Better Health Together (BHT) Meaningful Provider Engagement Summary Report

A Summary of Provider Input Used to Inform Medicaid Transformation Demonstration (MTD) Project Selection and Planning, and to Design BHT's Long-term Meaningful Provider Engagement Policy and Strategy

Overview

The BHT Meaningful Provider Engagement planning process involved several tiers of activity designed to secure input into the selection and planning of MTD projects and to yield a recommended policy and strategy for the BHT Board to consider adopting for ongoing meaningful engagement of providers in future Accountable Community of Health (ACH) and MTD activities. This report details findings from the first phase of activity: provider key informant interviews and focus groups.

Methodology: Provider Key Informant Interviews and Focus Groups

In total, 21 providers participated in key informant interviews and 24 providers participated in three separate focus groups to inform the selection and planning of MTD projects for the BHT region and to provide opinions and ideas for establishing a long-term meaningful provider engagement strategy for the activities of the ACH. Names of interviewees and host organizations for focus groups are included in Appendix A. Interviewees and focus group participants represented a divers cross-section of providers according to the following criteria:

- Geography (rural, urban, tribal)
- Race and ethnicity
- Health system/practice size and model (large, small, independent, university-affiliated, community non-profit, etc.)
- Sector representation (medical, behavioral, substance abuse, oral health, public health, MCO, etc.)
- Practice type/target population served (pediatric, geriatric, family medicine/primary care, internal medicine, tribal, homeless, psychiatric, etc.)
- Social determinants organizations (housing, food security, social services)

Provider Input Regarding Medicaid Transformation Demonstration

When asked the open-ended questions "what are the biggest challenges facing providers now," "what are the biggest barriers to providing whole-person care that improves health," and "what would make it easier/more efficient for providers to provide whole person care that improves health," the following themes emerged:

- **TIME AND ADEQUATE REIMBURSEMENT:** The most common theme, cited in one form or another by all providers in this research process, was "**lack of time and reimbursement to treat patients holistically**."
    - **Time.** Providers feel they lack sufficient time to treat: the whole person; more than one issue at a time; complex medical conditions; related social needs; or even a single medical issue adequately. They indicated that the "productivity model" is still the standard, and that even though there is a trend toward quality and value, they are still paid on a fee-for-service basis, which constrains them from effectively and efficiently meeting the comprehensive needs of their patients. Comments included:
        - "You can't do anything meaningful or effective in 15-20 minutes, much less treat the holistic needs of patients with multiple, complex conditions."
        - "My barber spends more time cutting my hair each time I see him (30 minutes) than I am given to treat a patient with diabetes and other complex health issues and multiple social needs."
    - **Reimbursement:** Providers cited "piecemeal" reimbursement as a detriment to patient health. One provider suggested that they are expected to deal with only one "problem" at a time for a patient, and are reimbursed in this way, when there are "6 interrelated problems—3 acute and 3 chronic—not to mention social needs, and we have 15 minutes to work some kind of a miracle."

- **INFORMATION EXCHANGE:** All providers indicated that information exchange amongst the various providers (clinical and community) was a significant barrier to their ability to provide quality care that makes a difference. Challenges cited included:
    - **Lack of Infrastructure and Interoperability for Health Information Exchange** challenges, including nonexistent, insufficient, or inefficient connections between or among: hospitals and primary care; behavioral health and primary care; primary care and community supports; primary care and specialty care. They noted the inability of Electronic Health Records to effectively interface with one another, and the lack of real-time access to diagnosis and treatment information at care transitions (particularly from inpatient discharges or Emergency Department visits) as barriers to effective whole-person care. Even when providers send referrals and patient information to specialists, they do not receive return information on diagnoses or treatment.
    - Comments included,
        - "We are doing our best as providers but we're driving blind a lot of the time."
        - "We are asked to collaborate on behalf of our patients but don't have the tools to do so out of our own systems."
        - "I need real-time ability to talk to other providers, exchange information, and treat the whole person at the time they need to be treated…when they are in my office."

- **ADMINISTRATIVE BURDENS:** Providers universally reported administrative burdens as one of the greatest challenges to their ability to provide excellent care and to meet the needs of their patients. They cited:
    - Too much documentation and administrative roadblocks to providing good care. Many providers noted the constant need to provide double, triple, or even quadruple data entry and documentation, noting that "it all takes away from our ability to treat the patients…and the data they are asking for isn't actually making a difference"
    - The constant need to find workarounds for data systems, various MCO coverage requirements
    - One provider said, "I spend more of my time typing rather than treating patients" (this sentiment received significant affirmative feedback).
    - Another provider suggested, "Each time they ask us to track one more thing, they say, 'it's just one more box to check,' but they don't realize that if you're only checking boxes, you can't treat the patient"
    - Finally, one physician noted, "if you want to see change happen, pay for the right activities that produce the right results and if you can't do that, at least unburden the provider who will be doing the work."

- **CARE COORDINATION AND CLINICAL/COMMUNITY LINKAGES:** Providers across all practice settings and disciplines cited significant challenges due to the lack of resources for care coordination, care transitions, and social determinant services that support optimal patient outcomes. Most interviews and focus groups shared some version of one provider's comment that "we spend more of our time being a social worker than a physician." Providers cited specific challenges, including:
    - **Provider Time Constraints for Effective Information Exchange**, particularly inadequate time to consult with other providers both within systems and across systems to meet the diverse needs of patients, and insufficient time to consult with family members on behalf of certain populations (children, elders, and at-risk populations such as those with chronic behavioral health issues). One provider noted, "even when I do get detailed patient information, I spend 20 minutes reading what I need to in order to treat the patient and that's how long I'm allotted for a patient visit."
    - **Resource Barriers for Information Exchange**, including the lack of reimbursement provider to provider consultation, care coordination, and family consults. Providers universally cited the inability to effectively coordinate care among the full care team and the various community providers and family members necessary to provide whole person care.
    - **Challenge of effectively integrating additional care coordination into existing clinic medical teams** (e.g., not enough staff to do the work, not enough funding to pay the staff, not enough training to revise patient and team flows, lack of space to provide these services).
    - **The need for immediate/real-time and co-located services**, particularly for behavioral health clients and the homeless (often patients fall into both categories), in the words of one provider: "in order to keep them from the revolving door of Emergency Department visits, inpatient hospitalizations, or incarceration." Co-located physical, behavioral, addiction, dental, and support services would vastly improve patient outcomes. Providers noted that these individuals need far more support for social needs such as transportation, supportive services, housing, employment, food security, and timely

addiction treatment. As one provider stated, “a referral two blocks away is often the same as a referral across town, and an appointment in two weeks is as good as no appointment at all.”

- **Consistently staffed and funded teams providing social determinant services and clinical supports** (housing, food security, transportation), as well as preventive education and support (dietitian, physical activity, health coaching) in order to advance health goals, but, as one provider noted, “this costs money and no one pays for it.” Another provider stated, “our emphasis now is dx and rx, not whole health…we need an expanded care team, the space to provide these resources, coverage for things that make a difference (like care coordination, dietitians, physical activity, social supports), and support getting the processes and integration set up in the clinical setting.” When asked where this function should reside, most providers preferred a community-based approach to care coordination that seamlessly and effectively integrates into the clinical setting. One provider noted, “this should be housed outside of our or anyone's system and should follow/serve the client.”
- **Consistent assessment of needs that impact clinical outcomes before patients see their providers.** Clinical settings could benefit from a care coordinator or community health worker who can perform full assessments of patients as they walk in the door, to identify if there are issues outside of the clinic that will prevent patients from being compliant and successful with treatment recommendations. As one provider suggested, “we need to address their hierarchy of needs, because if I tell them to go to the gym and they can’t afford rent this month, nothing gets solved.” And another noted, “no amount of treatment for diabetes will help if the patient is homeless and doesn’t have socks and shoes that keep their feet dry.” Another providers noted that “patients’ number one complaint is ‘the providers aren’t listening to me,’ when part of the problem is the patient can’t clearly articulate what they want or need…they need someone helping them do this so the provider can fully understand those needs and address them.”
- **Additions to the care team.** The most commonly cited providers that need to be added to the care team to provide whole-person care were: behavioral health providers, community health workers, care coordinators, and dietitians.

- **POLICY BARRIERS:** Providers repeatedly referenced policy barriers that inhibit whole-person care or prevent providers from effectively coordinating care on behalf of their patients. Examples of policy barriers included:
  - **Pronounced restrictions in provider coordination with behavioral health and substance abuse treatment** and their coordination with the medical care system. This was the most universal concern expressed by providers from all practice settings and disciplines. One provider noted, “we are handcuffed by legislation that actually prevents us from effective integration.”
  - **Inability to provide simple resolution of issues without additional billing and documentation.** Examples included not being able to provide an uncovered service that could resolve a simple need (e.g., providing a bandaid or gauze to a patient), or the requirement that you must attempt to collect co-pays for federally-funded programs when it costs the providers more to try to collect than it does to simply write off a copay.
  - **Required spenddowns for behavioral health clients.** Such practices profoundly interrupt care and result in unnecessary hospitalizations. Behavioral health clients could

be better served if there were funds available to draw on during that time to maintain continuity of care. One provider noted, “this practice is contrary to recovery"

- **Transitioning clients out of support services when they make advances in their health and life goals.** If they get jobs or make certain incomes they lose supports they need to stay healthy and stable, so advancing toward health and life goals “often pushes them out of services and puts them back on the streets or lands them in the hospital., only to start the cycle again.”

- **CLINICAL, COVERAGE, AND ACCESS CONSTRAINTS:** Providers note that there are a variety of clinical and coverage restraints that inhibit their practice of whole-person care. Examples include:
  - Formularies are too restrictive, particularly for specific issues (e.g. Suboxone treatment), and they are different from plan to plan, resulting in providers saying they have to “bob and weave all the time and constantly research alternative options for prescribing rather than treating the patient” (and again they cite they are not reimbursed to research alternative medications)
  - Medicaid doesn’t cover additional treatments for preventive and chronic health condition management (e.g., dietitians, physical activity, pain management modalities other than prescriptions) that commercial plans will pay for. One provider suggested that this is “discriminatory medicine”
  - Many providers indicated lack of access to drug addiction treatment (or long delays to enter treatment) as a major problem, as it causes us to “miss the window of intervention” when the patient is actually ready to enter treatment.
  - Patient transitions across the various MCOs create significant hardship because providers often have to create new treatment plans because the previous one doesn’t meet the new MCO’s requirements.
  - Access to care and medications is a challenge based on MCO panels—particularly when patients change MCOs, they are told who they can see (most often NOT a long-term provider they trust and who knows their history) and where they can get their medications (which often is NOT in their own neighborhood, causing more barriers to compliance).
  - Insufficient number or well-trained providers
    - Respondents indicated that there “are not enough providers who are well trained; advanced care providers have helped, but it’s not enough. There are so many things I do that someone else could do.”
    - Provider recruitment and retention is a major challenge, particularly in rural areas and in behavioral health. Respondents reported “poaching” of existing clinical staff from rural and safety net providers to go work for larger health systems and MCOs (better pay, better benefits, better quality of life), and an exodous of providers from rural and behavioral health safety net entities due to provider burnout and the challenge of trying to do patient- and mission-centered work amidst ever-growing caseloads and administrative burdens.
  - A variety of providers indicated fear that progress toward better integrated care teams would be thwarted by lack of access to new types of providers (e.g., community health workers) or administrative or policy challenges to allowing various care team members to work at the top of their certification/licensure to better meet patient needs. One provider noted, “we need to have all of us practicing at the top of our licenses so the physician/provider can help facilitate whole person care.”

- A number of providers also cited the critical nature of culturally-sensitive care, particularly citing the need for more effective partnerships with Tribes and refugee populations to define culturally-appropriate care. A number of respondents also called out the need for culturally-appropriate mental health and substance abuse treatment services, indicating there are few resources that effectively treat the whole person with this type of sensitivity.

- **ADDITIONAL CONCERNS: Providers surfaced a variety of other challenges to providing whole-person care:**
  - Change fatigue and burnout was cited by many respondents, with comments such as
    - "Burnout clouds our ability to treat the whole patient," and "adapting to these constant changes is almost impossible with all we're asked to do."
    - "Burnout is high, the treadmill is running faster than I have ever dealt with before. Being a doc has changed to a job more than a vocation."
    - "If you're going to add something, take something away. We can't just keep adding to what needs to be done. Providers are already too busy."
    - "Yes, change fatigue is a problem. We need to rally the troops to make system-wide change possible. It can't just rest on the shoulders of providers. We have to have a strong, mission-driven culture that energizes."
  - "We want to be able to just communication with our patients…there are too many lawyers and administrative layers that keep us from simply treating them," and "create ways of working with patients that work for patients."
  - Rural areas face unique and costly challenges for things like integration of behavioral health into clinical settings. One provider noted, "public hospitals aren't reimbursed sufficiently for this—they are doing so much on their own dime, and they can only do that for so long."

Once the open-ended questions presented the above-articulated themes, interviewees and focus group participants were asked specific questions about several focus areas in the Medicaid Transformation Demonstration, sharing the following feedback:

- **VALUE BASED PURCHASING:** When asked about the extent to which providers have the knowledge, skills, and readiness to move toward Value Based Purchasing, the following themes emerged:
  - The most common first response to the question about VBP was always some version of, "can someone please tell us what this means?"
  - Respondents felt that large systems and FQHCs are well poised to meet the new requirements under VBP because the former have significant administrative layers to support it and the latter have been working in patient-centered and value-based models long-term.
  - Participants felt that individual providers and smaller clinics/practices and independent providers probably have no idea what it means and/or how it will actually impact them or their patients or their practice of medicine, and they would not have the resources to manage the data and the systems required for VBP. There were concerns that smaller practices and rural providers would either simply close up shop or join one of the larger systems under duress, creating more dysfunction in the system.

- Providers indicated that they believe they are measured on too many metrics already (many of which are not aligned with what is really important), and that more are being added, creating more administrative burden and moving us further away from treating patients holistically.
- A number of providers were especially concerned about behavioral health metrics--they aren't convinced that there are "really good outcome measures" for behavioral health, yet integration is a huge (and critical) part of the Demonstration. And that the administrative and time burden of tracking metrics would continue to decrease time and focus for good patient care.
- Others were concerned that providers are being "graded" on outcomes that they don't have control over, in particular the social determinants factors that impact patient compliance with treatment recommendations and medications (this was particularly cited with regard to behavioral health clients). This concern was expressed across health systems and provider disciplines.

- **INTEGRATED CARE MODELS:** When asked the extent to which providers have the knowledge, skills, and readiness to move toward integrated care models, the following themes emerged:

  - Providers understand the integrated care model, they are constrained by many of the previously-listed issues (health information exchange, space, training on new care delivery models, workforce).
  - Again, providers noted that large systems are better poised to integrate behavioral health and physical health needs (as opposed to smaller clinics or independent providers), but no one is poised to support the social determinant needs that make integrated care really work. One respondent said, "health care systems are thinking about health care delivery only, but social determinants is really where we can make a difference. Providers aren't ready because they don't know how to help with food insecurity, housing, and things like that."
  - There were specific concerns about effective treatment for co-occurring mental illness and substance abuse, with some respondents noting that providers are ill-equipped to deal with this population and financing, policy, and system issues create "almost insurmountable barriers" to treating this population effectively. One provider summarized concerns expressed by several others about "the lack of scientific evidence of some of what is done in the behavioral world."

- **REDUCING EMERGENCY DEPARTMENT VISITS FOR NON-EMERGENT REASONS:** When asked what they thought would help reduce ED VISITS for non-emergent reasons, providers offered the following feedback:

  - Co-located services or transportation to services, and same-day access to care (particularly for high-risk behavioral health and chronic condition patients)
  - Real-time health information exchange and provider consult ability for those at highest risk.
  - Better medication education and reconciliation at discharge with appropriate follow-up after discharge to ensure patient compliance and access to medications
  - Incentives for primary care providers to continue practicing in primary care and incentives for seeing Medicaid patients. Same-day access to primary care and reductions in wait times to secure/see primary care providers. One provider noted, "there is incredible demand and very limited resources for effective primary care."

- Better access to same-day behavioral health services. As one provider noted, “if a patient has to schedule 3 weeks out to be treated for anxiety, the ED is their natural next step.”
- More effective and comprehensive care coordination for high utilizers (primarily behavioral health and significant chronic conditions), focusing on social determinants of health and building a trusted relationship that can help coach them to utilize resources more effectively and efficiently for their health needs and life goals.
- Diversion strategies that pair mental health professionals with EMS providers and police officers to avoid ED visits for non-emergent reasons and route patients into integrated care (primary care/behavioral health models) with robust care coordination for social supports. (One provider noted that policy and reimbursement changes would be needed to implement such strategies. This individual also noted “diversion isn’t the goal…appropriate, holistic, patient-centered care is the goal!”)
- Extended hours for primary care, more urgent care access, 24-hour phone care, and “behavioral health urgent care” models.

- **THE OPIOD CRISIS:** When asked what they thought would make the biggest difference in addressing the opioid crisis, providers shared the following comments:
  - Providers across all types of systems and practice areas indicated that we need more treatment modalities (options, coverage for, providers) to treat pain without prescribing opioids, including pain management specialists, massage therapy, physical therapy, acupuncture, etc.. As one provider noted, “they want us to stop prescribing and these patients with real pain issues don’t have alternative modalities that are covered.” Another stated, “The Health Care Authority’s approach to the opioid crisis is causing more problems for caring for the whole patient because we don't have other modalities to treat them.”
  - Providers need to see the data about prescribing practices and how they measure up to others, along with coaching on other treatment options where outliers exist.
  - “We need real-time access to the PDMP system through EHRs. Access after the fact doesn’t help.”
  - Across health systems and areas of practice, providers noted that for those addicted, we need more ready access to treatment, including better policies and coverage for MAT and better ability to prescribe Suboxone.
  - One provider (to the agreement of others in the room) stated “We must de-stigmatize the diagnosis and treatment of addiction. We don’t stigmatize diabetes or high blood pressure as a diagnosis…addiction should be similarly de-stigmatized.”
  - Patients who are ready to enter treatment need immediate access to substance abuse treatment options and more comprehensive funded addiction counseling and support.
  - Providers in all focus groups indicated that treating pain as a vital sign created this dynamic and, as one participant noted, “the pendulum needs to swing in the other direction…we need to face the problem we have created.” They called for provider education on effective pain treatments and access to appropriate services and supports for patients, balanced by patient education and support and social determinants supports to help treat underlying causes and avoid addiction.

Provider Input Regarding Long-term Meaningful Provider Engagement Strategy

Ideas for Provider Engagement

General Engagement and Communication Strategies

When asked their ideas on "which engagement strategies would be most effective in reaching providers for their input and ideas into the MDT and the long-term goals of the ACH?", the following themes emerged:

- **COMMUNICATE CLEARLY, CONCISELY, AND CONSISTENTLY:** The vast majority of respondents indicated that BHT will need to place strong emphasis on communicating more effectively and methodically with providers. As one respondent suggested, "Create a solid communication strategic plan that will drive them to engage." Themes included:
    - Build on current strengths
        - BHT was commended by many respondents for their demonstrated commitment to go out into communities and connect with partners (e.g., traveling to rural communities and having one on one meetings with partners throughout the region).
        - There were repeated references that BHT has made important progress in recent months focusing on Tribal relationships.
        - One participant suggested, "it's critical to continue this focus on rural and Tribal partners. Don't treat rural communities and Tribes as afterthoughts in this process."
    - Build name, mission, and trust recognition among providers:
        - "While there is good "brand identity" in general, especially among current partners and administrators, front-line providers (especially medical, dental, and mental health providers, as opposed to social determinants providers) don't know who BHT is or why they should care.
            - "Medical providers have no idea what BHT is. There's absolute lack of recognition of what the ACH or the waiver is doing, so there's no platform to build engagement on. Those who are seeing patients don't have an understanding of why it's important and why they should pay attention."
            - "It's all still pretty fuzzy to most, if not all, providers if they're not actively leading an arm of this work."
            - "BHT does a great job of communicating with the administrators, but what we need is clear communications with providers about how this impacts their patients, their practice, and their paycheck."
            - "Providers need to be educated on what the waiver is and is not (e.g., it is not a grantmaking opportunity), and they need clear, consistent

communication with opportunities to ask questions and determine 'what's in it for them and for their patients.'"

- Of note. Several respondents indicated that some of the current communications "can feel like marketing rather than engaging. We want people wanting to lean in, not feeling 'sold' on something."

- Focus on the unique value proposition for each audience or individual
  - "Always focus communication and meetings on the 'why should I be here or care' game—people need to know why they're being asked to do something and how it will affect them/their practice. This needs to be standard for all communications and meetings—highlighting the value proposition and making good use of people's time and expertise."
  - "Keep the value statement up front in all communications and keep reminding people in clear language of exactly what you are making a decision on and why it's important to them."
  - "Sell the benefit. Tell me the value proposition for my patients, for me as an individual practitioner, and as a practice/organization. This is where the engagement will happen."
- Share what you do know when you know it
  - Most acknowledged that BHT is in a challenging role, disseminating information that is constantly changing or slowly emerging at the state and federal levels.
  - Still, providers suggested, "even if the HCA isn't definitive on something, say 'here's what we DO know, here's what we're thinking, the timeline we're anticipating, and the next decisions we will be making based on what we know now."
- Use the right language for the audience and purpose of communication
  - The most commonly cited suggestion for improving communication was summed up by this provider: "Share key information in 'plain speak' for all audiences." Many respondents shared similar comments—keep communication short, simple, and tailored.
  - Several participants suggested the "three bullet rule," with providers themselves suggesting they don't have the time (or won't take the time amidst their other priorities) to read more than that unless they feel drawn in by a topic. The 3 bullets should introduce the key information and provide links to where people can get equally concise but more detailed information on each topic. (Of note: several respondents specifically suggested NOT directing people to the toolkit or other state resources, as they are too convoluted).
  - "Ask physicians, PAs, ARNPs, etc., what kind of language would make it more likely that their respective groups would listen, and then use it."
  - "Remember that BHT has the conversation every day every week. It is easy to forget what you have shared with different audiences…find a way to make sure that everyone gets the key information."
- Respect and rely on organizations and providers who do this work and have done it long-term
  - Rely on providers who have been doing this work and who are the experts in their respective fields to help inform the right communication and engagement approaches.

        - "BHT is the newbie in this landscape. Consult the people who have been holding the risk and contending with the challenges for 25 years. Respect the expertise of established institutions and partner with them to innovate."
        - One person shared a contrary opinion to the above, stating, "We need to mine every corner for changemakers, interesting ideas, and energy. Don't ask the old people who have been doing this for 20 or 30 or 40 years and never changed a thing in that time." Several others suggested similar requests to "hear new voices" and "seek out those who haven't been asked for their opinions."
    - Listen both to the supporters and to the dissenters
        - "Really listen to the concerns of providers and balance the hope inherent in innovation with the real challenges and fears that they have. There is some feeling that if you're asking tough questions or posing counterpoints, you'll be disregarded as a naysayer. But we need to examine all sides of these issues, not just the positive ones."
        - "Be careful to listen, not just tell."
        - "Have honest, bold conversations with those who aren't at the table, asking them, 'what will it take to get you there?'"
        - Other providers suggested being responsive to what you hear by dispelling myths in respectful ways and using conversations about fears to inform thoughtful project research and planning.
    - Be specific, brief, and choose the best time to engage
        - "Be very clear about telling providers, 'here is what we are asking you to do.' They are confused because the messaging hasn't been clear."
        - "Providers need to be told what is being asked of them so they can test it against their business model, staffing model, and what it would take to be successful operationally. This isn't happening. Or not well."
        - Take into consideration provider time constraints and invite them into the planning and the process "when they can actually make a difference"
            - "Don't have open-ended, blank slate conversations. Give us something to respond to based on our experience and our patient's needs."
            - "The 'so what do YOU think we should do' conversation won't work. It's a waste of their time and you run the risk of losing their engagement long-term. Bring ideas and suggestions that providers can respond to."
    - Go to them
        - As one individual suggested, "find places to intersect with providers where they already are. Where do they meet? Go to them."
        - Ideas included medical staff meetings, grand rounds, conferences or meetings like the Primary Care Update and CME events.
    - Consistency and transparency are both important
        - "BHT has a near-impossible task to try to keep communication and transparency up with the ever-changing landscape at the state. They do a great job with what they've been given. AND it will be helpful for them to keep refining their communication approach to be more methodical, consistent, and transparent."
        - "We need more consistent communication, overviews, and clear pictures of how decisions will be made and projects will move forward. For example, on a weekly basis, saying, "here is our understanding of the latest and greatest."
    - Electronic communication improvements

        - Numerous respondents indicated that the BHT website needs to have simple-to-find and easy-to-understand information for each audience based on their needs (front-line providers, administrators, consumers, community partners, etc.).
        - Providers and partners are also asking for "push" notifications of key decisions, timelines, opportunities, or outcomes in carefully constructed and very concise email or web alerts. (Recall the "3 bullet" rule referenced above). Note: given that BHT sends out regular updates, perhaps this request could be best honored with a provider-focused template and mailing list and/or sent out through trusted messengers through their channels (e.g., SCMS and other associations).
        - Providers are requesting consistent reporting on goals, timelines, benchmarks, and successes. "Knowing progress has been made will make the biggest difference in long-term provider engagement."
    - Learn from communication errors and be open to guidance on how to do better
        - One example cited by many respondents was the method used to communicate the LOI process for project ideas, in particular how this process would be used to inform project selection, what methodology would be/was used for "scoring," and what the next steps would be. In general, community partners felt either confused or dissatisfied with the communication about this process, which led to questions about transparency (or an acknowledgement that others could have questioned transparency even if the individual respondent didn't feel this way). This was cited as a "learning lesson" regarding how to approach communication more carefully ad methodically for future ACH activities.
        - Another example cited was the invitation to providers to join the integrated care team, where one provider noted, "I received an email that presumed that I would take part, but this was the first I had heard of it. Even though I'm interested and would likely want to be involved, the wording of the email was off-putting to me. And it seemed to come out of nowhere."

- **CAPITALIZE ON TRUSTED MESSENGERS AND ESTABLISHED COMMUNICATION CHANNELS:** Most respondents noted that trusted messengers help get people to the table: "I come to the table when someone I trust says to be there.
    - Suggested trusted organizations included the Spokane County Medical Society (cited by a large percentage of respondents), Washington State Medical Association, Washington Academy of Family Physicians, and various specialty groups like the regional meeting of pharmacists.
        - "I'd pay attention to some kind of tailored, special notification from SCMS."
        - Others cited turning to their professional journals or association newsletters for specialty areas of practice.
    - When asked for ideas of other organizations that would be helpful in engaging providers, the following were suggested:
        - Medical teaching facilities in Spokane
            - "Leverage these partnerships to inform how we engage providers now and how we train new providers to engage in the future."
            - "We need to build on the connections our University partners have with established and emerging providers."

        - Washington State Community Action Partnership
        - The Homeless Coalition
        - Washington State Dental Society
        - Rural Health Coalitions
        - Community Action Councils
        - Federally Qualified Health Centers
        - Rural Health Systems
        - Specialty Practices, with several respondents noting, "they aren't around the table and health system reform won't work without them."
        - Practices seeing the most Medicaid clients, with one provider suggesting, "Look at the data on the providers that are seeing the biggest percentage of Medicaid lives and start talking with them directly."
    - Several respondents mentioned individual thought leaders that they would be likely to respond to if invitations or communications came from them, including Jay Fathi, MD; John McCarthy, MD; Tom Martin, and Tom Wilbur. One participant noted that these professionals should be looked to as "active disseminators" due to their trusted status in the professional community.

- **BUILD ON AND EXPAND THE IMPACT OF THE LEADERSHIP COUNCIL AND THE BHT BOARD:** One of the most commons strengths cited by respondents was the breadth and depth of expertise on the BHT Leadership Council and Board, and the progress made over the past year to expand representation.
    - "Tap into the wealth of expertise at the table already (board and Leadership Council) and let them guide the next steps for provider engagement."
    - Respondents called for continued development of these leadership bodies to represent the diversity and professional capacities needed to transform the health system.
    - A variety of participants spoke to the expansion of diversity and building "a true equity lens," in the work of the ACH, including the following comments:
        - "We need a truly diverse board with an equity lens and a strong focus on cultural competence would make the biggest difference in attracting providers and serving the needs of our community."
        - "The leadership table/exec level that come to the board and meeting tables tend to be a lot of white people. We need the voice of diverse providers both providers themselves and the communities they serve."

Which Provider Populations Should Be Informing the Work of the ACH?

- Respondents noted that, "overall we have a good cross-ection of "the usual suspects," and could benefit from engaging the following providers
    - Front Line Medical Providers
        - Primary care providers
        - Hospitalists and ER Physicians
        - Pharmacy and med management
        - Specialty care
        - Behavioral Health

        - Oral Health
        - Long-term Care
        - Comments included:
            - "We have a lot of former providers in the room, and a lot of administrators. We really need the current front-line providers or Medical Directors who are the conduit to the front-line providers, but they need to be asked into the conversation when they can really make a difference or we'll lose them. We really need primary care, dentists, ER docs in the room to inform from the real-world experience of what's happening, not from the administrative lens."
            - "Reach down to the grassroots providers. I've never seen a small single owned dentist or small group practice or independent mental health professionals at the Leadership Council."
    - Social Determinants/Support Organizations
        - Transportation providers, "we have a lot of the traditional medical and community organizations, but we really need creative solutions for how we're going to get people to appointments."
        - Refugee and other minority populations
- Respondents also noted the need to ensure more diversity in provider representation, including:
    - Smaller Providers
        - "As with any business, when you bring in the top tiered entities in the profession their voices are usually consolidated around income vs. impact. We also need to hear the voices of the smaller providers who are determined to make impact even at the expense of income."
        - "Smaller providers. You're going to get the big ones anyway. Some of the smaller providers have innovative programs with excellent results. We should be learning about and building on these….they are effective because they are nimble and innovative."
    - Diverse of Providers
        - "Expand our range: rural/urban, communities of color, drug addiction and recovery, those serving the working poor, seniors, young mothers, etc.".
        - "We need engagement across the spectrum of provider sizes and types, but the problem is always that you can't take small/mid and independent practitioners away from their practices or patients don't have care and providers can't get paid. We need to address this."
    - Providers Who See the Most Medicaid Clients
        - "Work more deeply with the FQHCs, rural health centers, and Native health centers, who have been doing many of these innovative things for a long time. Learn from their experience and expertise. These are also the entities that are serving the highest percentage of those impacted by the waiver."
        - "Small rural health systems…not everything can be defined and designed by large health systems or FQHCs. Innovation in rural communities needs to come from rural providers. It's easy to focus on urban and big players to get the

outcomes at the expense of the areas that don't have a lot of access and may need the most help."

- "The larger health systems that serve huge numbers of people (Providence, Rockwood, etc.). That's who sees the largest number of Medicaid lives and some big opportunities for impact."

Project Planning and Implementation, Transitioning into Longer-term Engagement

- **SHORT-TERM STRATEGIES FOR PROJECT PLANNING AND IMPLEMENTATION:** Respondents suggested that the most appropriate short-term strategies for securing input into project planning and specific implementation activities should include:
  - "More voices and more innovative dialogue right now."
  - Numerous respondents suggested that BHT rely on "focus groups and forums early on to start the wave of communication and engagement," but that these methodologies would not suffice long-term for ongoing engagement.
  - As plans are coming together, identify any gaps and any providers, get them in and up to speed right away to provide their insights.
  - Get people together by project area early and consistently so decision-making isn't last-minute, which "creates more risk of failure and partner distrust."
  - "You will get the most meaningful engagement if people know what money is available and how they might have a reasonable chance of accessing some of it to make a difference."
  - Seek much more provider involvement early on "to balance the fact that the toolkit is so prescriptive—their expertise will help shape interventions in meaningful ways."
  - Many respondents suggested that BHT should cultivate structured conversations that allow providers to respond to project models and ideas, including comments such as:
    - "Offer ideas not in a 'pre-decided' way but in a way they can respond to something…not just talking in amorphous, open-ended ways. [Providers] are frustrated when it's not a good use of their time—give them a 'straw man proposal' to respond to."
    - "Begin with the end in mind: here is what a successful project would look like, and work backward from there with them to see what providers would need to do to make that happen. Have those very specific, detailed conversations with them about the 'how'."
    - "On the portfolio…once you have it, make a specific plan to engage the people who are going to impact most or be most impacted by the priorities and activities that are selected. What is the plan for sharing and expanding those portfolio processes across the region so it will be a transformed system? But you don't want to go too broad….focus on depth of involvement rather than everyone at superficial level.
    - "Consider what are you going to do to engage providers who are cut out of the projects or who won't be receiving funds. Have a plan for the 'fallout'."

- Input regarding combined and separate planning audiences and processes:
  - Several respondents wanted to make sure that people from different types of systems (rural/urban, FQHC/large health system/independent providers, primary care/behavioral health, etc.) come TOGETHER for planning in order to make sense of the global needs and opportunities in our systems, e.g., "don't have rural and urban systems planning separately…we need the full continuum of care and care across care type, geography, and life span in the room to create a rational health system."
  - Other respondents noted that different types of systems and various practice disciplines "have different languages, cultures, priorities, and ways of doing things, so it is important to let them meet on their own to work things out." For instance, the way of transforming an FQHC would be different from a large health system or a rural health system. "We need to work together on a vision and we need to work independently on how that vision gets enacted in our own healthcare world."

- **LONG-TERM STRATEGIES FOR PROJECT IMPLEMENTATION AND THE BROADER VISION OF THE ACH**: Many of the strategies for communication and short-term engagement (all detailed previously) were cited as long-term strategies, as well. Additional suggestions included:
  - Many respondents repeatedly suggested creating a provider advisory group that has representation from diverse representatives from different sectors to guide the ACH over time.
    - Participants repeatedly reference cultural competence and representation across the various practices of medicine/specialties, the age spectrum, and sizes of practices
    - "We need to hear more from providers that not only have the hard desire for this work but have lots of education about cultural competence."
    - "We have a great system that produces good clinicians but would love to see greater retention of those people here, not fleeing to other markets. We want to involve providers who want impact vs. income. Those who want to stay here, give back, help improve the health here."
  - Providers also cautioned against relying *exclusively* on an advisory board, because, "one provider's experience and opinion is one provider's experience and opinion." As such, they suggested:
    - When dealing with larger organizations or systems, "Use the internal processes they have (Medical Directors, provider leadership meetings) to incorporate knowledge from their providers, since "100 providers would give 100 answers." Ask them to distill what they know from the more global provider feedback."
    - "Reference the previously-detailed suggestions regarding general communication and engagement, such as "go to where they are" (e.g., existing meetings and events), "use trusted advisors" (e.g., SCMS, specialty associations), and "communicate with better clarity and frequency" (e.g., electronic dissemination improvements).
  - Regarding all of the above-listed options for engaging providers, respondents suggested:
    - Schedule meetings and planning at times that providers can actually engage (e.g., early morning or evening).
    - Provide alternative ways for them to take part (e.g., videoconferencing, etc.).

- Provide resources for smaller organizations and practices to participate, as, "they don't have the resources or administrative support that large systems have, so they need extra support to be involved."

How Success Will Be Measured

When asked, "how will you know that BHT had been successful in meaningfully engaging providers?" the following themes emerged:

- **PROVIDER KNOWLEDGE, TRUST, AND ONGOING INVOLVEMENT**
  - "Primary Care Providers would know what BHT stands for, and would know what financial implications and quality of care implications were being worked on."
  - "If strategies that the ACH is advancing are consistent with and reflective of input given by providers."
  - "The right people are still at the table and there's enough depth of providers to do the heavy lift for some of these projects."
  - Providers understand clearly articulated goals, projects, and methods of evaluating them."
  - "Consistent attendance at leadership council meetings from across the spectrum of providers."
  - "No glaring gaps between who is at the table and who should be at the table to make these interventions successful."
  - "Providers keep showing up and are tremendously supportive because they see value and impact. This would mean they have been treated fairly, there has been good communication, and there are performance measures in place showing impact."
  - "Every organization that needs to be at the table is there and every population that needs to be at the table says, 'yes, this works for my population.'"
  - "The Leadership Council has expanded to include all of the gaps that currently exist (small practices, independent providers, specialty, etc.)."
  - "You would know in your gut based on the relationships and trust that was built through this process."

- **COMMUNITY AND SYSTEM METRICS**
  - "We are moving the metrics and improving health."
  - "If people are doing the right thing at the right time in the right place in the right way to improve health and health care. (e.g., Emergency Rooms are for Emergencies)."
  - "Truly integrated systems, where primary care and behavioral health, hospitals and long term care, and community systems are all supporting better health, better care, better quality, and we are replicating (or scaling and spreading) innovative programs that really work, not just talking about it."
  - "Organizations who didn't historically talk to one another are interacting in a way that patient outcomes have improved or that patients aren't falling through the cracks."

    - "If services for vulnerable individuals, organizations, workforces aren't destabilized in the process."
    - "Successful outcomes on the outcome metrics. The projects are sustainable. If you don't hear uproar from providers, there is seamless adoption, and providers are being paid as they should."
    - "A sense of trust and awareness that we've made improvements and changes, and we are effective getting where we want to be (reaching our goals."
    - Evidence of change
        - "We need to tell the stories of the impact we've had…on people, communities, practices. That's what keeps people coming back."
        - "Make sure the data and metrics are paired with stories, so that we have the numbers and the voices and faces sharing the same message."

- **PATIENT HEALTH, SATISFACTION, AND ENGAGEMENT**
    - "Patients are healthier and are taking more of a proactive role in their health."
    - "Clients are being polled and their satisfaction is high."
    - "Clients are telling us they are getting good quality services.

In What Other Ways Can BHT Continue to Improve Provider Engagement Over Time?

Respondents provided a variety of other comments, requests, or cautions regarding engagement that didn't readily fit into other categories but merited inclusion here:

- "Be mindful of not inadvertently misleading organizations or building expectations that aren't going to be fulfilled."
- "Don't make things worse by destabilizing systems, causing staff to leave, making changes that make it harder for clients to get care. Disrupt for the better and disrupt for the long haul. Don't polarize in the process."
- "Work to better understand provider organizations' business models. Part of the difficulty is that I'm not sure BHT has the practical knowledge in many of these areas about what the providers actually do and how they do it. BHT can come across as strong in marketing but shallow in terms of practical knowledge of the system, so they have to count on the providers (and consumers) to define and shape the new priorities. There should be more depth of knowledge and expertise that actually resides at BHT itself."
- "We need to make sure we have good research that will inform us appropriately about how DSRIP models have worked elsewhere and how they apply to Washington state, understand funds flow and whether we have an equitable arrangement in place, and look at workforce and clinical data flow--what kind of analytics and how can they be used downstream?"
- "Attend carefully to the viability of rural and Tribal health systems. Many of these changes could radically destabilize or cause the failure of whole systems that serve their communities. Then what have we done?"