Hospital Association

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Preface

The Washington Rural Health Access Preservation (WRHAP) project was created to design, test and implement improvements in the payment and delivery of health care in Washington's smallest and most remote communities where Critical Access Hospitals (CAHs) are at risk of closing. The participating hospitals, all operated by Public Hospital Districts, serve as the platform for a broad range of health care services in the community, ranging from primary to acute, and long-term care. Financial problems at the hospitals jeopardize both the health of the residents as well as the economies of each community. The goal of the WRHAP project was to develop ways to ensure continued access to high-quality, essential health services in these communities; and to align those services—to deliver better health, better care, and lower costs. The WRHAP pilot authorized by House Bill 1520 was a voluntary pilot that sought to sustain access to essential services in these vulnerable communities.

The WRHAP project received financial and technical support from the Washington State Hospital Association (WSHA), the Washington State Department of Health (DOH), the Washington State Health Care Authority (HCA), the Washington State Department of Social and Health Services (DSHS), and the Association of Washington Public Hospital Districts (AWPHD); with consulting assistance from the Center for Healthcare Quality and Payment Reform (CHQPR), Health Facilities Planning & Development, and Dingus, Zarecor & Associates (DZA).

The contractual service agreement between HCA and WSHA required periodic updates on the WRHAP implementation process and management of the transitional funding provided under this program. The program implementation period was July 2018 through December 2020 with final program sunset on June 30, 2021. Phase One of implementation included a report outlining the project planning and progress to-date (2018). Phase Two of the program consisted of reports which described the implementation status and technical assistance provided to WRHAP participants during benchmark reporting periods (2019). Phase Three of the program consisted of status updates on continued program administration and activities related to sunset of the program including data collection, workforce survey, focus groups and analysis in preparation for a final report to be submitted at the conclusion of the program.

This final program report delivers a summary of activities and trends throughout the WRHAP implementation period. It highlights program and service strengths and identifies remaining challenges in sustaining access to improved care coordination and behavioral health care within the participating WRHAP hospitals. This report provides considerations and recommendations for future rural transformation initiatives.

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FIGURES

TABLES

COMMON ACRONYMS

ACH—Accountable Community of Health

ACO—Accountable Care Organization

AWPHD—Association of Washington Public Hospital Districts

BHM—Behavioral Health Measure

CAH—Critical Access Hospital

CCM—Care Coordination Measure

CMS—Centers for Medicare and Medicaid Services

DOH—Washington State Department of Health

DSHS—Washington State Department of Social and Health Services

ED—Emergency Department

EHR—Electronic Health Record

HCA—Washington State Health Care Authority

HIE—Health Information Exchange

HIT—Health Information Technology

MCO—Managed Care Organization

QBS—Quality Benchmark System

RN—Registered Nurse

WRHAP—Washington Rural Health Access Preservation

WSHA—Washington State Hospital Association

OVERVIEW

Financial challenges at rural hospitals jeopardize both the health of the residents as well as the economies of each community. In 2015 the Washington Rural Health Access Preservation (WRHAP) group was formed to develop a sustainable alternative payment model for 13 of Washington's smallest, most isolated and financially distressed critical access hospitals. The Washington State Legislature appropriated a total of $6.1 million in state and federal funds to support the transition into a new payment model. These funds were tied to quality improvement metrics that were to be implemented over a three year period, beginning in June 2018, and sunsetting in December 2020. Washington State Hospital Association (WSHA) was contracted by the Healthcare Authority (HCA) to manage the program implementation and provide routine updates on the program's progress, with a final report highlighting key activities, program strengths, and recommendations for next steps.

PROGRAM GOALS

The program's goal was to develop ways to ensure continued access to high quality, essential health services, and to align those services to deliver better health, better care, and lower costs. WRHAP hospitals selected both a process and a health outcome measure and made incremental improvements each reporting period. The selected focus areas for improvement were:

- Depression screening with a documented follow up plan—to move hospitals towards behavioral health integration.
- Anti-depressant medication management—to improve newly diagnosed patients' adherence to treatment.
- Contact with patients following discharge from the emergency department (ED)—to improve care coordination.
- Potentially avoidable ED use—to reduce the number of patients seen in the ED for diagnoses that are treatable in lower levels of care.

WRHAP hospitals completed internal program and operations planning, implementation activities, and external engagement with WSHA. The hospitals also engaged in learning opportunities and stakeholder meetings throughout the program.

PROGRAM HIGHLIGHTS & CONSIDERATIONS

Over the program period, most hospitals made steady progress both in ED follow-up and depression screening rates. Hospitals with greater program success shared some of the following characteristics:

- At least a part-time, dedicated staff coordinating all activities related to follow-up out of the ED.
- Communication and tracking templates were used consistently by program staff.
- A written process for ensuring all patients were contacted and method for ensuring consistency.
- An internal champion willing to own the workflow.
- Collaboration with primary care clinics to schedule follow-up appointments.
- After-hour appointment availability for urgent follow-up.
- Standardized referral procedures and tools to streamline communication outside of primary care.
- Established trust and strong relationships with tribal leadership, independent rural clinics, corrections facilities and referring partners.
- Staffing plans and documented program knowledge to reduce the risk of service disruption during shifts in workforce.
- Employment of a population health nurse and quality improvement team to evaluate workflows and apply continuous quality improvement strategies.

Overall, clinical staff and executive leadership felt that the quality improvement components of the WRHAP program were successfully implemented. They have a positive outlook about the long-term benefits for patients and the community. The WRHAP hospitals plan to continue the core activities of the program despite the lack of ongoing funding, but also acknowledged that focus and priorities may shift without such funding.

WRHAP hospitals demonstrated their commitment to change, and effectively incorporated evidence-based standards of care and best practices for patient coordination, care management, and behavioral health integration. This was accomplished despite the significant barriers of workforce shortages, limited staff capacity and burnout, financial limitations, and provider resistance to change. Some of the more common challenges hospitals faced were:

- Hospitals had less success with the health outcome measures, in part, because it was implemented halfway through the program. A lack of timely data impacted hospitals' ability to react to poor treatment adherence or ED utilization.
- Dips in patient contact and depression screening rates were most often attributed to workforce turnover especially in quality leadership.
- Shortages in qualified mental health providers as well as preexisting provider resistance were the biggest challenges to behavioral health integration.
- The WRHAP hospitals had to shift operations, attention, and staff to COVID-19 emergency planning and response during the program's final year—further exacerbating preexisting challenges with staffing.

- The most significant effect of COVID-19 on the program was staff burnout and competing priorities (e.g., state reporting and emergency planning).
- Despite hospitals' interest and the availability of funding for onsite technical support, rapid shifts in staff capacity limited the ability to receive onsite training in billing and coding for new, integrated services.
- Establishing a cost effective option for tracking behavioral health patients was challenging and often occurred outside the hospitals' electronic health record (EHR).
- Telehealth emergency waivers related to COVID-19 dramatically changed the ability of hospitals to leverage tele psych services in the integrated care setting. But patient preference and access to reliable technology posed significant barriers to its use for most WRHAP hospitals.
- Outdated EHRs and difficulty with data filtering and extraction persisted throughout the program.

Some communities faced challenges with unique populations, including inmates, tribal, and non-English speaking populations. Hospitals tailored their solutions to address each community's challenges with access to coordination and behavioral health care. Hospitals' adaptive approaches demonstrated a high degree of flexibility and innovation.

No two rural communities are the same. This report defines success not just by data, but also by hospitals' incremental, long-term achievements towards rural health care transformation. As shifts in health care progress, rural hospitals need external stakeholder alignment and policy makers' support to achieve the goals of better access, better health, and lower costs. Below are the key recommendations which resulted from the WRHAP quality program.

- Federal policy makers should act to incentivize interoperability, prioritize data standardization guidelines, and fast track interoperability regulation.

- Funding and grant programs for rural provider and workforce training should be expanded to incorporate continuing education opportunities in best practices for behavioral health integration, billing, coding integrity, and effective care coordination strategies for both emergency and outpatient settings.

- New sustainable funding mechanisms should be multi-payer, to improve hospital participation and reduce risk of duplication, silos, and misaligned programs across stakeholders.

- Workforce development activities must coincide with new model implementation expectations and address the staff crisis caused by COVID.

- New career tracks need sufficient reimbursement for hospitals to leverage and incorporate them into patient care.

- Reimbursement should be comprehensive and cover the full spectrum of activities required to coordinate care for patients transitioning across care settings and those faced with complex needs, such as mental and behavioral health, and substance use disorder.

- Flexibility in value-based purchasing contracts and the ability to aggregate populations will encourage MCO and hospital participation in smaller rural communities.

- Ensure the new models' reimbursement structure incentivizes and rewards hospitals who shift priorities to care management and preventative activities long-term.

- New models need robust technical support and peer-to-peer opportunities to collaborate and learn.

- A stronger and more coordinated approach across transformation activities will allow rural hospitals to focus resources and move towards a uniform goal.

- Free or low cost options for EHR training, health information technology resources and support from vendors and other EHR experts are needed for small facilities to fully realize the capabilities of their EHR.

BACKGROUND

In June 2015, during discussions with Washington state's smallest, most isolated, and financially distressed CAHs, four key issues facing the communities were identified:

1) ensuring access to high-quality primary care,
2) sustaining emergency department services,
3) providing medical and long-term care for residents with chronic disease and,
4) providing access to behavioral health services.

The group agreed that significant changes in current payment systems were necessary to address these issues. Subsequent discussions with 13 of the hospitals and the DOH, HCA, WSHA, and AWPHD were held throughout 2015-2017 to develop recommendations for a sustainable alternative payment model for the state's smallest CAHs.

This was the beginning of the WRHAP group. Through these discussions and partnership with key legislators House Bill (HB) 1520 was passed in April 2017. Under HB 1520, HCA was tasked with developing an alternative payment model for WRHAP hospitals in conjunction with CMS and other payers. The Washington State Legislature appropriated a total of $6.1 million in state and federal funds to support the transition into a new payment model. HCA tied the transitional funding to quality improvement activities targeting two of the four key areas identified by participating hospitals. The WRHAP group chose to focus on providing access to behavioral health services and sustaining emergency department services. The program funds were earned through incentive payments from contracted Managed Care Organizations (MCO) when participating hospitals met their quarterly quality benchmarks. WSHA was contracted by HCA to administer the WRHAP quality improvement program and to continue engagement with stakeholders on an alternative payment model for WRHAP hospitals.

CORE PROGRAM IMPLEMENTATION ACTIVITIES

In 2018 WSHA successfully hired a Rural Program Manager to manage implementation of the WRHAP Quality Improvement Program. During implementation, the program manager conducted expected contractual activities including program administration, technical support, status reports, and updates. WRAHP hospitals selected one process quality improvement metric and were given six months to onboard new staff and begin implementing depression screening or emergency department (ED) discharge care coordination activities. The chosen quality improvement measures were selected in collaboration with the WRHAP hospitals, HCA, WSHA, and Center for Healthcare Quality and Payment Reform. They were:

1) Behavioral Health Integration Track: Percentage of Medicaid patients screened for clinical depression and documented follow-up plan (NQF 0418/MIPS 134).
2) Emergency Department Care Coordination Track: Percentage of patients seen in the emergency department who received follow-up contact following discharge.

The depression measure remained the same throughout the program. The ED care coordination measure (CCM) however, required modifications to improve alignment with best practices. For example, the original measure didn't define what counted as "patient contact". It also didn't provide details on special exclusions, such as minors seen for contraception or mental health reasons. For the depression measure (BHM) language, and to view historic changes to the ED measure please see Appendix A.

WRHAP hospitals completed internal program and operations planning, implementation activities, and external engagement with WSHA's Rural Program Manager. Hospitals had to onboard and train staff required to implement their selected measure. They had to establish provider workflows, set up Electronic Health Record (EHR) reports, and input values for their measure. In some cases, this also meant paying their EHR vendor to build ad-hoc reports and/or modify existing patient intake templates to capture required program data. WRHAP hospitals were expected to use best practices to implement behavioral health screening and follow-up after emergency room visits. The hospitals developed procedures to code and bill for anticipated new services. They also had to ensure staffing and quality improvement plans were in place to reduce disruption to patient care throughout the program. Hospitals that chose the behavioral health integration track had to develop patient tracking or registries for managing newly diagnosed or ongoing mental health conditions. Additionally, WRHAP hospitals had to extract Medicaid-only data for reporting into WSHA's Quality Benchmark System (QBS). This data was used by the Rural Program Manager to determine if incremental increases in the benchmark milestones were met for each hospital. Those that met the milestones earned quarterly incentive payments from contracted MCOs.

In addition to implementation activities, each hospital had to engage with WSHA in learning opportunities and stakeholder meetings throughout the program. From June 2018-2019, WSHA hosted weekly WRHAP calls with hospital executive leadership. Examples of participants included Chief Executive Officers (CEOs), Chief Financial Officers (CFOs), and Chief Nursing Officers (CNOs). Key project information was passed to WRHAP participants. Executives shared their progress and challenges with implementation. The calls allowed space for program feedback, peer learning, and discussion of next steps for rural transformation. The implementation challenges identified were used to develop communication and training resources for participants and to improve the overall chances of program success. WRHAP hospitals also agreed to in-person meetings and onsite visits with the Rural Program Manager, as needed, to ensure implementation success. In the fourth quarter of 2018, WSHA launched a forum for WRHAP quality leadership and support staff to gather for peer-to-peer learning. The meeting objectives were to:

1) Identify individual challenges with WRHAP processes and clinical implementation.
2) Provide education on evidence-based approaches to implementing transitional care and behavioral health integration measures.

3) Refine the WRHAP measures and their integration into daily operations, for maximum reach and benefit to patients.

These calls were well attended, and topics received positive feedback from participants. Technical support was also provided via phone and email to individual clinical and administrative staff on an as-needed basis within each WRHAP hospital.

Technical assistance was provided to the MCOs contracted with the WRHAP hospitals. These calls and emails occurred at least once a year. These calls provided MCOs with contractual updates and ensured each MCO's contact person was up-to-date for submitting data and payment requests. The calls were also used to assist MCOs in understanding the program purpose, incentive payment and reimbursement process, and ensured the MCOs were aware of their contractual obligations.

Table 1 outlines WSHA's scheduled engagement with participating WRHAP hospitals between July 2018 and March 2021. This does not include ad-hoc calls, routine support, and outreach to participating hospitals and staff. Note that all in-person and onsite hospital visits were canceled in 2020 due to COVID-19. This also impacted the frequency of routine check-ins and trainings offered while hospital resources were redirected to emergency response.

Table 1. Number of Scheduled Meetings Throughout WRHAP Implementation by Type

Executive Calls	In-person & Onsite Visits	Quality Webinars	MCO Calls	Scheduled Technical Support Calls
19, 2-hour virtual meetings	12, 2-hour in-person meetings	22, 1-hour webinars	15, 30-60 minute virtual meetings	Approximately 46, 30-60 minute virtual meetings

In 2019 the WRHAP program received additional funding. A portion of the funds were tied to two new health outcome measures. Each hospital had to select one of the metrics to implement, alongside their previously selected process measure. The following two measures were selected using a collaborative approach between HCA, WSHA, and WRHAP hospitals. Of the presented options, the two selected were the most relevant to the program's original quality improvement tracks (BHM and CCM). A baseline performance year (SFY2018) was used as a starting point for improvement. The health outcome measures were reevaluated in SFY2020 to determine if benchmark milestones were achieved during the program period. The two selected outcome measures included the following (Please see Appendix B for full language):

1) Behavioral Health Integration Track: Anti-Depressant Medication Management (AMM) (NCAQ HEDIS®)—Defined as a 10% improvement in anti-depressant medication treatment adherence; closing the gap between baseline rate and the HEDIS®90th percentile national benchmarks.

2) Emergency Department Care Coordination Track: Potentially Avoidable ED Use (Stewarded by Washington Health Alliance)—Defined as a reduction of 1% of potentially avoidable ED use in the period SFY 2018 to the period SFY2020.

DATA TRENDS, PROCESS IMPROVEMENT, WORKFORCE DEVELOPMENT & QUALITY RELATED ACTIVITIES

WRHAP hospitals selected one quality improvement process measure for implementation and reporting. Table 2 outlines the measures selected by each hospital. While not required, two of the 13 hospitals opted to work on both care coordination and behavioral health integration. For the program, data trends were only monitored for their incentive-based focus area.

Table 2. Quality Improvement Process Measure Track by Participant

Behavioral Health Integration Track	ED Care Coordination Track
Arbor Health (Morton General Hospital)	Columbia Basin Hospital*
Cascade Medical Center	East Adams Rural Healthcare
Columbia County Health System	Ferry County Memorial Hospital
Mid-Valley Hospital	Forks Public Hospital
Odessa Memorial Healthcare Center*	Garfield County Hospital District
	North Valley Hospital
	Three Rivers Hospital
	Willapa Harbor Hospital
*Opted to integrate both tracks.	

EMERGENCY DEPARTMENT CARE COORDINATION

Over the program period, all but one hospital saw steady improvement in the number of patients contacted following ED discharge. Figure 1 displays the rate of follow-up during the first quarter of the program compared to the final quarter of the program for the eight hospitals that selected the ED Care Coordination track. Five of the eleven milestones were missed by the same hospital. The other hospitals met or exceeded the milestone each reporting period.

In the final quarter of 2020, hospitals participating in the ED Care Coordination track had to contact at least 60 percent of Medicaid patients discharged from the emergency department. Combined, hospitals exceeded the 60 percent milestone, and, on average, contacted 82 percent of Medicaid patients that were discharged. When the hospital that missed the final milestone was removed, the average rate of contact increased to 86 percent across the remaining participants.

While the program targeted Medicaid recipients, six hospitals implemented the measure across all patients seen in the ED. Reasons given for an all patient approach included a simplified internal workflow and better front-end tracking. One hospital stated that the measures focusing on a single-payer were especially complicated for reporting, increased the administrative burden to implement, and created unnecessary divisions in patient care. Hospitals with more advanced versions and newer EHRs had fewer challenges with filtering and data extraction from the EHR. For others, all ED patients seen on a given day were first filtered within the EHR, then extracted to Excel for data clean up and filtered by payer type. Data was then combined with other lists or printed templates to track calls. Finally, this combined dataset was used to tabulate the numerator and denominator for submission into QBS. None of the hospitals were able to complete all steps of the process within their EHR. Attempted and successful calls were always documented within the individual patient record.
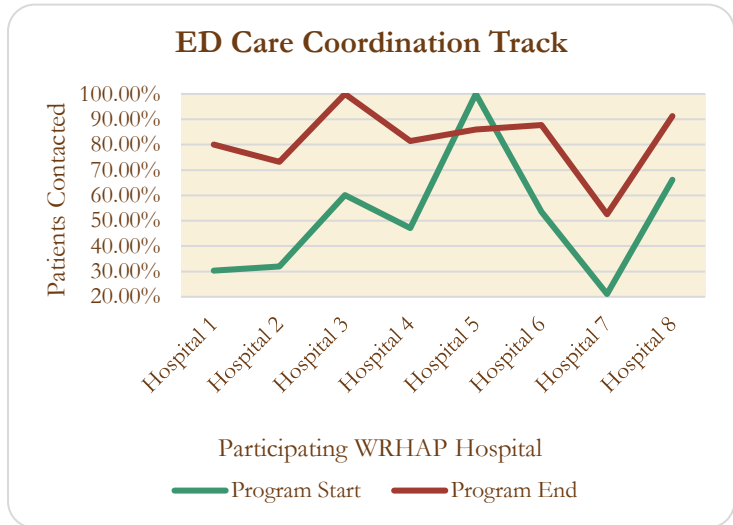
Figure 1. Program Beginning Contact Rate Compared to Program End Contact Rate

Hospitals with consistent and higher rates of follow-up shared some of the following characteristics:

- At least a part-time dedicated staff coordinating all activities related to follow-up.
- Communication and tracking templates were used consistently by program staff.
- A written process for ensuring all patients were contacted and method for ensuring consistency.
- An internal champion willing to own the workflow.

"When patients come to be seen we don't look at their insurance and say, 'oh this patient should be set aside and treated as such because of their insurance'. We treat them all the same and then go back in and [must] filter and figure out how to extract only that payer to get the data…it takes forever. [It is] so much easier to implement for everyone and extract for everyone."

One hospital took follow-up one step further. They sorted patients by primary diagnosis and then assigned the appropriate care coordinator (e.g., licensed clinical social worker for mental and behavioral health, front office for non-clinic follow-up, and a bi-lingual clinical staff for Spanish speaking patients). While more laborious on the front end, the general opinion from staff was that it was a

better connection with the patient, and the likelihood that the follow-up call would provide patient benefit improved. Anecdotally, hospitals reported that patients appreciated receiving calls after leaving the hospital. Some patients provided feedback during the calls, including gratitude that someone cared enough to call. Other patients explained that the discharge process was a blur, either because they were in pain at the time, or other physical symptoms prevented them from paying attention to the discharge nurse. In some instances, the follow-up calls alerted the care coordinator to time-sensitive challenges, such as difficulty filling important medications, or finding transportation to follow-up care. Care coordinators were able to address subsequent patient needs based on the follow-up calls. Over the program period, one hospital saw improvement in their ED utilization rate for frequent visitors. They felt confident that follow-up calls contributed to the improvements yet agreed further evaluation would be needed to prove the calls were effective at changing patient outcomes.

Dips in contact rates and missed milestones were most often attributed to workforce turnover. Specifically, hospitals experienced challenges when the quality improvement leader or care coordinator responsible for follow-up contact left without notice or was out for an extended period.

For the hospital that continuously missed milestones, workforce capacity and turnover were mentioned as the main barriers to meeting program milestones. They had several key staff leave the organization during the implementation period, including their quality leader, making implementation of new initiatives especially difficult. The Chief of Operations stepped in to manage the data extraction and reporting. Also, the Chief Nursing Officer was required to make follow-up calls until a more permanent solution could be found. They saw some improvement when they leveraged their IV Therapy nurse to contact patients. This nurse had flexibility in their patient schedule and daily downtime, making them an ideal team member to step in, to support. While they couldn't meet many of the program milestones, they did achieve significant improvement from their baseline to program completion.

The WRHAP hospitals had to shift operations, attention, and staff to COVID-19 emergency planning and response during the program's final year—further exacerbating preexisting challenges with staffing. Staffing plans and ensuring that more than one individual understood the purpose of patient contact and the workflow process to follow, were key strategies to reduce disruption.

One challenge with care coordination originating in the ED was the resistance from nurses to own the follow-up and care coordination process. One reason cited for this opposition was that staff felt calls from the ED were an added responsibility that wouldn't benefit the patient long-term. They felt the task should lie with primary care. Quality leadership addressed the concerns by providing training to the ED workforce (providers, nurses, and clinical support staff) about the patient benefits of care coordination following a visit to the ED. Evidence based information on care coordination combined with concrete examples of best practices out of the ED, improved ED staff's willingness to own the work. ED and Clinic managers also worked to streamline follow-up between the ED and primary care. This coordinated effort further improved buy-in from nurses in the ED.

For hospitals that relied on independent primary care clinics, rural health clinics or Federally Qualified Health Centers, coordination was challenged by inconsistent access to a point-of-contact within the independent provider's office. This inconsistent access often limited the ability of the participating hospital's care coordinator to do more to close the care-loop for the patient. The follow-up calls were often limited to patient discharge instructions coupled with verbal recommendations that the patient follow-up with their primary care provider. Where possible, hospitals employed social workers or care navigators to handle more complex coordination. These individuals were sometimes housed within the ED but were also shared across inpatient, primary and specialty care services. This meant that at times, the number of patients in need of complex coordination exceeded the availability of the case worker—causing delays in follow up.

Another implementation challenge included concern over HIPAA violations when leaving voicemails for patients, or placing a patient seen for domestic abuse or a protected minor visit at risk by leaving a voicemail asking for a return call. To address the concern of patient privacy, WSHA developed a generic template for phone calls and the participating hospitals shared their internal tools developed for calling patients. Documentation in the EHR was recommended for any patient who had not received a call and who was subsequently excluded from the measure's denominator.

In some communities, successful contact with Medicaid patients was hindered by patient behavior. For example, some patients refused to answer calls from the hospital, while others would hang up on the care coordinator after they identified themselves. In other instances, a patients' access to reliable methods of communication was often reported as a reason for an unsuccessful follow-up attempt. For example, many Medicaid patients had inconsistent access to cell phone or landline services, which further reduced contact rates. Hospitals shared anecdotal reports of patient follow-up being more successful at the beginning of the month rather than the end. Care Coordinators and Quality Leadership suspected that this was likely due to individuals on low-income or financial assistance cell-phone (e.g., prepaid programs) plans running out of data and/or minutes before the end of the month, making contact impossible within the expected time frame.

For participating hospitals with higher rates of ED visits from prisoners, the ability to follow-up was largely dependent on the willingness of the correction facility to partner and provide access to information about the patient after leaving the hospital. Hospitals with state prisons in or near the community reported that the prison usually had providers on staff that were willing to coordinate after discharge. County and city jails, on the other hand, were often described as a big barrier to successful follow-up. Hospital efforts to establish a partnership with the local jail for improved coordination were usually met with resistance, and for one hospital, hostility. The reasoning for this was not clear, but one participating hospital indicated a difference in leadership styles and priorities led to most of the conflict with local law enforcement.

Some of the participating hospitals are in rural communities with one or more sovereign Native American Tribes. Not all the tribes have access to tribal clinics, or other options for health care on tribal lands, which can be vast and isolated. They often rely on the small hospitals nearby to access health care services.

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Participating hospitals reported that contact with this patient population was exceptionally challenging once they returned to tribal lands. One quality lead explained that accessing patients for follow-up once they return to their families can be challenging because they may not have a reliable phone or internet, may not have primary care or transportation, may live with a family member who mistrusts the health care system, or may prefer to access follow-up with tribal healers in an informal but culturally sensitive environment, making it difficult for the hospital to close the loop on discharged patients. Hospitals had more success contacting Native American patients living on tribal lands when there was established trust and a relationship with respected tribal leadership. This relationship was said to improve overall trust in hospital staff and receptivity of members to receive care outside of the tribe. Also, hospitals that built partnerships with providers within tribal clinics were more successful in developing reliable methods to contact patients after discharge.

Hospitals also noted challenges related to clinical documentation. Some of the hospitals routinely used transcription services to document patient care from the ED. Sometimes, access to the discharge information was not available because of weekend delays, or the transcription agency turnaround time was irregular. Other hospitals struggled with follow-up calls for non-English speaking patients due to the limited availability of interpreter services. For example, one hospital described an instance where their one interpreter onsite (a clinical staff member who was bilingual), was occupied assisting with a patient and was not available to assist with follow-up calls. Because of this, non-English speaking patients were not called. The phone interpreter services are cost-prohibitive for most smaller facilities and use of the service is reserved for communication of critical health care information to patients and families during their in-person visit. This structural challenge contributes to inequitable care among patients leaving the ED.

Finally, hospitals described tracking the region's Medicaid providers as critical to care coordination but extremely difficult. The churn of patients in and out of Medicaid coupled with frequent changes in provider-MCO contracts created an administrative barrier for patients wishing to maintain a consistent care team. As MCO contracts with regional providers shifted (typically occurring every 6-12 months) Medicaid patients would be reassigned to a new care team that may not include their original care team (e.g., a new clinic, a new provider within the same clinic, or a different provider out of town). This meant that the hospital care coordinator's ability to reliably coordinate care for a Medicaid patient was greatly reduced because the patient may not know who their newly assigned primary care provider is or have the desire to go somewhere new. To address these shifts for preexisting patients, the care coordinator had to call the MCO and request that the patient be placed back with their preexisting care team. This process could take at least one month, and greatly impacted not only follow-up, but also the number of inappropriate visits to the ED, while patients waited to receive access to their primary care team. For patients, this delay was frustrating and resulted in inconsistent access to care.

While follow-up contact and care coordination for patients discharged from the emergency department presented many challenges throughout the implementation period, WRHAP hospitals developed solutions to address and reduce their impact on patient care coordination efforts. For example, most hospitals learned the best time of the day to attempt follow-up calls for their patients. Some found that for their community, calling before 1:00 PM almost always meant "no answer". Others incorporated a question about the best time

for a follow-up call into their discharge process. In one of WSHA's peer-to-peer learning webinars, one hospital shared that the chances a patient would call back improved if they provided a direct line, instead of the general hospital number. To improve staff support, some hospital quality leadership had to proactively oversee the work, or it would get lost in the day-to-day ED operations. To reduce the risk of this happening, one hospital developed a detailed follow-up contact sheet. Patients seen in the ED for any given day were individually transferred over to the sheet, which identified the patient's name, contact info, primary diagnosis, primary care provider, and any notes related to follow-up or attempted calls made. Each patient was assigned a case worker, and follow-up attempts were documented on the form, along with a checklist to ensure that documentation in EDIE, their EHR, and the Excel patient tracker were completed for each patient. Once contact occurred, the information was transferred to the patient record and the sheet was destroyed.

Another hospital shared their experience trying to schedule follow-up appointments out of the ED using the shared EHR scheduling system. In their first attempt at scheduling patients for follow-up with their primary care provider, they had a 60% no-show rate. This led to lost time in the clinic, and appointment slots were unavailable for other patients. They altered their strategy and worked with the providers in their primary care clinics to ensure they were alerted when one of their patients was discharged from the emergency department. In turn, the primary care clinic's patient coordinator would follow-up to schedule appointments. First, patients received a preliminary follow-up call from the ED to address any emergent issues related to medications or discharge instructions. Second, patients received a call from the scheduler at their preferred primary care clinic. By working collaboratively with the primary care clinics, the no-show rate for appointments declined and support from the primary care clinics for care coordination out of the ED improved.

Some hospitals leveraged routine staff huddles to ensure follow-up calls were being made, and the charge nurse would use checklists to ensure that follow-up calls were triaged appropriately. For example, one hospital used the charge nurse to triage questions received from patients during follow-up calls. If the call required clinical judgment, or provider follow-up, the charge nurse would address or redirect to the appropriate provider. All other patients were contacted and then a hand-off to new primary care was done for patients without an identified primary care provider.

Some follow-up calls resulted in the need for a timely visit to primary care. Many hospitals worked with clinic managers to identify providers available and willing to see same-day and short-notice appointments so patients would not have to return for another costly emergency room visit. Other hospitals developed a shared process that ensured access to primary care during off-hours or for same-day follow-up. This partnership and participation by primary care providers demonstrated the overall buy-in across the entire organization to better patient care. However, hospitals described these collaborative efforts as fragile due to limited staff. If one provider left, it could disrupt the entire process and derail the coordinated efforts between emergency and primary care teams.

Hospitals that opted to implement the Behavioral Health Integration track saw greater monthly fluctuations in depression screening rates and struggled to consistently meet quarterly milestones. At the end of the program, three out of five hospitals had depression screening rates at or below their baseline screening rates. Figure 2 displays the rate of depression screening during the first quarter of the program compared to the final quarter of the program. To meet the final milestone, hospitals were expected to screen and document any recommended follow-up for at least 65 percent of Medicaid patients. The two hospitals that met the final milestone were screening 95 percent of all Medicaid patients for depression and documented any follow-up plan in the medical record. This significantly skewed the overall average screening rate, which was 68 percent across participating hospitals. The three hospitals that missed the final milestone were screening half of their Medicaid patients on average at the end of the implementation period.

All five participating hospitals implemented depression screening, using either the PHQ2 + suicidal ideation question, or PHQ9 questionnaire. Most of the hospitals used conservative ranges for the determination of a "positive screen". For example, patients who had a moderate risk for depression based on screening (score between 5-10) were flagged for re-screening within 3 months. Provider clinical judgment and patient preference were always applied to patients scoring greater than 10 on the PHQ9. One hospital opted for the PHQ2 + suicidal ideation questionnaire. They explained that it worked better for provider workflows and was their clinics' preferred approach to screening. Patients who screened positive were subsequently given the PHQ9 to further evaluate their risk for depression.
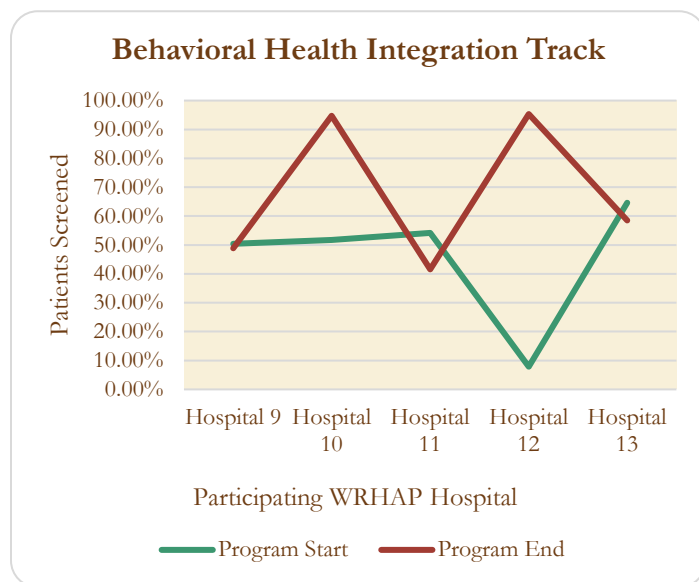
Figure 2. Program Beginning Screening Rate Compared to Program End Screening Rate

While the US Preventative Services Task Force recommends routine screening for depression, evidence pointing to specific screening timing and interval is unavailable. Because of this lack of reliable evidence on screening frequency, WSHA's recommendation for minimum screening intervals was based on the CMS Medicare allowable reimbursement (which reimburses for depression screening annually). Screening strategies differed, including:

- An "every patient, every time" policy.
- Only screen individuals scheduled for their annual wellness visits.
- Exclusion of patients being seen for acute injury or illness.
- Exclusion of patients seen within the past month for follow-up or chronic conditions.

Despite this variation, all hospitals adhered to the measure's age requirements and had appropriate follow-up plans in place for patients who screened positive. Examples of follow-up included:

- Outside referral to community mental health or behavioral health care specialists.
- Pharmacologic or behavioral therapeutic intervention.
- Continued monitoring of patients' mental state with repeat screening and scheduled follow-up.

The hospitals who chose to screen every patient, every time, explained that it simplified the administration process for the front office staff. It also reduced resistance from clinical staff because it was embedded with other routine information gathered at in-take. This freed up time for clinical staff to quickly gather other clinical information needed during the visit (e.g., medication changes, physical vitals, and other preventative screens). They also explained this approach addressed best practice, which recommends that patients with existing mental health diagnoses be routinely screened during follow-up to assess changes in depression and medication effectiveness. By incorporating an "every patient, every time" policy, patients with preexisting mental health conditions were treated the same as other patients seen in the clinic. This universal screening approach was said to improve the perception of patient privacy in the lobby and capture patients who may be coming in with psychosomatic symptoms. Mental and behavior health disorders have seen growing recognition for their impact on quality of life, but societal stigmas associated with treatment remain problematic. This has been especially true for many of the WRHAP hospitals when trying to shift community perception, provider resistance, and individual willingness to come in for care. Quality leaders hoped universal screening would demonstrate to staff and community members that their hospital had adopted an organization-wide culture that promotes wellness, prevention, and acceptance.

Most of the challenges with implementation of the behavioral health track stemmed from provider buy-in and access to qualified mental health providers. One hospital had been using Locums providers for over two years while searching for a permanent primary care provider. This same hospital also struggled to recruit a behavioral health provider. It took them over seven months to recruit a licensed clinical social worker. Once they had successfully hired someone, the provider stayed only long enough for the hospital to pay for licensing and credentials in Washington state and then left the organization for a position within a larger community. This experience is not uncommon for small rural hospitals and was especially true for this WRHAP hospital. They were ultimately effective in recruiting a replacement behavioral health provider and once the provider was settled, they were successful in improving their screening rates. Most of the hospitals that selected the behavioral health track also participate in a rural accountable care organization (ACO) and the depression screening measure is required for participation. Provider and nurse attitudes towards mental health were said to make the difference between success and failure for implementation. By scripting the PHQ9 intake process, providing education to staff on the importance of screening, and encouraging ownership of the work (identified champions),

"COCM visits [are] still super complicated to bill and get all the elements so we are still not able to get everyone billed. And this still doesn't cover the entire service line."

hospitals saw improved acceptance of the workflow and process. Better screening rates and rapid improvement in provider willingness to participate were achieved when hospitals standardized referral procedures, and developed tools to streamline communication outside of primary care.

One hospital expressed challenges with patients approved for Medicaid who lacked an assigned MCO. There was no clear guidance from HCA or the MCOs as to how patients in this temporary state should be billed. Because reimbursement is critical to hospital viability, understanding how to code for these patients was important. Unless a patient was actively assigned to an MCO, reimbursement was denied for depression screening and mental health care. It was not clear whether this was a recurring challenge, or happened infrequently but demonstrated the need for additional training and improved communication from payers. It also highlighted staff confusion over how to bill for new screening and behavioral health services. WSHA provided access to billing and coding webinars, and revenue cycle specialists. Other resources included technical assistance funds for onsite trainings and consultation. Despite universal interest, most of the WRHAP hospitals found staff capacity limited their ability to employ outside experts to provide onsite training and support.

Establishing a behavioral health patient registry within the electronic health record proved challenging for hospitals. The two most common scenarios were:

1) A patient was screened and scored positive for mild symptoms of depression but the provider and patient agreed to reevaluate in three months. The provider would document the score and follow-up plan in the patient chart. But, there was no location to enroll the patient for monitoring and follow-up.
2) A patient was screened and scored positive for severe symptoms of depression and agreed to begin immediate pharmacologic intervention with referral to psychotherapy. The primary care provider would document the score, official diagnosis, and treatment plan in the patient's medical record. The diagnosis would be added to the patient list of active conditions but wouldn't be distinguishable from other chronic conditions or easily tracked for follow-up. The therapist would then create a separate episode of care within the existing medical record for each patient encounter. The records would be filed by date and mixed with other visits and medical records which made tracking the patient's mental state, treatment adherence, and progress difficult.

To address this, two of the hospitals opted to utilize the program developed by the University of Washington AIMS Center. The AIMS Center, which focuses on developing integrated mental health solutions offers a Caseload Tracker for behavioral health providers. Designed to assist providers in managing behavioral health caseloads, providers, and therapists separately input information on behavioral health visits, PHQ scores, medications, and psychiatric case review dates into the tracker. The registry is available as either a web-based or EHR-integrated tracker making it accessible to those with limited EHRs. The other three hospitals used a variety of tools to monitor and follow-up with patients who screened positive.

Participating hospitals acknowledged the potential to leverage telehealth to support behavioral health integration and add essential providers to the workforce. Yet, working with external telehealth providers and vendors proved to be too difficult for some. One hospital described a scheduled patient visit where the patient arrived for an initial visit, and sat waiting in the patient room for 45 minutes for a provider that never showed up. The hospital expressed frustration about the disconnect and concern about more missed opportunities for patients who may be reluctant to come in person for care. Establishing a telehealth program before COVID-19 was also challenging due to regulatory and reimbursement restrictions, including site of origination limitations for Rural Health Clinics, reliable live-streaming bandwidth, and provider and patient technical expertise. After the emergency waivers were established, all the participating hospitals launched telehealth services for patients, but most hospitals found that patients preferred to receive behavioral health services in-person. Other patients opted to wait to be seen, and would forgo follow-up to avoid coming into the clinic during the COVID-19 pandemic. This varied greatly by community, patient preference, age, and comfort with virtual care. This further supported the concept that access to health care in rural communities would require a multi-pronged approach.

Other challenges related to implementation included data extraction, turnaround times for reporting, and the often manual process for filtering and tracking patients for reporting and follow-up. Challenges related to data and reporting persisted throughout the implementation period. Solutions for data management are often cost-prohibitive while existing staff may lack the knowledge to fully leverage their EHR system. For some hospitals with significantly outdated EHRs the only solution is to upgrade, which requires extensive planning and financial investment. This may prevent the smallest hospitals from being able to accomplish better data capabilities without external financial support. This is a serious and often overlooked barrier to quality-based incentive programs.

Workforce stability also remained a persistent challenge throughout implementation. Once selected, each participating hospital was expected to have all the required staff hired and trained (benchmark one), no later than June 30, 2018, with actual follow-up and screening activities beginning July 1, 2018. For some participants, recruitment, training, and retention of the appropriate staff (e.g., licensed clinical social workers, nurse practitioners, case workers and care coordinators), remained an ongoing challenge throughout the program. Some of the participating hospitals opted to utilize existing staff while searching for candidates, which increased the strain placed upon the workforce..

Turnover among rural quality leadership also presented a challenge during implementation. Changes in quality improvement staffing consistently correlated with dips in screening and contact rates. Overall, participating hospitals successfully hired appropriate staff for implementation. For the behavioral health integration track, demand for services rapidly increased, and in some instances, the need for more than one provider was required. Higher demand for behavioral health appointments demonstrated the community benefits of adding integrated services. Yet, hospitals that chose to focus on integration faced organizational risk and the potential for long-term sustainability challenges. Strategically, the WRHAP hospitals must evaluate overall community need and available hospital resources and determine which programs to cut, keep, or expand.

Without sufficient reimbursement for behavioral health care, it is difficult for small facilities to expend the needed resources despite their recognition of the importance.

For ED follow-up contact and screening rates by hospital and benchmark period please reference Appendix C.

HEALTH OUTCOME METRICS, IMPLEMENTATION ACTIVITIES, AND TRENDS

With the addition of two health outcome metrics halfway through the program, hospitals felt ill-equipped to incorporate effective strategies into their existing implementation plans in a timely and meaningful manner. Despite the hesitation, each WRHAP hospital selected an additional outcome measure that was tied to incentive-based payment (Table 3). Out of the participating hospitals, ten selected the ED utilization measure. The remaining three chose to pursue the anti-depressant medication management measure. The Health Care Authority provided baseline data on ED utilization and anti-depressant medication management for each hospital (data for hospitals with less than ten patients was suppressed). This initial baseline report (Appendix D) was used by hospitals to select their outcome measure. Once selected, WSHA also provided intermittent status reports on ED utilization by leveraging their access to the All-Payer Claims Database. There was no way for WSHA to provide reports on the anti-depressant medication management measure, which hospitals said hindered their ability to make improvements in a timely manner. Hospitals felt that they were expected to implement a measure without any real information. Hospitals participating in the ED utilization measure were given resources on patient education, access to WSHA's ER is for Emergencies materials, and ideas for reducing inappropriate utilization which were shared during peer-to-peer learning opportunities. Further, WSHA provided a list of the 170 ICD-10 codes identified as inappropriate for an ED visit so quality leadership could run internal reports and target specific diagnoses common for their facility.

Table 3. Selected Health Outcome Measure by Hospital

Anti-Depressant Medication Management (AMM)	ED Inappropriate Utilization
Ferry County Memorial Hospital	Arbor Health (Morton General Hospital)
Forks Public Hospital	Cascade Medical Center
Willapa Harbor Hospital	Columbia Basin Hospital
	Columbia County Health System
	East Adams Rural Healthcare
	Garfield County Hospital District
	Mid-Valley Hospital
	North Valley Hospital
	Three Rivers Hospital
	Odessa Memorial Healthcare Center

In status updates from implementation leads, hospitals who selected the medication management measure had little to report and chose to focus on improving screening and integration activities (e.g., consistent follow-up plans, therapy referrals and use of pharmacologic intervention for patients where appropriate), with the hope that these activities would promote medication adherence for patients newly diagnosed with depression. Two of the hospitals saw improvement in medication adherence for the initial 84 days, but only one saw an overall improvement in patient's adherence to medications during the performance year. One hospital failed to meet either of the metrics within the AMM measure. Of note, none of the hospitals that selected the AMM measure were actively working on behavioral health integration through the WRHAP program, but all the hospitals had separate efforts either through a relationship with their Accountable Community of Health (ACH), ACO, or simply due to community demand.

> *"If the emergency department is the only care available, a parent whose kid has an earache isn't going to wait to be seen and let their kid be miserable all weekend. It's bad for the parents and bad for the kiddo."*

For hospitals working on ED utilization, many expressed challenges with changing patient behavior; especially when alternative care options were limited. For example, most of the communities lacked access to alternative forms of care on weekends and holidays, when outpatient clinics are often closed. Individuals in need of urgent care also struggled to access care in the hours after clinics closed. Coaching patients about their behavior in a respectful way posed another challenge. Hospitals claimed this was a delicate conversation and that they could not legally turn anybody away if they came in. This further limited hospitals' ability to address patient behavior. Hospitals also hesitated to encourage someone to wait to seek care because of the risk that the patient would delay necessary care. While triage nurses and consult lines are useful in some circumstances, hospitals felt that establishing an actual policy placed patients at greater risk of harm and placed the hospitals at greater risk of litigation. Some of the hospitals incorporated information about who to contact with questions, follow-up, or how to access nurse consultation lines into their discharge papers for patients, with the hope that they could target repeat utilization through education and access to alternative resources for non-urgent issues (e.g., free online care guides and decision trees for parents and caregivers, free nurse consultation lines available through most insurers, etc.).

Hospitals with established primary care were provided training and resources on patient education, such as booklets for parents that provide information on common childhood illnesses and when to call your doctor (provided in Spanish and English). With the measure largely impacted by individual patient and family behavior, the ED leadership felt limited in their ability to address common diagnoses without help. Hospitals used data provided by WSHA to develop outreach and follow-up for patients seen in their primary care clinics who were at risk of some of the more common diagnoses, including urinary tract and upper respiratory infections. For example, if the hospitals' most common inappropriate visit to the emergency room was pediatric viral, the primary care clinic developed materials targeting parent education and provided bi-lingual resources and nurse call lines for patients to use when determining whether to be seen. If the most common diagnoses were older patients with urinary tract infections, the quality leadership was able to work with their

swing bed and long-term care programs to improve timely identification and referral to primary care for ailments commonly seen in elder populations. For patients with back pain, referral to pain management, physical therapy, and other outpatient services could reduce the risk of a repeat visit to the ED.

Despite these efforts, patients in communities without alternative options to after-hour care had no choice but to visit the emergency department. Due to low volumes, providing after-hours clinics is not financially viable for the hospitals. Some hospitals did offer after-hour care but relied on providers willing to volunteer their time to care for patients. For those with a more formalized program, providers were expected to rotate into the off-hour clinic, which increased overall provider burnout and potential workforce losses. Despite these challenges, five of the hospitals saw improvements in ED utilization from baseline.

Please see Appendix E for pre and post changes in AMM adherence and ED utilization rates for each participating hospital.

COVID-19 RESPONSE & PROGRAM IMPLEMENTATION

The COVID-19 pandemic began in the final year of WRHAP implementation and presented special challenges for participating hospitals. For hospitals focused on care coordination, the ED became the epicenter of planning and care for COVID-19 patients. Staff were forced to shift priorities and routinely placed themselves at risk of exposure while the nation rushed to understand how the virus was transmitted. Hospital leadership, including Chief Medical Officers, Chief Nursing Officers, and Quality leadership, were pulled into emergency response planning and reporting requirements for COVID-19; most of the routine quality improvement programs and activities were placed on hold or were delegated to other staff with less knowledge of the program details. During the peak of the pandemic, some hospitals furloughed providers and clinical staff or requested voluntary quarantining at home while the Governor's orders restricted non-essential services. These decisions had additional consequences for hospitals implementing the behavioral health integration track because most outpatient services were restricted, and patients were hesitant to come in for care. For some, the spread of misinformation in social media outlets likely contributed to them avoiding care. While behavioral health was considered essential, hospitals reported patients were confused about which services were available and which had been paused.

Waivers for telehealth improved the hospitals' ability to resume access to some routine care and outpatient services, including primary care and behavioral health, but patient willingness to utilize virtual care varied greatly by community. Although hospitals continued care coordination follow-up with patients discharged from the ED, the most significant adverse impact of COVID-19 was staff burnout and competing priorities for staff with finite capacity. Not all the WRHAP hospitals saw high volumes of COVID-19 patients, but all hospitals were required to have the same level of readiness for response. This meant that staff were expected to provide the same high level of planning, expertise, and readiness as more resource rich urban centers.

For the WRHAP program, short-term impacts from the pandemic included dips in contact and screening rates, setbacks in program implementation, and in some instances, a reset on quality improvement programs organization-wide. While detrimental to existing quality work, some hospitals said the pandemic provided opportunities to reevaluate their programs and redefine their priorities going forward. COVID-19 also highlighted cracks in workforce stability and offered insights into how to leverage staff for non-traditional roles in the future. While the pandemic is not over, hospitals are positive that they are equipped to address COVID-19.

PROGRAM EVALUATION & GAPS ANALYSIS

WRHAP hospitals demonstrated their commitment to change and effectively incorporated evidence-based standards of care and best practices for patient coordination, care management, and integration, despite significant barriers. Hospitals implemented effective tools and clinic workflows to incorporate follow-up calls into discharge planning protocols. Where behavioral health was the focus, demand increased for appointments and access improved. Staff attitudes towards the program morphed from one of hesitation to commitment and full ownership of the process; this transition is required for a cultural shift towards value-based care and population driven health outcomes.

Some communities faced challenges with unique populations, including inmates, tribal, and non-English speaking populations. Hospitals tailored their solutions to address each community's challenges with access to coordination and behavioral health care. Hospitals' adaptive approaches demonstrated a high degree of flexibility and innovation.

No two rural communities are the same. It is difficult to compare WRHAP hospitals and to define program success for each individual hospital. This report defines success not just by data, but also by hospitals' incremental, long-term achievements towards rural health care transformation.

While hospitals made progress in reporting, data management, and utilization of existing health information technology (HIT), a significant opportunity remains to support rural hospitals with HIT and timely health information exchange (HIE). The complexities and costs associated with EHR upgrades, combined with a lack of access to a highly skilled IT workforce, present continual challenges for the smallest of Washington's hospitals. While WSHA supports rural members by providing quality dashboards and access to other valuable hospital data, the day-to-day use of data for quality improvement depends on staff's time and knowledge of their systems. Hospitals' ability to maximize existing technical tools are constrained by staff capacity, and financial resources for hiring external consultants. One way to assist rural hospitals with leveraging their data to make better decisions is incentivize EHR vendors to provide for more free training and resources. Hospitals are interested in HIT solutions including telehealth but hesitate to invest limited resources given the

high degree of uncertainty around the future of existing HIE systems and rapidly shifting interoperability regulations.

To further evaluate the quality aspects of the program, clinical staff and hospital executives participated in a survey (only clinical staff), program exit peer-to-peer call (only clinical staff), and executive leadership focus group. WSHA leveraged the CDC Framework for Program Evaluation to inform the definition of program success and aid in the creation of both the survey and focus group guides (Please see Appendix F for a WRHAP Program Success Framework). The survey questions and focus group guide are available in Appendix G. Please find a discussion of the survey and focus group results below.

CLINICAL STAFF SURVEY

One employee each, from nine hospitals, responded to the clinical survey. It was designed to evaluate program success from the perspective of clinical staff. Using the WRHAP Program Success Framework, participants were asked 23 questions evaluating staffing, procedural activities, program buy-in, and program sustainability. A variety of staff, from C-suite leadership, to Allied Health Professionals, were involved in the implementation process. While not exhaustive of all personnel required to implement the WRHAP Program, Figure 3 represents staff who respondents cited as critical to implementation activities. Despite the broad variety of workforce composition required to conduct activities under the

Figure 3. Most Common Role Leveraged for Implementation

care coordination and behavioral health integration tracks, RNs and quality improvement leadership comprised the most frequently employed roles for program implementation. Ensuring that implementation teams understand participation expectations and their individual responsibility towards program success upfront, contributes to the overall likelihood of program success. Further, recognizing the valuable role each individual plays in the overall implementation improves commitment to the process and re-energizes individuals at risk of burn-out. For hospitals planning future programs, defining the workforce burden and responsibilities for each role upfront better prepares the organization to balance new transformational work with preexisting staff responsibilities. For external stakeholders and state agencies, understanding which workforce a hospital will most likely leverage during program implementation aids in setting realistic goals and expectations for new value-driven initiatives and improves chances of successful implementation.
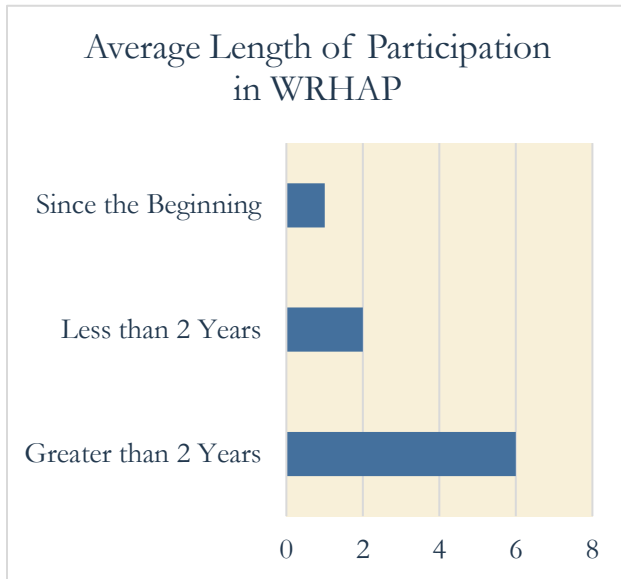
Most of the clinical survey respondents were involved with the WRHAP Program for between two to three years and held significant historical knowledge of the program's purpose and transformation goals (Figure 4).

Only one respondent was a part of the original design of the program. Retention of historical knowledge (either written or through experts on staff), improves program integrity and overall success. For hospitals facing higher rates of staff burnout or turnover, written documentation of the program's progress, processes, and workflows ensures that the program continues to achieve its intended objectives and tracks lessons learned for future program development.

Figure 4. Length of Time Involved in Implementation Activities

When asked about staffing and planning, all participating hospitals responded that they have sufficient and appropriate staff for future program sustainability. The one hospital without an established staffing plan for WRHAP related workflows stated that they would benefit from WSHA's continued support to build a behavioral health staff plan.

On a Likert scale of one to five, seven respondents somewhat agreed that staff and providers recognize the value of care coordination or behavioral health integration and are committed to sustaining gains made throughout the program. The other two respondents stated that they were neutral. Respondents cited the challenge of fitting follow-up calls into ED staff workflow as one outstanding barrier to full buy-in. One respondent described a workflow that shared follow-up call responsibility across the emergency department nurse pool. These nurses were expected to make calls during their downtime. Some nurses resisted, or intentionally delayed making calls and were then too busy to complete their follow-ups. Hospitals facing staff resistance could increase adherence to new standards through a reevaluation of staff workflow and accountability structures.

Respondents noted that resistance to behavioral health integration resulted from providers' and clinical staff's lack of confidence using available behavioral health screening tools and clinical care options. One respondent also noted that the current incorporation of screening and follow-up into daily workflows impeded acceptance of behavioral health integration. A lack of onsite counseling services increased primary care physicians' hesitancy to screen patients due to concerns around inadequate follow-up care. One hospital struggled to move patients between primary care and onsite behavioral health services due to challenges with the exchange of behavioral health records. Respondents noted that continuing education about screening and other available patient resources improved provider buy-in to screening. Additionally, hospitals that employed a population health nurse and quality improvement team to evaluate workflows and apply continuous quality improvement strategies to the program significantly decreased delayed patient care and improved overall team endorsement of the behavioral health integration process.

When asked what barriers remain to patient buy-in, respondents cited the following:

- Access to reliable patient contact information,
- Lack of patient interest in being contacted,
- Stigmas associated with behavioral health,
- Access follow-up care options,
- Financial barriers, and,
- Resistance to repeat depression screening.

These barriers prevented patients from engaging in the care coordination and behavioral health integration activities. Some individual patient behaviors are more readily addressed than others. Most patients resistant to repeat screening will likely adapt to hospital policy changes over time. Educating patients about health information collection, usage, and storage policies can reassure patients with privacy concerns. Hospitals can embed behavioral health screening into their culture and reduce the risk of provider and staff bias by conducting universal depression screening. Universal depression screening may also increase individual patients' willingness to be seen. Finally, hospitals can improve vulnerable patients' access to and understanding of insurance, Charity Care, and Medicaid by educating patients about the financial rights and resources available to them.
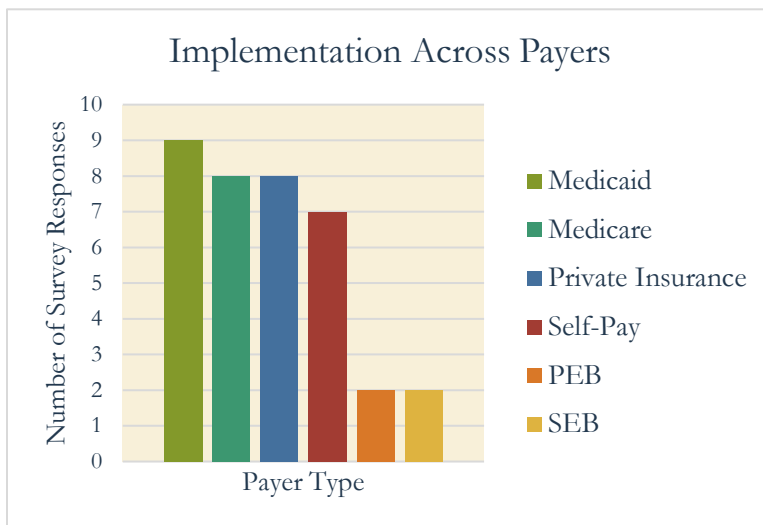
Figure 5. Implementation of Care Coordination Measure by Respondent and Payer Type

Five of the survey responses came from hospitals participating in the care coordination track. Of the responses, three stated their plans to continue using the ED Follow-up measure to monitor patients post-discharge. The other two stated that they will continue with the calls, but plan to modify the measure to focus on high-risk patients. All but one of the respondents stated that they apply the measure across most payers (Figure 5). Individual perspectives on the impact of follow-up calls on ED readmissions and utilization varied across respondents. Three stated that the measure has not significantly impacted utilization or readmission rates. Two stated they have seen quantifiable decreases in ED readmissions over the implementation period and an increase in the utilization of clinics for follow-up appointments. One respondent stated that although they do not have evidence that the measure has improved utilization rates, overall patient satisfaction has improved.

Two hospitals mentioned that they have additional quality improvement steps in place that could have had an impact on ED utilization and/or readmission rates, but neither of these respondents claimed a quantifiable decrease in ED utilization or readmission. These additional efforts included: application of the WRHAP follow-up measure across all payers, not just Medicaid, and provision of patient education materials to all patients leaving the ED. These procedural differences, while important to note, are not significant findings from the survey because similar activities and strategies were applied by other participants throughout the program period and may be universally contributing to overall program success. They cannot be said to be the sole cause of reduced ED utilization and readmission.

> *"I don't think we have seen much of a change in ED utilization, but I think it boosts the community's faith in us as providers and increases satisfaction. It shows we care about them and allows an opportunity for them to ask questions they may not have thought of in the moment."*

The COVID-19 pandemic presented operational challenges for most hospitals. From the perspective of WRHAP clinical staff, COVID-19 did not significantly alter the follow-up process for contacting patients discharged from the ED. ED follow-up continued throughout the pandemic with minimal disruption. One hospital noted that they experienced greater delays in the time between discharges and calls, but that calls continued to be made. Documentation and data input became more complicated. These delays likely stemmed from increased demand for staff to care for acute patients, conduct COVID-19 testing, and to take on other responsibilities during the pandemic. When respondents were asked what plans were in place to reduce potential inequities in patient follow-up, some stated that they do not have a plan because they did not believe their current process had any gaps. One respondent mentioned that timely access to bilingual staff who could assist with follow-up calls was essential for ensuring all patients received equitable care. Another respondent mentioned that their plan included improving scheduling and coordination with primary care providers to ensure all patients receive a follow-up visit within seven days of their ED discharge. While not everyone mentioned a specific plan, most respondents acknowledged the need to continuously monitor the process and adjust as needed to ensure that all patients receive timely follow-up calls regardless of payer, socioeconomic status, race, religion, or ethnicity. Respondents recommended updating phone numbers at intake and reconfirming with a discharge nurse as concrete actions to reduce inequities in access to patient care. Additionally, respondents believed that vendor and state-run programs that provide communication devices to low-income individuals should update their programs to allow unlimited minutes or offer program modifications to accommodate the increasing technical demands individuals face in today's technology-dependent society.

Hospitals participating in the care coordination track were required to make at least three attempts to contact the patient for the measure to be considered met. When asked what percentage of the patients discharged fell into this group, only one hospital responded that half of their patients fell into this category. To address follow-up when patients are unavailable after three contact attempts, all but one of the hospitals stated that

they have plans in place to continue closing the loop on patient care. Table 4 summarizes the strategies hospitals used to improve follow-up for patients who cannot be contacted.

Table 4. Mitigation Strategies to Improve Patient Follow-up Rates by Respondent

Respondent	1	2	3	4	5
# Of patients with 3+ failed contact attempts	Less than half	Almost none	Almost none	Half	Less than half
Mitigation strategies	Press Ganey survey	Check with clinics to see if there was any follow-up care provided.	Attempt to follow up with PCP at the clinic to see if they have a follow-up scheduled or documented.	Verify if PCP visit was scheduled. We also request PCP to attempt contact.	If after calling/leaving messages 3 times, we considered the patient contacted and made no further attempts.

Four of the survey responses were from hospitals participating in the behavioral health integration track. As mentioned previously, there are no evidence-based standards that define screening timing and frequency. Consequently, hospitals were responsible for developing a protocol that aligned with provider workflow and the patient populations served. Survey respondents were asked to describe the screening frequency and any patient visits always excluded from screening. Table 5 outlines screening frequency and exclusions for each responding hospital.

Table 5. Depression Screening Frequency and Patient Exclusions by Respondent

Respondent	6	7	8	9
Screening frequency	Total population annually; BH population at every visit	Total population annually; BH telehealth every visit; Currently revising workflows.	Transitioned to every patient, every time.	Total population annually; for positive PHQ9- within 4-6 weeks and then bi-monthly thereafter.
Patient visits always excluded	Sick visits	Exclusions will be addressed in workflow revisions, but for patients actively seen in BH, no screening is conducted with PCP. It will all be handled within BH.	Procedure follow-up appointments unless staff interaction with the patient triggers the need to rescreen.	No exclusions. We have tried to also include walk-in appointments for screenings.

Only half of the hospitals that responded to the behavioral health integration questions stated that staff and providers adhered to workflow protocols established for the program. For the two hospitals whose staff and providers failed to adhere to workflow protocols, the barriers identified included resistance to the proposed process and workflow, lack of data transparency, the need for continuing staff education throughout the program, and loss of a champion which derailed the development of new workflows. To address these barriers, implementation leadership collaborated with providers and staff to modify workflows, provide education opportunities, and consistently share screening data with providers. Hospitals were asked what additional staff were required for implementation of the measure. In addition to those previously mentioned, respondents leaned on clerical staff within each clinic, clinic directors, and informatics staff. All four responding hospitals plan to continue screening using the HEDIS measure.

Survey respondents stated that COVID-19 presented challenges in the behavioral health track, primarily due to patient fears of coming in person to the clinic and high volumes of cancellations. Other issues cited included:

- Challenges with developing a telehealth program on short notice (e.g., vendor contracting, infrastructure, broadband access, internet bandwidth, etc.).
- The need for new hybrid documentation and workflows.
- Limited technological capabilities of patients.
- The inability of telehealth visits to be directly incorporated into the patient medical record for documentation and treatment planning.

Despite these and other implementation challenges, all respondents stated that they are confident that these outstanding challenges will be resolved. One hospital also mentioned that they were selected to participate in the AIMS COHORT II for integrated behavioral health and are excited to continue improving their program under the AIMS program.

Finally, survey respondents were asked to describe their plans for reducing inequities related to patient access to depression screening and behavioral health services. All four respondents have a plan in place that includes routine depression screening, as well as additional screening for patients previously screened positive and/or diagnosed with a behavioral health condition. Two of the hospitals' plans included proactive chart preparation before any patient appointment and routine chart review and audit for screening and follow-up plans. One hospital also incorporated strategies to increase available resources to aid patients in bridging medical and social determinant gaps identified during the patient visit.

Overall, clinical staff felt that the quality improvement components of the WRHAP program were successfully implemented and had a positive outlook about the long-term benefits for patients and the community.

EXECUTIVE LEADERSHIP FOCUS GROUP

WRHAP hospital executive leadership was asked to participate in a one hour focus group. Eleven of the thirteen hospitals participated. Attendees included hospital Chief Executive Officers, and Chief Nursing Officers, as well as a small number of Quality Leads. Using the focus group guide, Appendix G, and open-ended follow-up questions, the interview captured executive perspectives on overall program successes, outstanding gaps in sustainability, and their strategic visions for ongoing transformation. Most of the feedback about the program's structure and the overall success of quality improvement activities mirrored comments and perspectives that had been captured through continuous program feedback and the clinical survey. The focus group also highlighted additional areas of strength and key areas for future growth. These are outlined in greater detail below.

"One of our biggest challenges is that we are small and at risk. We are looking for sustainability [and] that won't come without external funding. Every decision we make must be based on the bottom line despite the value-add to the community. If this program becomes another redline, we may have no choice but to cut the program for the sake of sustaining other critical services in the community."

Participants were asked whether the incentive payments received throughout the program were sufficient to implement their chosen WRHAP track and whether they felt new services were financially viable with the program sunsetting. All respondents stated that they intend to continue the implemented activities, despite the discontinuation of incentive payments, however, they also collectively acknowledged that focus and

priorities are naturally forced to shift with funding availability. This is especially true for aspects of patient care that are not reinforced through a sustainable reimbursement model. Without additional financial incentives, or a community-driven interest to direct limited resources towards follow-up calls or screening, at least one hospital may be forced to modify the program.

PROGRAM STRENGTHS

- Significant alignment of program goals and activities across various initiatives made it possible for hospitals to leverage incentive funds from ACHs and ACO incentive payments to augment WRHAP implementation activities.
- Some hospitals have begun screening for social determinants of health to complement their behavioral health integration program.
- Collaboration with community-based behavioral health providers, when available, has been a critical piece for connecting patients, especially for hospitals where a fully integrated behavioral health model is not possible due to clinic size, workforce shortages, and funding.
- WRHAP has strengthened hospitals' local referrals and community-based partnerships.
- Hospitals remain open to alternative payment models and are willing to engage in value-based purchasing discussions with MCOs, should MCOs provide funding that enables transformation. Small contracts will not be sufficient to make a real impact.
- WRHAP calls and screening were significant for connecting patients and improving lives during COVID-19. Hospitals' ability to screen and treat patients struggling with depression during the pandemic and to coordinate follow-ups for patients leaving the ED provided a significant community benefit and morale booster for staff often weary from working the front lines.
- COVID-19 required modifications and scaling back of strategic planning for some hospitals, but overall, the goals and three-year vision incorporated plans to focus on quality improvement, building existing service line volumes, and a continued focus on the management and prevention of both chronic disease and COVID-19 through vaccination and patient education.
- Hospitals appreciated the timely statistical analysis and data, technical support, and peer-to-peer learning opportunities WSHA provided throughout the program.

> *"There has been a huge impact for patients across Washington and ultimately that is the best part [of this work]."*

OPPORTUNITIES FOR IMPROVEMENT

- Care coordination activities are only covered by Medicare. This is a significant barrier to hospitals' ability to move toward value driven health care for all patients.
- All the hospitals are currently unable to participate in meaningful value-based purchasing arrangements due to small population size and a lack of interest from payers to negotiate. Small contracts offered little

financial incentive and often required significant upfront investment. Payers are not aligned on their programs and population focus which makes the cost prohibitively high for small rural hospital participation.

- ✑ External funding (WRHAP, ACH, ACO, Grants), all hit at the same time, making it possible to launch a successful initiative under WRHAP, but with term-limited funding expiring, hospitals are concerned about sustaining the work long-term.
- ✑ A disconnect remains between hospitals' ability to leverage new alternative workforce (e.g., peer support services, community health workers, and using Allied Health professionals at full scope) and the ability to reimburse for services they provide.
- ✑ Without billing codes to bill and sufficient payment for care coordination and all the steps of caring for behavioral health patients, implementing WRHAP provides limited long-term financial relief.

> *"Finding good people to do this work is really hard….You are always forced to ask yourself: Will billing be enough to sustain the staff you are required to hire for this work?"*

Overall, hospital executive leadership felt that strong collaboration with outside stakeholders, contributed to the progress made within WHRAP's quality improvement activities. Despite concern about long-term sustainability, all hospital executive leadership remain optimistic about the future path to better health for their communities.

KEY THEMES AND LESSONS LEARNED FOR HOSPITALS

Throughout the program, WRHAP hospitals identified ways that future quality improvement initiatives could be improved. Below are some of the key themes captured in discussions and lessons learned throughout the program that hospitals can apply to future programs:

- Clearly define needed workforce roles and how they will be met at the beginning of a program. This better prepares the organization to balance new transformational work with preexisting staff responsibilities and can reduce burnout.
- Conduct universal screening and embed these workflows to help reduce risk of inequitable care due to staff bias.
- Regularly evaluate workflows and incorporate staff feedback to adapt the program as it evolves.
- Provide continuing education regarding behavioral health screening benefits and best practices to address provider buy-in.
- Provide patient education regarding patient privacy and data policies.
- Retain historical knowledge of the program in the event of staff or leadership turn over. Include the following in documentation:
    - o Program goals,
    - o Workplans and timelines,
    - o Data captured and quality metrics tracked,
    - o Final program policies and procedures,
    - o Provider and staff workflows and processes,
    - o Implementation challenges and mitigation strategies.
- Store the program implementation and progress over time in a secure and shared location, preferably in digital form. Use this knowledge for future program planning, integrity, and success.

FINAL PROGRAM RECOMMENDATIONS

Based on the WRHAP Program Evaluation Framework, the overall implementation of both the behavioral health integration and care coordination tracks under WRHAP was successful. Despite the gains achieved under the program, much work remains to be done to embed and sustain this work into the future. Based on an overall assessment of the program, and WSHA's long-term participation as both administrator and collaborator, several key recommendations have been developed for next steps.

SUSTAINABILITY & EXPANSION OF WRHAP ACTIVITIES

KEY RECOMMENDATIONS

- New sustainable funding mechanisms should be multi-payer, to improve hospital participation and reduce risk of duplication, silos, and misaligned programs across stakeholders.
- Workforce development activities must coincide with new model implementation expectations and address the staff crisis caused by COVID.
- New career tracks need sufficient reimbursement for hospitals to leverage and incorporate them into patient care.
- Reimbursement should be comprehensive and cover the full spectrum of activities required to coordinate care for patients transitioning across care settings and those faced with complex needs, such as mental and behavioral health, and substance use disorder.
- Funding and grant programs for rural provider and workforce training should be expanded to incorporate continuing education opportunities in best practices for behavioral health integration, billing, coding integrity, and effective care coordination strategies for both emergency and outpatient settings.

Hospitals have limited ability to expand WRHAP programs. There are no plans to end developed services, but some hospitals have opted to focus their quality improvement efforts on other measures that track similar health outcome objectives, or measures that are better aligned with work conducted with other partners (e.g., rural health collaboratives, ACHs, ACOs). This is especially true for the ED contact measure. Hospitals expect the work will continue, but ongoing process improvement and routine monitoring will cease. Most hospitals feel confident that the shift in workflow was successful, and the process is now fully integrated into daily patient care. For behavioral health, depression screening will remain an important quality improvement measure, not only for ACO participation, but also for Medicare. All the hospitals recognize the value of

community access to behavioral health. But, sustainability, and expansion of service rely heavily on several key factors including:

- Future reimbursement models
- Payers' willingness to pay for coordination-related services and the various elements of mental health management that are not currently reimbursed.
- Balanced progress in reimbursement rates and the implementation of best practices in patient care.

Without financial support to sustain a hospital until new providers can bill and have full schedules, the cost-benefit of expansion is not feasible. Further, hospitals wishing to innovate by incorporating new workforce into patient care (e.g., peer support, care navigators and managers, community health workers, etc.) do not see a financial return due to billing limitations. This reduces the hospitals' ability to approach care coordination and integration activities creatively due to the threat of financial loss.

ORGANIZATIONAL CAPACITY, EXPANSION, & OPPORTUNITIES TO SUPPORT INTEGRATION OF PHYSICAL & BEHAVIORAL HEALTH CARE

KEY RECOMMENDATIONS

- Ensure the new models' reimbursement structure incentivizes and rewards hospitals who shift priorities to care management and preventative activities long-term.
- Federal policy makers should act to incentivize interoperability, prioritize data standardization guidelines, and fast track interoperability regulation.
- Free or low cost options for EHR training, health information technology resources and support from vendors and other EHR experts are needed for small facilities to fully realize the capabilities of their EHR.

Most WRHAP hospitals are working on either strengthening their existing behavioral health resources (e.g., referrals, community partnerships, screening, and early identification, etc.), or are focusing on building an integrated delivery model. While none of the hospitals anticipate removing service lines related to care coordination or behavioral health, financial viability is always a contributing factor in hospitals' strategic planning and long-term outlook. Without sufficient funding to support preventative care, there is little financial incentive for hospitals to willingly reduce their access to funding available through inpatient and emergency services. By incorporating consistent, accurate reimbursement for preventative activities, hospitals are more likely to shift their priorities.

ROLE OF WSHA IN PROVIDING CONSULTATIVE SUPPORT ON ALIGNMENT OPPORTUNITIES

KEY RECOMMENDATION

☝ New models need robust technical support and peer-to-peer opportunities to collaborate and learn.

Hospitals required significant assistance with quality-related activities, including: understanding the complexities of best practice, measure guidelines, data extraction, and reporting. WSHA's ability to address and elevate hospital challenges fuels hospitals' development and adoption of innovative solutions. WSHA continues to remain actively engaged with WRHAP hospitals, ACHs, and state stakeholders on a sustainable path forward for rural health care.

USE OF AND ALIGNMENT WITH EXISTING COMMUNITY TRANSFORMATION RESOURCES

KEY RECOMMENDATION

☝ A stronger and more coordinated approach across transformation activities will allow rural hospitals to focus resources and move towards a uniform goal.

Hospitals' abilities to align budgets, transformation activities, service expansion and strategic priorities is tenuous without predictable, consistent funding streams. Without strong coordination across payers and stakeholders, hospitals' ability to dedicate scarce resources to transformation will remain challenging. Further, relying on temporary funding (e.g., IGT, ACH, grant, 1115 Waiver, etc.) as a plan for long-term sustainability places hospitals at increased risk of complications should funding be pulled. Real change can only occur when upfront funding is followed by reliable reimbursement for ongoing services. There must be consistency across healthcare stakeholders including payers, community partners, state agencies, and hospital systems big and small for maximum community benefit.

EVALUATION OF EXISTING PARTNERSHIPS (FORMAL & NON-FORMAL), & THE IDENTIFICATION OF NEW PARTNERSHIPS REQUIRED TO COORDINATE CARE & IMPROVE THE HEALTH OF THE REGION

KEY RECOMMENDATION

☞ Flexibility in value-based purchasing contracts and the ability to aggregate populations will encourage MCO and hospital participation in smaller rural communities.

Improved coordination between MCOs, HCA, and hospitals will reduce billing complications and help streamline care for patients. Despite hospitals' interest in participation, payers are often not interested in engaging small hospitals due to the small number of patients they see.

CONCLUSION

Throughout the WRHAP program, participating hospitals experienced many challenges and moments of triumph. The activities, quantitative trends and qualitative observations described throughout this report highlight many areas of growth and opportunities for future improvement as WRHAP hospitals move along the continuum towards better health, better care, and lower costs. While the quality aspects of implementing WRHAP have come to an end, there is much more that needs to be done to address the underlying challenges still facing Washington's smallest rural hospitals. The above recommendations provide actionable steps for moving WRAHP hospitals forward. Above all, it is our combined determination to improve access to rural health care, resiliency under duress, and hope for a better, more sustainable future that drives progress.

APPENDIX A. IMPLEMENTED PROCESS QUALITY MEASURES

Below are the two measures identified for use during the WRHAP implementation period. Because the ED follow-up measure was developed specifically for this program it has no national or state standardized language. As such, modifications to the contract language to further clarify the measure's numerator and denominator were required. These changes are reflected below and highlighted in red.

JUL-DEC 2018 ED CARE COORDINATION PROCESS MEASURE

If the Participant indicates that the majority of the new services delivered will be chronic care management or care coordination services (other than psychiatric collaborative care management services), the Participant submits a report on the care coordination quality measure (percent of residents with phone contact or face-to-face visit within seven (7) calendar days of ED or hospital discharge) for a three month period that shows the Participant has met the benchmark for that period….The measure shall be calculated by the Participant as follows:

Numerator: Number of Enrollees with a phone contact or face-to-face visit with the care coordinator or a primary care provider within seven (7) calendar days following discharge from the ED or the hospital where the Enrollee was admitted following the ED visit.

Denominator: Number of Enrollees who (1) are residents of the Public Hospital District, (2) visit the Emergency Department operated by the Public Hospital District, and (3) are discharged alive to their homes following the ED visit or following a hospital admission resulting from the ED visit during the performance period (calendar quarter).

JAN-JUN 2019 ED CARE COORDINATION PROCESS MEASURE

If the Participant indicates that the majority of the new services delivered will be chronic care management or care coordination services (other than psychiatric collaborative care management services), the Participant submits a report on the care coordination quality measure (percent of residents with phone contact or face-to-face visit within seven (7) calendar days of ED or hospital discharge) that shows the Participant has met the benchmark for that period….The measure shall be calculated by the Participant as follows:

Numerator: Number of Enrollees with a phone contact or face-to-face visit with the care coordinator or a primary care provider within seven (7) calendar days following discharge from the ED or the hospital where the Enrollee was admitted following the ED visit. For a contact to have occurred: (1) A phone or face-to-face visit within seven calendar days of ED or hospital discharge must occur OR, (2) WRHAP patient follow-up must be attempted daily until contact is made OR 7 days post-discharge have passed. On the eighth (8) day without contact, you may consider the measure met for that patient.

Denominator: Number of Enrollees who (1) are residents of the Public Hospital District, (2) visit the Emergency Department operated by the Public Hospital District, and (3) are discharged alive to their homes following the ED visit or following a hospital admission resulting from the ED visit during the

performance period (calendar quarter). The denominator should exclude Medicaid enrollees who are identified as LWBS (left without being seen) OR AMA (against medical advice).

JUL-DEC 2019 ED CARE COORDINATION PROCESS MEASURE

If the Participant indicates that the majority of the new services delivered will be chronic care management or care coordination services (other than psychiatric collaborative care management services), the Participant submits a report on the care coordination quality measure (percent of residents with phone contact or face-to-face visit within seven (7) calendar days of ED or hospital discharge) that shows the Participant has met the benchmark for that period….The measure shall be calculated by the Participant as follows:

Numerator: Number of Enrollees with a phone contact or face-to-face visit with the care coordinator or a primary care provider within seven (7) calendar days following discharge from the ED or the hospital where the Enrollee was admitted following the ED visit. For a contact to have occurred: (1) A phone or face-to-face visit within seven calendar days of ED or hospital discharge must occur OR, (2) an attempted contact where the first attempt is initiated within the first 48 to 72 hours of discharge and there are a minimum three daily attempts within the seven days following discharge.

Denominator: Number of Enrollees who (1) visit the Emergency Department operated by the Public Hospital District, and (2) are discharged alive to their homes following the ED visit or following a hospital admission resulting from the ED visit during the performance period (calendar quarter).

JAN-JUN 2020 ED CARE COORDINATION PROCESS MEASURE

If the Participant indicates that the majority of the continued services delivered will be chronic care management or care coordination services (other than psychiatric collaborative care management services), the Participant submits a report on the care coordination quality measure (percent of residents with phone contact or face-to-face visit within seven (7) calendar days of ED or hospital discharge) that shows the Participant has met the benchmark for that period….The measure shall be calculated by the Participant as follows:

Numerator: Number of Enrollees with a phone contact or face-to-face visit with the care coordinator or a primary care provider within seven (7) calendar days following discharge from the ED or the hospital where the Enrollee was admitted following the ED visit. For a contact to have occurred: (1) A phone or face-to-face visit within seven calendar days of ED or hospital discharge must occur OR, (2) an attempted contact where the first attempt is initiated within the first 48 to 72 hours of discharge and there are a minimum three daily attempts within the seven days following discharge.

Denominator: Number of Enrollees who (1) visit the Emergency Department operated by the Public Hospital District, and (2) are discharged alive to their homes following the ED visit or following a hospital admission resulting from the ED visit during the performance period (calendar quarter).

JUL-DEC 2020 ED CARE COORDINATION PROCESS MEASURE

If the Participant indicates that the majority of the continued services delivered will be chronic care management or care coordination services (other than psychiatric collaborative care management services), the Participant submits a report on the care coordination quality measure (percent of residents with phone contact or face-to-face visit within seven (7) calendar days of ED or hospital discharge) that shows the Participant has met the benchmark for that period. To receive a percentage of the quality performance payments, the participant must meet the minimum performance target rate of 40 percent of total Medicaid ED patients for each three-month period....The measure shall be calculated by the Participant as follows:

Numerator: Number of Enrollees with a phone contact or face-to-face visit with the care coordinator or a primary care provider within seven (7) calendar days following discharge from the ED or the hospital where the Enrollee was admitted following the ED visit. For a contact to have occurred: (1) A phone or face-to-face visit within seven calendar days of ED or hospital discharge must occur OR, (2) an attempted contact where the first attempt is initiated within the first 48 to 72 hours of discharge and there are a minimum three daily attempts within the seven days following discharge.

Denominator: Number of Enrollees who (1) visit the Emergency Department operated by the Public Hospital District, and (2) are discharged alive to their homes following the ED visit or following a hospital admission resulting from the ED visit during the performance period (calendar quarter).

SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN

Quality ID #134 (NQF 0418): Preventive Care and Screening: Screening for Depression and Follow-Up Plan
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention, Treatment, and Management of Mental Health

2019 COLLECTION TYPE:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per measurement period** for patients seen during the measurement period. The most recent quality-data code submitted will be used for performance calculation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening".

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians using Medicare Part B claims. The listed denominator criteria are used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure on the claim form(s). All measure-specific coding should be submitted on the claim(s) representing the denominator eligible encounter and selected numerator option.

DENOMINATOR:
All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

> **DENOMINATOR NOTE:** *Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.*

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 12 years on date of encounter
> **AND**
> **Patient encounter during the performance period (CPT or HCPCS):** 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99483, 99484, 99492, 99493, 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, G0101, G0402, G0438, G0439, G0444

NUMERATOR:
Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ2

- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD)

- **Perinatal Screening Tools**
  Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

Follow-Up Plan – Documented follow-up for a positive depression screening ***must*** include one or more of the following:

- Additional evaluation or assessment for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Examples of a follow-up plan include but are not limited to:

* Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder

* Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale

* Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression

* Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options

* Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) –

- Patient has an active diagnosis of depression prior to any encounter during the measurement period- F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345

- Patient has a diagnosed bipolar disorder prior to any encounter during the measurement period-
  F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61,
  F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78,
  F31.81, F31.89, F31.9

Patients with a Documented Reason for not Screening for Depression (Denominator Exception) –
One or more of the following conditions are documented during the encounter during the measurement
period:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment
  would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy
  of results of standardized depression assessment tools. For example: certain court appointed
  cases or cases of delirium

<u>**Numerator Instructions:**</u>
A depression screen is completed on the date of the encounter using an age appropriate standardized
depression screening tool AND if positive, either additional evaluation for depression, suicide risk
assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological
interventions, or other interventions or follow-up for the diagnosis or treatment of depression a follow-up
plan is documented on the date of the positive screen. Depression screening is required once per
measurement period, not at all encounters; this is patient based and not an encounter based measure. The
name of the age appropriate standardized depression screening tool utilized must be documented in the
medical record. The depression screening must be reviewed and addressed in the office of the provider
filing the code on the date of the encounter and the screening should occur during a qualified encounter.

<u>**Numerator Quality-Data Coding Options:**</u>
Depression Screening or Follow-Up Plan not Documented, Patient not Eligible
Denominator Exclusion: G9717:   Documentation stating the patient has an active
diagnosis of depression or has a diagnosed bipolar
disorder, therefore screening or follow-up not required

<u>OR</u>

Screening for Depression Documented as Positive, AND Follow-Up Plan Documented
Performance Met: G8431:   Screening for depression is documented as being
positive AND a follow-up plan is documented

<u>OR</u>
Screening for Depression Documented as Negative, Follow-Up Plan not Required
Performance Met: G8510:   Screening for depression is documented as negative,
a follow-up plan is not required

<u>OR</u>

Screening for Depression not Completed, Documented Reason
Denominator Exception: G8433:   Screening for depression not completed, documented
reason

<u>OR</u>

Screening for Depression not Documented, Reason not Given
Performance Not Met: G8432:   Depression screening not documented, reason
not given

<u>OR</u>
**Screening for Depression Documented as Positive, Follow-Up Plan not Documented, Reason not
Given**

Performance Not Met: G8511:   Screening for depression documented as positive,
follow-up plan not documented, reason not given

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease increased health care utilization, and impaired functioning (Pratt, Brody 2014). 2014 U.S. survey data indicate that 2.8 million (11.4 percent) adolescents aged 12 to 17 had a major depressive episode (MDE) in the past year and that 15.7 million (6.6 percent) adults aged 18 or older had at least one MDE in the past year, with 10.2 million adults (4.3 percent) having one MDE with severe impairment in the past year (Center for Behavioral Health Statistics and Quality, 2015). Data indicate that severity of depressive symptoms factor into having difficulty with work, home, or social activities. For example, as the severity of depressive symptoms increased, rates of having difficulty with work, home, or social activities related to depressive symptoms increased. For those twelve and older with mild depressive symptoms, 45.7% reported difficulty with activities and those with severe depressive symptoms, 88.0% reported difficulty (Pratt & Brody, 2014). Children and teens with major depressive disorder (MDD) has been found to have difficulty carrying out their daily activities, relating to others, and growing up healthy with an increased risk of suicide (Siu and USPSTF, 2016). Additionally, among pregnant women, especially during the perinatal period, depression and other mood disorders, such as bipolar disorder and anxiety disorders, can have devastating effects on women, infants, and families. Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (American College of Obstetricians and Gynecologists, 2015).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients (Borner, 2010, p. 948). "Coyle et al.(2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner, 2010, p. 948). "In nationally representative U.S. surveys, about 8% of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated" (Sui, A. and USPSTF, 2016). Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs. "In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011" (Sui, A. and USPSTF, 2016).

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 360).

"Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up" (ICSI, 2013, p.16).

Adult Recommendation (18 years and older):

"The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui, A. and USPSTF, 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."

2. "Clinicians should establish and maintain follow-up with patients."

3. "Clinicians should screen and monitor depression in pregnant and post-partum women." (Trangle, 2016 p.p. 9 – 10)

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2019 Medicare Part B Claims Flow for Quality ID #134 NQF #0418:
Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Denominator

Start

Patient Age at Date of Service ≥ 12 Years
- No → Not Included in Eligible Population/Denominator
- Yes ↓

Encounter as Listed in Denominator* (1/1/2019 thru 12/31/2019)
- No → Not Included in Eligible Population/Denominator
- Yes ↓

Include in Eligible Population/Denominator (100 patients)   d

Numerator

Depression Screening or Follow-Up Plan Not Documented, Patient Not Eligible*
- Yes → Data Completeness Met + Denominator Exclusion G9717 (10 patients)   x[1]
- No ↓

Screening for Depression Documented as Positive, And Follow-up Plan Documented
- Yes → Data Completeness Met + Performance Met G8431 (20 patients)   a[1]
- No ↓

Screening for Depression Documented as Negative, Follow-up Plan Not Required
- Yes → Data Completeness Met + Performance Met G8510 (30 patients)   a[2]
- No ↓

Screening for Depression Not Completed, Documented Reason
- Yes → Data Completeness Met + Denominator Exception G8433 (10 patients)   b[1]
- No ↓

Go To Next Page

*See the posted Measure Specification for specific coding and instruction to submit this measure.

NOTE: Submission Frequency: Patient-process

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The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

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2019 Medicare Part B Claims Flow for Quality ID #134 NQF #0418:
Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Numerator Con't

Go To Next Page

Screening for Depression Not Documented, Reason Not Given —Yes→ Data Completeness Met + Performance Not Met G8432 (10 patients) c^1

No

Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given —Yes→ Data Completeness Met + Performance Not Met G8511 (10 patients) c^2

No

Data Completeness Not Met Quality-Data Code Not Submitted (10 patients)

SAMPLE CALCULATIONS:

Data Completeness Rate=

$$\frac{\text{Denominator Exclusion } (x^1=10 \text{ pts})+\text{Performance Met } (a^1+a^2=50 \text{ pts}) + \text{Denominator Exception } (b^1=10 \text{ pts}) + \text{Performance Not Met } (c^1+c^2=20 \text{ pts})}{\text{Eligible Population / Denominator } (d=100 \text{ patients})} = \frac{90 \text{ patients}}{100 \text{ patients}} = 90.00\%$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2=50 \text{ patients})}{\text{Data Completeness Numerator (90 patients) − Denominator Exclusion } (x^1=10 \text{ patients}) − \text{Denominator Exception } (b^1=10 \text{ patients}) = 70 \text{ patients}} = \frac{50 \text{ patients}}{} = 71.43\%$$
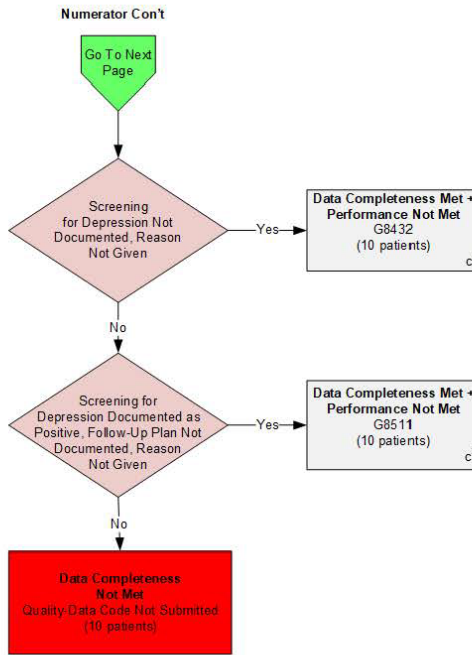
*See the posted Measure Specification for specific coding and instruction to submit this measure.
NOTE: Submission Frequency: Patient-process

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The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

v3

2019 Medicare Part B Claims Flow Narrative for Quality ID #134 NQF #0418:
Preventative Care and Screening: Screening for Depression and Follow-Up Plan

Please refer to the specific section of the Measure Specification to identify the denominator and numerator information for use in submitting this Individual Specification.

1. Start with Denominator

2. Check Patient Age:

    a. If the Patient Age is greater than or equal to 12 Years on Date of Service and equals No during the measurement period, do not include in Eligible Population. Stop Processing.

    b. If the Patient Age is greater than or equal to 12 Years on Date of Service and equals Yes during the measurement period, proceed to check Encounter Performed.

3. Check Encounter Performed:

    a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.

    b. If Encounter as Listed in the Denominator equals Yes, include in the Eligible Population.

4. Denominator Population:

    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 100 patients in the Sample Calculation.

5. Start Numerator

6. Check Depression Screening or Follow-Up Plan Not Documented, Patient Not Eligible:

    a. If Screening for Depression or Follow-Up Plan Not Documented, Patient Not Eligible equals Yes, include in Data Completeness Met and Denominator Exclusion.

    b. Data Completeness Met and Denominator Exclusion letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter x^1 equals 10 patients in the Sample Calculation.

    c. If Screening for Depression or Follow-Up Plan Not Documented, Patient Not Eligible equals No, proceed to check Screening for Depression Documented as Positive, And Follow-up Plan Documented.

7. Check Screening for Depression Documented as Positive, And Follow-up Plan Documented:

    a. If Screening for Depression Documented as Positive, And Follow-up Plan Documented equals Yes, include in Data Completeness Met and Performance Met.

    b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 20 patients in the Sample Calculation.

    c. If Screening for Depression Documented as Positive, And Follow-up Plan Documented equals No, proceed to check Screening for Depression Documented as Negative, Follow-up Plan Not Required.

8. Check Screening for Depression Documented as Negative, Follow-up Plan Not Required:

a. If Screening for Depression Documented as Negative, Follow-up Plan Not Required equals Yes, include in Data Completeness Met and Performance Met.

b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 30 patients in the Sample Calculation.

c. If Screening for Depression Documented as Negative, Follow-up Plan Not Required equals No, proceed to check Screening for Depression Not Completed, Documented Reason.

9. Check Screening for Depression Not Completed, Documented Reason:

a. If Screening for Depression Not Completed, Documented Reason equals Yes, include in the Data Completeness Met and Denominator Exception.

b. Data Completeness Met and Denominator Exception letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.

c. If Screening for Depression Not Completed, Documented Reason equals No, proceed to check Screening for Depression Not Documented, Reason Not Given.

10. Check Screening for Depression Not Documented, Reason Not Given:

a. If Screening for Depression Not Documented, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.

b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

c. If Screening for Depression Not Documented, Reason Not Given equals No, proceed to check Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given.

11. Check Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given:

a. If Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.

b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

c. If Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given equals No, proceed to check Data Completeness Not Met

12. Check Data Completeness Not Met:

a. If Data Completeness Not Met, the Quality Data Code was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

SAMPLE CALCULATIONS:

Data Completeness Rate=

$$\frac{\text{Denominator Exclusion } (x^1=10 \text{ pts})+\text{Performance Met } (a^1+a^2=50 \text{ pts}) + \text{Denominator Exception } (b^1=10 \text{ pts}) + \text{Performance Not Met } (c^1+c^2=20 \text{ pts})}{\text{Eligible Population / Denominator } (d=100 \text{ patients})} = \frac{90 \text{ patients}}{100 \text{ patients}} = 90.00\%$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2=50 \text{ patients})}{\text{Data Completeness Numerator } (90 \text{ patients}) - \text{Denominator Exclusion } (x^1=10 \text{ patients}) - \text{Denominator Exception } (b^1=10 \text{ patients}) = 70 \text{ patients}} = \frac{50 \text{ patients}}{} = 71.43\%$$

Anti-Depressant Medication Management (NCAQ HEDIS®) outcome measure the performance expectation is a 10 percent improvement in anti-depressant medication treatment adherence; closing the gap between baseline rate and the HEDIS® 90th percentile national benchmarks. For example, if baseline performance is 76 percent, the improvement target is set at 77.68 (76.0+1.68) percent, based on the metric absolute benchmark of 92.80 (90th percentile). The baseline for the selected measure will be state fiscal year (SFY) 2018 and will be compared to performance year SFY 2020 (Jul 2019 through June 2020). Performance will be determined during calendar year (CY) Quarter 3 of 2020. Payment of at least $10,000 based on performance improvement will be dispersed in CY Quarter 4 of 2020 (by December 2020).

Measure definition: The percentage of Medicaid beneficiaries 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an anti-depressant medication treatment. Two sub-metrics are reported: (1) Effective Acute Phase Treatment: The percentage of Medicaid beneficiaries who remained on an antidepressant medication for at least 84 days (12 weeks); and (2) Effective Continuation Phase Treatment: The percentage of Medicaid beneficiaries who remained on an anti-depressant medication for at least 180 days (6 months).

> **Numerator: (**1) Number of individuals from the denominator population who remained on anti-depression medications for 84 days or more, over a 114 day period from the initial start of therapy; and (2) Number of individuals from the denominator population who remained on anti-depression medications for 180 days or more, over a 231 day period from the initial start of therapy.

> **Denominator:** Eligible population age 18 years and older, who had a diagnosis of major depression and were newly treated with antidepressant medication, during the measurement time period.

> If the Participant indicates that they elect the Potentially Avoidable ED Use (Washington Health Alliance) outcome measure, the performance expectation is a reduction of 1 percent of potentially avoidable ED use during the performance period. The baseline for the selected measure will be SFY 2018, and will be compared to performance year SFY 2020 (July 2019 through June 2020). Performance will be determined during CY Quarter 3 of 2020. Payment of at least $10,000 based on performance improvement will be dispersed in CY Quarter 4 of 2020 (by December 2020).

Reference: National Committee for Quality Assurance. Antidepressant Medication Management (AMM). Available at: https://www.ncqa.org/hedis/measures/antidepressant-medication-management/

Potentially Avoidable ER Visits: This measure identifies the percentage of all emergency room visits during the measurement year that are potentially avoidable.

Definitions of Emergency Department (ED) / Emergency Room (ER): A section of a hospital or a free-standing institution that is staffed and equipped to provide rapid and varied emergency care, especially for those who are stricken with sudden and acute illness or who are the victims of severe trauma. The emergency department may use a triage system of screening and classifying clients to determine priority needs for the most efficient use of available personnel and equipment. Also called emergency room.

Impact of the measure: This measure assesses potentially avoidable emergency room visits utilization. Emergency rooms (ERs) are an important part of our health care system. For people suffering from a serious, acute problem, ERs help patients get the immediate care that they need. However, not all care that happens in the ER should be happening there. Too many people are using ERs for health problems that can be safely and effectively treated in a primary care provider's office or in an urgent care clinic for a fraction of the cost. Nationally, it's been estimated that up to 40 percent of emergency room (ER) visits are not urgent. Many of these visits occur when patients cannot be seen by their primary care physician[i]. Avoidable use of emergency care contributes to ER overcrowding, a common problem in the United States[ii]. In addition, using the ER for non-emergency conditions contributes to the high cost of health care. ER visits can cost up to ten times more than the same treatment in an outpatient setting.

Eligible Population:

Product lines—Commercial, Medicaid, Medicare (report each product line separately).

Ages—Age 1 year and older as of date of service (ER visits). Report the following age stratifications:

- 1 to 17
- 18 years and above
- Total

Continuous enrollment—No continuous enrollment requirement – include all members who meet age criteria and who were enrolled at any point during the measurement year.

Allowable gap—Not applicable.

Anchor date—None.

Benefit—Not applicable.

Event/diagnosis—An emergency room visit in the measurement year.

Denominator set: All emergency room visits for members aged 1 year and older in the measurement year.

Step 1: Identify all ER (emergency room) visits for members aged 1 year and older (as of the date of service) in the measurement year. (See detailed measure spec for relevant codes)

Step 2: Exclude all ER visits from the denominator that resulted in inpatient admission on the same day (date of service for ER visit is same as date of admission to inpatient facility and the admit and discharge dates are populated). Where there is one or more than one claim for a member that meets the criteria in step 1 with the same incurred date, the denominator count will be one. Claims with the same incurred date count as one in the denominator. (See detailed measure spec for relevant codes)

Numerator set: Number of avoidable ER (emergency room) visits in the measurement year.

Detailed specifications for numerator:

Step 1: From the ER visits identified in the denominator after exclusion, identify all visits with any diagnosis code listed in workbook "Avoidable ER Visits_Final List_ 04 04 2017" at primary position during the measurement year. (See detailed measure spec for workbook)

Step 2: Final numerator population = All avoidable ER visits identified in Step 1. Where there is one or more than one claim for a member that meets the criteria in step 1 with the same incurred date, the numerator count will be one. Claims with the same incurred date count as one in the numerator.

Calculation of the measure: The quality measure is calculated as: Numerator / Denominator X 100

Note: A high score indicates high rate of potentially avoidable ER visits. A lower score is better for this measure.

References: Washington Health Alliance. Potentially Avoidable Emergency Room Visits. Available at: https://wahealthalliance.org/wp-content/uploads/2019/06/2018-Measure-Specification-Potentially-Avoidable-Emergency-Room-Visits.pdf [i]Institute for Healthcare Improvement. Primary Care Access. Available at: http://www.ihi.org/IHI/Topics/OfficePractices/Access/ [ii]Institute of Medicine. 2003. The Future of Emergency Care in the United States Health System. Available at: http://www.nap.edu/openbook.php?record_id=11926&page=4

In 2017, the Potentially Avoidable Emergency Room Visits measure specification was approved for use in the Washington State Common Measure Set and the Alliance's Community Checkup. For the purposes of the WRHAP program, the above measure was modified to include Medicaid patients only. The language below represents the measure as written for implementation by participating WRHAP hospitals.

Measure definition: The Percentage of patient visits to an emergency department for conditions that could have been managed in a primary care or in another non-acute setting.

> **Numerator:** The number of patient (ages 1+) visits to an emergency department for conditions that could have been managed in a primary care or in another non-acute setting.

> **Denominator:** The number of all outpatient visits to an emergency department for Medicaid clients age 1 or older.

Emergency Department Care Coordination Track- Follow-Up Contact

Quarterly Benchmark Rates	
Milestone 2	30%
Milestone 3-7	40%
Milestone 8	45%
Milestone 9	50%
Milestone 10	55%
Milestone 11	60%

Quarterly Patient Contact Rates by Hospital 2018-2020

■B11 Rate ■B10 Rate ■B9 Rate ■B8 Rate ■B7 Rate
■B6 Rate ■B5 Rate ■B4 Rate ■B3 Rate ■B2 Rate
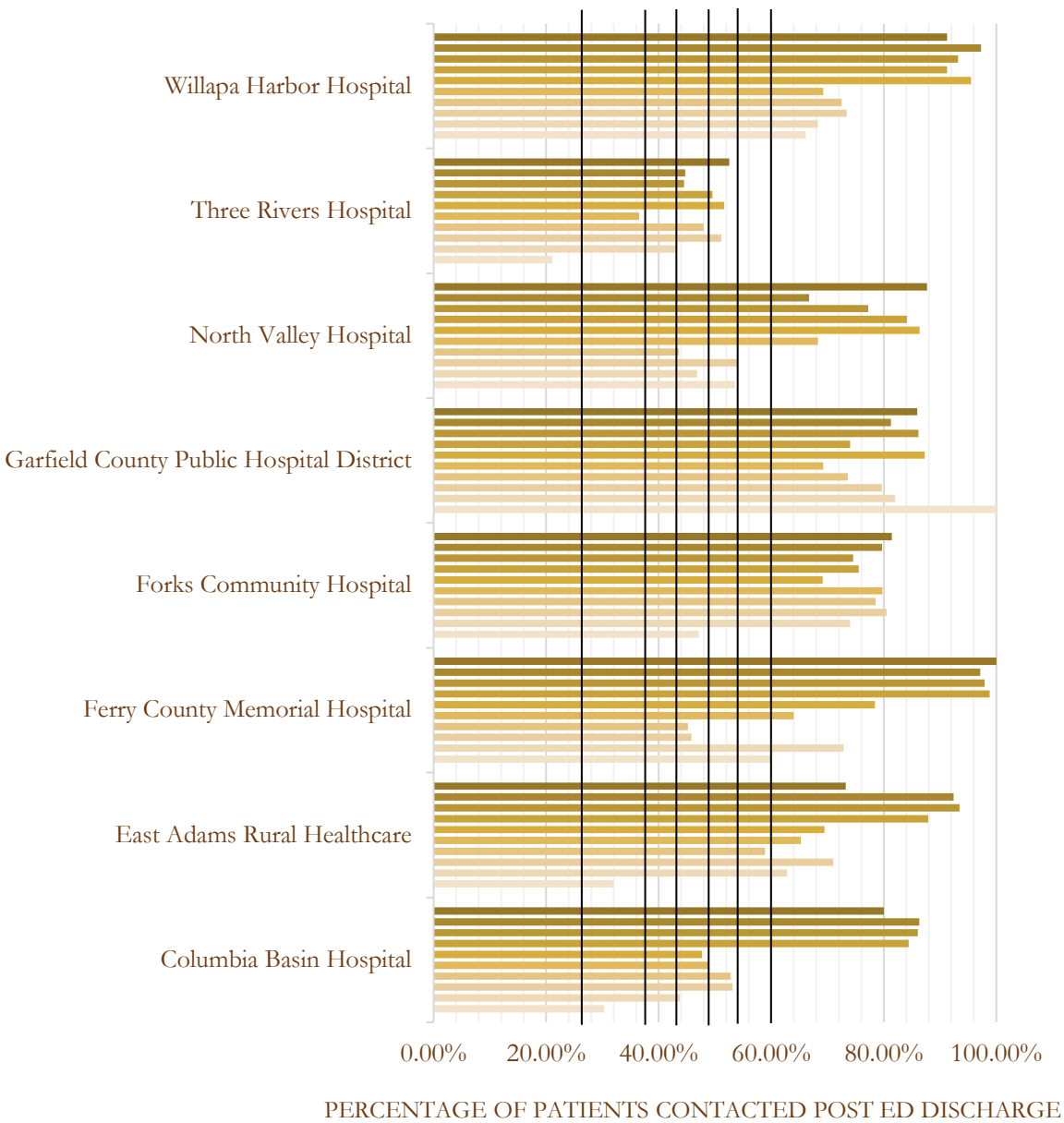
PERCENTAGE OF PATIENTS CONTACTED POST ED DISCHARGE

Willapa Harbor Hospital
Three Rivers Hospital
North Valley Hospital
Garfield County Public Hospital District
Forks Community Hospital
Ferry County Memorial Hospital
East Adams Rural Healthcare
Columbia Basin Hospital

0.00%   20.00%   40.00%   60.00%   80.00%   100.00%

Washington State Hospital Association

Quarterly Patient Contact Rates
by Hospital 2018-2020

Quarterly Benchmark Rates	
Milestone 2	28%
Milestone 3-7	53%
Milestone 8	56%
Milestone 9	59%
Milestone 10	62%
Milestone 11	65%

Legend:
- B11 Rate
- B10 Rate
- B9 Rate
- B8 Rate
- B7 Rate
- B6 Rate
- B5 Rate
- B4 Rate
- B3 Rate
- B2 Rate

Hospitals (top to bottom):
- Odessa Memorial Healthcare Center
- Arbor Health
- Mid-Valley Hospital
- Columbia County Health System
- Cascade Medical Center

X-axis: PERCENTAGE OF PATIENTS SCREENED FOR DEPRESSION (0.00%, 20.00%, 40.00%, 60.00%, 80.00%, 100.00%)
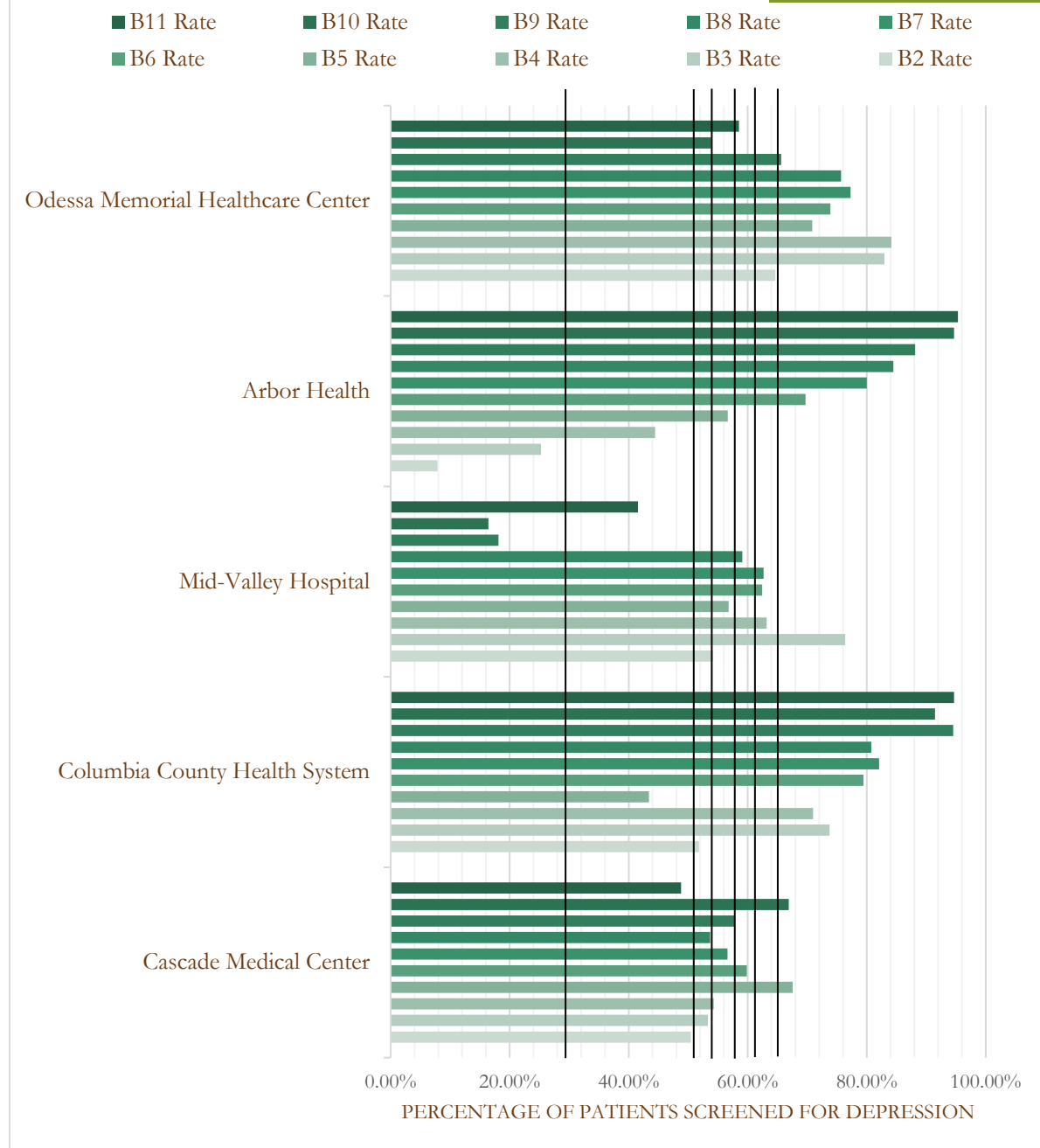
WRHAP Hospital Performance Baseline Metrics, FY 2018

WRHAP Implementation Track	WRHAP Hospital (Proxy for the Hospital District They are Representing)	WHA Potentially Avoidable ED Visits*			NCQA HEDIS Anti-depressant Medication Management (AMM)#				
		Num	Denom	Measure	Num 84 Day	Num 180 Day	Denom	Measure Rate 84 Day	Measure Rate 180 Day
Behavioral Health Integration	Cascade Medical Center	137	772	18%	7	7	16	43.8%	43.8%
Care Coordination	Columbia Basin Hospital	325	2042	16%	10	6	23	43.5%	26.1%
Behavioral Health Integration	Dayton General Hospital	77	548	14%	16	13	28	57.1%	46.4%
Care Coordination	East Adams Rural Hospital	32	245	13%	10	9	13	76.9%	69.2%
Care Coordination	Ferry County Memorial Hospital	86	557	15%	15	10	31	48.4%	32.3%
Care Coordination	Forks Community Hospital	348	2174	16%	8	5	17	47.1%	29.4%
Care Coordination	Garfield County Memorial Hospital	38	220	17%	NA	NA	NA	-	-
Behavioral Health Integration	Mid-Valley Hospital	646	3721	17%	NA	NA	NA	-	-
Behavioral Health Integration	Arbor Health Hospital	202	1277	16%	14	9	27	51.9%	33.3%
Care Coordination	North Valley Hospital	233	1650	14%	NA	NA	NA		
Behavioral Health Integration	Odessa Memorial Healthcare Center	27	140	19%	NA	NA	NA	-	-
Care Coordination	Three Rivers Hospital	242	1209	20%	NA	NA	NA	-	-
Care Coordination	Willapa Harbor Hospital	246	1393	18%	44	35	86	51.2%	40.7%

* Measure production done by the HCA Financial Analytics Section following Washington Health Alliance's (WHA) Potentially Avoidable ED Visit Measure Specs released in 2017.

\# Measure Production done by HCA Analytics, Research, and Measurement Team Using NCQA HEDIS AMM Measure Specs 2019 released by NCQA in 2018.

Potentially Avoidable ED Use: WRHAP Hospitals below selected this outcome measure stewarded by Washington Health Alliance. Defined as the performance target that individual participating CAHs had to achieve was set as a reduction of 1% of potentially avoidable ED use in the period SFY 2018 to the period SFY2020. The measure is calculated as a proportion of avoidable ED visits over all ED visits at these hospitals.

Hospital	Cascade Medical Center	Columbia Basin Hospital	Dayton General Hospital	East Adams Rural Hospital	Garfield County Memorial Hospital	Mid-Valley Hospital	Arbor Health (Morton)	North Valley Hospital	Three Rivers Hospital	Odessa Memorial Healthcare Center
Baseline Year FY 2018: # of Inappropriate/ Total Visits	114/785	290/2,043	87/579	38/328	36/239	494/3,499	188/1,349	234/1,664	273/1,433	24/137
Baseline Year FY 2018: Percentage	14.5%	14.2%	15.0%	11.6%	15.1%	14.1%	13.9%	14.1%	19.1%	17.5%
Performance Benchmark 1, FY 2019: # of Inappropriate/ Total Visits	137/772	325/2,042	77/548	32//245	38/220	646/3,721	202/1,277	233/1,650	242/1,209	27/140
Performance Benchmark 1, FY 2019: Percentage	17.7%	15.9%	14.1%	13.1%	17.3%	17.4%	15.8%	14.1%	20.0%	19.3%
Performance Benchmark 2, FY 2020: # of Inappropriate/ Total Visits	69/732	272/1,902	82/537	37/293	34/207	394/3,534	197/1,362	229/1,660	161/1,177	15/126
Performance Benchmark 2, FY 2020: Percentage	9.4%	14.3%	15.3%	12.6%	16.4%	11.1%	14.5%	13.8%	13.7%	11.9%
Baseline Performance 2: SFY2018-SFY1010	5.10%	-0.11%	-0.24%	-1.04%	-1.36%	2.97%	-0.53%	0.27%	5.37%	5.61%
Target: 1% improvement from baseline	14.38%	14.05%	14.88%	11.47%	14.91%	13.98%	13.80%	13.92%	18.86%	17.34%
Baseline-Target Difference	0.15%	0.14%	0.15%	0.12%	0.15%	0.14%	0.14%	0.14%	0.19%	0.18%
Benchmark Met	**YES**	**NO**	**NO**	**NO**	**NO**	**YES**	**NO**	**YES**	**YES**	**YES**

Anti-Depressant Medication Management: WRHAP Hospitals below selected this outcome measure (NCAQ HEDIS®). Performance expectation is 10% improvement in anti-depressant medication treatment adherence: closing the gap between baseline rate and the HEDIS®90th percentile national benchmarks.			
Hospital	Ferry County Memorial Hospital	Forks Community Hospital	Willapa Harbor Hospital
Baseline 1 FY 2018: # Who remain on medication at day 84/Total prescribed	15/31	8/17	44/86
Baseline 1 FY 2018: Measure Rate 84 Day	48.40%	47.10%	51.20%
Baseline FY 2018: # Who remain on medication at Day 180/ Total Prescribed	10/31	5/17	35/86
Baseline 2 FY 2018: Measure Rate 180 Day	32.30%	29.40%	40.70%
Performance Benchmark FY 2020: # Who remain on medication at day 84/ Total prescribed	15/31	17/33	14/22
Performance Benchmark FY 2020: Measure Rate 84 Day	48.40%	51.50%	63.60%
Performance Benchmark FY 2020: # Who remain on medication at day 180/ Total prescribed	8/31	13/33	8/22
Performance Benchmark FY 2020: Measure Rate 180 Day	25.80%	39.40%	36.40%
NCQA 90th Percentile Benchmarks: 84 Day	64.72%	64.72%	64.72%
NCQA 90th Percentile Benchmarks: 180 Day	49.24%	49.24%	49.24%
Performance Rate: to Achieve 10% Improvement Target 84 Day	50.02%	48.82%	52.52%
Performance Rate: Achieve 10% Improvement Target 180 Day	33.96%	31.39%	41.55%
Benchmark Met: 84 Day	NO	YES	YES
Benchmark Met: 180 Day	NO	YES	NO

The below framework was extracted from the CDC's Program Evaluation Framework and was used to guide the development of both the clinical survey questions and the focus group guide for WRHAP participants. This framework was also applied to the overall evaluation of the program.

What is being evaluated:

Implementation of the quality measures under the Washington Rural Health Access Preservation Program (WRHAP)

Criteria to judge program performance:

Were activities implemented as planned?

- Frequency: Were you screening/contacting patients based on evidence-based standards of care (e.g., every patient, every time?) If not, explain what your process was and why.
- Location: Were you successful in implementation in both the in-person and virtual settings of care? (Including phone-based and virtual platforms)
- Duration: Were you successful in developing a plan and starting the implementation on time? Were you able to maintain the program for the expected duration?

To what extent was there program fidelity?

- Adherence to the measure?
- Exceptions?
- Regional variation in interpretation of the measure?

What standards of performance on the criteria must be reached for the program to be considered successful?

- Staffing in place?
- Process/protocols in place?
- Buy-in?
- Meeting benchmarks?
- Workflow and process protocols in-place? Do leadership and staff responsible for screening or patient contact understand and adhere to the workflow/process implanted within your facility?
- Please provide a summary of the workflow for your organization.
- Have you met the minimum benchmark(s)?
- Have you seen quantitative improvement in your rates?
- Qualitative anecdotal evidence that the program is well received by staff, providers, patients?
  - Do your patients/staff/providers understand the purpose of the measure?
  - What is the general workforce buy-in to continuing the program long-term?

Short term outcomes met?

- Staff in-place

- Screening or making calls.
- Developed protocols/process for implementation.
- Staffing plan in place

Mid-term outcomes met?

- Measure benchmarks being met?
- Staff adherence to process?
- Ongoing process improvement occurring within each organization?
- Sustainability plan under development?

Long-term outcomes?

- Sustainability plan in place for the continuation of work started under WRHAP?
- Plan to expand the program to other departments, patient populations, or service lines?
- New community partnerships because of the program? (If not, is this in your long-term plans for sustaining implementation efforts)?

PROGRAM EXIT SURVEY GUIDE—CLINICAL

Survey Key	
Questions 1-15	Completed by all respondents
Questions 16-23 (first set)	Completed by depression screening participants only
Questions 16-22 (second set)	Completed by emergency department follow-up participants only

Clinical Implementation Survey:

This survey will take XX minutes to complete. The purpose is to evaluate Washington Rural Health Access Preservation Program (WRHAP) over the course of its three-year implementation period.

Recognizing that not all individuals have participated in the program since it began, please answer the following based on your knowledge of the program.

1. Role
2. *What is your organization name? [1 LINE TEXT BOX]
3. *What is your role within the organization? [1 LINE TEXT BOX]
4. *What is your role(s) within the WRHAP program? [LONG TEXT BOX]
5. *How long have you personally been a participant in WRHAP? [1 LINE TEXT BOX]
6. Please list contact info of anyone else outside of C-suite who should answer the survey questions within your organization. [OPTIONAL 1 LINE TEXT BOX]
7. *Please list the job titles of other staff actively involved in the implementation of WRHAP within your facility. [LONG STRING TEXT BOX]
8. *Is there appropriate staff in place to sustain the program into the future? [DROP DOWN-EITHER or LOGIC TREE]
   a. YES/NO
      i. If NO, please explain what is needed to ensure appropriate staff levels are in place.
9. *Do you have a staffing plan in place to address changes in the workforce and unplanned absences that will allow the program process to continue operating without interruption (including patient contact/data collection/quality improvement)? [DROP DOWN-EITHER or LOGIC TREE]
   a. YES/NO
      i. If NO, do you need support from WSHA or examples from peers of their staffing plans for the program? YES/NO
10. *Please rate the level of staff-buy to the measure and its purpose inpatient care. [BULLETS]
    a. Likert Scale (High to Low Buy-in)
11. What, if any outstanding barriers remain in garnering full participation from providers and staff? [LONG STRING TEXT BOX]
12. What, if any barriers remain in patient buy-in to accepting contact/screening as part of routine care? [LONG STRING TEXT BOX]

13. *Has this program been implemented across all-payer patient populations? [DROP DOWN-EITHER or LOGIC TREE]
    a. YES/NO
        i. If NO, do you plan to expand beyond Medicaid patients? YES/NO
14. Please rate the overall success of implementation of the WRHAP program within your organization.
    a. Likert scale (Highly to Not Successful)
15. *Select the measure you are responsible for reporting to receive incentive payments tied to the program. [DROP DOWN-Either or Logic Tree]
    a. Implementation of depression screening with a follow-up plan documented in the clinic setting.
    b. Follow-up contact within seven days of patient discharge from the emergency department.

---DEPRESSION MEASURE ONLY---
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16. *Briefly explain how often you are screening patients for depression. (e.g., every patient/every time, annual well visits, etc.) [LONG STRING TEXT BOX]
17. *Regarding the screening frequency, please list any visit types always excluded from the process (e.g., follow-up appointments, sick visits, etc.) [LONG STRING TEXT BOX]
18. *Were staff and providers successful in adhering to workflow protocols established within your organization?
    a. YES/NO
19. Please explain any reasons why staff were unable/unwilling to comply with the established protocols? [LONG STRING TEXT BOX].
20. *Do you plan to continue screening for depression within your clinic/RHC after the program ends? [DROP DOWN-EITHER or LOGIC TREE]
    a. YES/NO
        i. If NO, please explain why and how you will identify patients at risk for depression?
21. *Briefly explain what impact COVID-19 has had on your ability to screen patients for depression and document a follow-up plan.
22. Describe any outstanding challenges you are experiencing with depression screening as a tool to identify at risk patients.
23. *How are you ensuring equitable access to screening and follow-up care for patients diagnosed with depression?

---ED FOLLOW-UP MEASURE ONLY------------------------------------
16. *Do you plan to continue with, modify, or use a different measure to continue monitoring patients post-discharge once the program has ended? [DROP DOWN-EITHER or LOGIC TREE]
    a. Continue with/Modify/Use Different
        i. If Use Different, please explain which measure you will use going forward [LONG STRING TEXT BOX]
17. *Describe any changes to your ED readmission or utilization you have observed since implementing follow-up calls.

18. *During the program, did you implement any other quality measures that could potentially impact ED readmission rates or utilization?
    b. YES/NO
    c. If YES, please list the measures you think would impact ED utilization and/or readmission rates.
19. Please explain what, if any, impact COVID has had on your ability to successfully contact all patients leaving the emergency department.
20. *What plans are in place to reduce potential inequities in patient follow-up?
21. Describe any remaining challenges that you face with sustaining contact with all patients discharged from the ED.

Under this measure, patients who were called three times but unavailable were considered "contacted". Please answer the following questions about this subgroup:

22. Based on your knowledge of the data reported in QBS, how much of your patient population leaving from the ED falls into this category?
    d. Almost all/more than half/half/less than half/almost none

Describe how you follow up with patients if they cannot be contacted through traditional telephone attempts?

PROGRAM EXIT FOCUS GROUP GUIDE—EXECUTIVE LEADERSHIP

1) The implementation and expansion of behavioral health and care transitions were aided by incentive payments for the duration of the program. With incentives ending, do you have what you need to see the program continue?
2) Anecdotally, do you feel that the funds provided via incentive payments were sufficient to achieve the quality improvement/service expansion aims of WRHAP?
   a. Why/why not?
3) Please share your strategy for sustaining the program and/or expanding the program once incentive payments are gone.
4) In prioritizing organization-wide strategic goals, how does the work you accomplished under WRHAP rank?
   a. High priority: We have a timeline; staff plan and budget for next steps.
   b. Medium high priority: The aims of WRHAP are important and we are discussing a plan while looking for path forward.
   c. Medium priority: We have had some discussions but no clear path forward or resources to dedicate at this time.
   d. Medium low priority: This may be something we consider will later or lean on partners to achieve.
   e. Low priority: We have no interest and/or resources to dedicate to sustaining the program. Or we are looking at other services/gaps that better align with our community's needs.
5) Please tell me of any value-based payment arrangements you have?

      a.   Are you willing to consider additional VBP arrangements that align with the aims of WRHAP?

      b.   Prompt: Interest or existing participation in ACOs, discussion with MCOs or private insurers?

6) The COVID response has required intensive focus from all our hospitals. How has COVID impacted your timelines for strategic planning and making additional efforts towards better care coordination and access to behavioral health services?

7) What worked well with the program? Share one positive aspect about the experience.