Medicaid Transformation
Accountable Communities of Health (ACH)

Implementation Plan Template:
Work Plan Instructions & Portfolio Narrative
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SUBMISSION INSTRUCTIONS

Building upon Phase I and Phase II Certification and Project Plan submissions, the Implementation Plan provides a further detailed roadmap on Medicaid Transformation project implementation activities. The Implementation Plan contains two components:

- *Project work plans.* Work plans are a key component of the Implementation Plan. ACHs must detail key milestones, work steps to achieve those milestones, deliverables, accountable ACH staff and partnering provider organizations, and timelines from DY2, Q3 to DY5.

- *Portfolio narrative.* ACHs must respond to a set of questions, included in these instructions, which detail implementation approach and activities with partnering providers and coordination with health systems and community capacity building and other initiatives across their portfolio of projects between DY2, Q3 through DY3, Q4. The intent of describing roles and activities for a narrow timeframe is to capture concrete examples of implementation steps as they get underway, while not overly burdening ACHs to report on the full timeframe of Medicaid Transformation, or the full scope of work by partnering providers.

ACHs will be asked to report against progress in the Implementation Plan, and project risks and mitigation strategies in future Semi-annual Reports. Successful completion of the Implementation Plan is a key P4R deliverable and an opportunity for ACHs to earn incentive payments in DY 2.

Work Plan Template. The Implementation Plan Work Plan Template (Excel workbook) provided by HCA is for use by ACHs in completing the Work Plan component of the Implementation Plan. ACHs may submit an alternative work plan format; however, ACHs must meet the minimum requirements outlined below, and provide complete responses to all questions in the Portfolio Narrative section.

File Format and Naming Convention. ACH submissions will be comprised of at least two documents: the Work Plan (in Microsoft Excel or Word, or Adobe Acrobat) and Portfolio Narrative (in Microsoft Word). Use the following naming convention:

- Work Plan(s): ACH Name.IP.Work Plan.Project Identifier.10.1.18.
  - Depending on the approach, ACHs may choose to submit separate work plan documents by project area(s). Please indicate in the work plan naming convention the project areas included in the Work Plan.
- Portfolio Narrative: ACH Name.IP.Portfolio Narrative.10.1.18

Submission. Submissions are to be made through the Washington Collaboration, Performance, and Analytics System (WA CPAS), found in the folder path "ACH Directory/Implementation Plan."

Deadline. Submissions must be uploaded no later than 3:00 pm PT on October 1, 2018. Late submissions will not be accepted.

Questions. Questions regarding the Implementation Plan Template and the application process should be directed to WADSRIP@mslc.com.

PROJECT WORK PLAN REQUIREMENTS

ACHs must submit a work plan with information on current and future implementation activities. This work plan acts as an implementation roadmap for ACHs, and provides HCA insight into ACH and partnering provider implementation activities. Based on the review of the work plan, HCA should be able to understand:

- Key **milestones**.
- **Work steps** the ACH or its partnering providers will complete to achieve milestones.
- Key **deliverables/outcomes** for each task.
- The **ACH staff and/or partnering provider organization**[1] accountable for completion of the work step, and whether it is the ACH staff or the partnering provider organization that is leading the work step, or whether responsibilities are shared.
- **Timeline** for completing action steps and milestones.

Format. Recognizing that implementation planning is underway, HCA is providing ACHs with the option of completing:

(1) HCA's template work plan in the attached Excel format, or
(2) An ACH-developed format

If an ACH chooses to use its own format, the ACH must communicate to the Independent Assessor its intention to submit the work plan in an alternative format by **July 31, 2018**. ACHs **are not required** to submit their work plan for approval. However, ACHs can voluntarily submit their alternative template to the Independent Assessor if they have concerns with, or questions about, meeting expectations. All questions and correspondence related to alternative formats should be directed to the Independent Assessor (WADSRIP@mslc.com).

Minimum Requirements. Using HCA's template or an ACH-developed format, ACH must identify work steps to convey the work that is happening in the region. ACH Implementation Work Plans must meet the following minimum requirements, regardless of the format selected:

- *Milestones:* Work plans must address all milestones for a given project, categorized in three stages (Planning, Implementation, Scale & Sustain). The milestones are based on the Medicaid Transformation Project Toolkit, and are included in these instructions. In the development of the Implementation Plan Template, HCA reviewed all milestones in the Medicaid Transformation Project Toolkit and updated or omitted some milestones for the sake of clarity and applicability.

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[1] Partnering provider organizations must include both traditional and non-traditional providers. Traditional providers are those traditionally reimbursed by Medicaid (e.g. primary care providers, oral health providers, mental health providers, hospitals and health systems, nursing facilities, etc.). Non-traditional providers are those not traditionally reimbursed by Medicaid (e.g. community-based and social organizations, corrections facilities, Area Agencies on Aging, etc.).

- o Beyond the milestones, ACH work plans must address additional, self-identified milestones and associated work steps to convey the work happening in their regions.
- o Work plans that respond only to the milestones associated with the Toolkit below will not be sufficient.

- *Work Steps*: For each milestone, identify key tasks necessary to achieve the milestone.
  - o *Health Systems and Community Capacity Building*. Work steps should include the collaborative work between HCA, the ACHs and statewide providers (e.g., UW, AWPHD) on health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment).
  - o *Health Equity*. Equity considerations should be an underlying component of all transformation activities. Work steps should include activities related to health equity (e.g. conducting provider training to address health equity knowledge/skills gaps, distributing health equity resources).

- *Key Deliverables/Outcomes:* For each work step, identify concrete, specific deliverables and expected outcomes.
  - o *Health Systems and Community Capacity Building*. Key deliverables/outcomes should reflect the collaborative work between HCA, the ACHs and statewide providers (e.g., UW, AWPHD) on health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment).
  - o *Health Equity*. Equity considerations should be an underlying component of all transformation activities. Key deliverables/outcomes should reflect or be informed by health equity considerations (e.g., committee charter that acknowledges health equity goals).

- *ACH Organization:* For each work step, identify ACH staff role (e.g., Executive Director, Project Manager, Board Chair) who will be primarily accountable for driving progress and completion. ACH staff may also include contractors and volunteers. Contractors and volunteers should be identified at the organization level. If the ACH organization is not primarily accountable for the work step, "None" is an appropriate response.

- *Partnering Provider Organization:* For each work step, identify partnering provider organization(s) (e.g., Quality Care Community Health Center) that will be primarily accountable for driving progress and completion. If there are multiple partnering provider organizations, but a lead partnering provider organization is coordinating efforts, identify all organizations and designate the lead partnering provider organization as "Lead." If a partnering provider organization is not primarily accountable for the work step, "None" is an appropriate response.

- *Timeline*: For each work step, identify the timeframe for undertaking the work. Identify completion of the work step at a calendar quarter level. (The timeline for the

completion of the milestone, as reflected in the Toolkit, has been included for reference.)

MINIMUM REQUIRED TOOLKIT MILESTONES

Project 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation

Stage 1: Planning Milestones

- Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)
- For 2020 adopters of integrated managed care: Ensure planning reflects timeline and process to transition to integration of physical and behavioral health including: engage and convene County Commissioners, Tribal Governments, Managed Care Organizations, Behavioral Health and Primary Care providers, and other critical partners. (Completion no later than DY 2, Q4.)

Stage 2: Project Implementation Milestones

- Develop guidelines, policies, procedures and protocols (Completion no later than DY 3, Q2.)
- Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)
- Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care activities. (Completion no later than DY 3, Q4.)

Stage 3: Scale & Sustain Milestones

- Increase use of technology tools to support integrated care activities by additional providers/organizations. (Completion no later than DY 4, Q4.)
- Identify new, additional target providers/organizations. (Completion no later than DY 4, Q4.)
- Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.
    - Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices. (Completion no later than DY 4, Q4.)
- Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5 (Completion no later than DY 4, Q4.)

- Identify and resolve barriers to financial sustainability of Project activities post-DSRIP (Completion no later than DY 4, Q4.)

Project 2B: Community-Based Care Coordination

Stage 1: Planning Milestones

- Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)
- Identify project lead entity, including:
    - Establish HUB planning group, including payers (Completion no later than DY2, Q4)

Stage 2: Project Implementation Milestones

- Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)
- Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways. (Completion no later than DY 3, Q2.)
- Implement project, which includes the Phase 2 (Creating tools and resources) and 3 (Launching the HUB) elements specified by AHRQ:
    - Create and implement checklists and related documents for care coordinators. (Completion no later than DY 3, Q4.)
    - Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach. (Completion no later than DY 3, Q4.)
    - Develop systems to track and evaluate performance. (Completion no later than DY 3, Q4.)
    - Hire and train staff. (Completion no later than DY 3, Q4.)
    - Implement technology enabled care coordination tools, and enable the appropriate integration of information captured by care coordinators with clinical information captured through statewide health information exchange. (Completion no later than DY 3, Q4.)
- Develop description of each Pathway scheduled for initial implementation and expansion/partnering provider roles & responsibilities to support Pathways implementation. (Completion no later than DY 3, Q4.)

Stage 3: Scale & Sustain Milestones

- Expand the use of care coordination technology tools to additional providers and/or patient populations. (Completion no later than DY 4, Q4.)
- Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)

- Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)
- Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)

Project 3A: Addressing The Opioid Use Public Health Crisis

Stage 1: Planning Milestones

- Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)

Stage 2: Project Implementation Milestones

- Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)
- Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)
- Implement selected strategies/approaches across the core components: 1) Prevention; 2) Treatment; 3) Overdose Prevention; 4) Recovery Supports. (Completion no later than DY 3, Q4.)
- Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan. (Completion no later than DY 3, Q4.)
- Convene or leverage existing local partnerships to implement project, one or more such partnerships may be convened. (Completion no later than DY 3, Q2.)
    - Each partnership should include health care service, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency medical services, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions.
    - Establish a structure that allows for efficient implementation of the project and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges and overall progress.
    - Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase.
- Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers). (Completion no later than DY 3, Q4.)

Stage 3: Scale & Sustain Milestones

- Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g. to cover additional high needs geographic areas), as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges. (Completion no later than DY 4, Q4.)

- Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas. (Completion no later than DY 4, Q4.)
- Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches. (Completion no later than DY 4, Q4.)
- Convene and support platforms to facilitate shared learning and exchange of best practices and results to date (e.g., the use of interoperable HIE by additional providers providing treatment of persons with OUD). (Completion no later than DY 4, Q4.)
- Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)
- Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)

Project 3D: Chronic Disease Prevention and Control

Stage 1: Planning Milestones

- Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)

Stage 2: Project Implementation Milestones

- Develop guidelines, policies, procedures and protocols. (Completion no later than DY 3, Q2.)
- Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)
- Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve:
  - Self-Management Support
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems (including interoperable systems)
  - Community-based Resources and Policy
  - Health Care Organization
  (Completion no later than DY 3, Q4.)
- Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies. (Completion no later than DY 3, Q4.)

Stage 3: Scale & Sustain Milestones

- Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes. (Completion no later than DY 4, Q4.)
- Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)
- Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies (e.g., the use of interoperable Clinical Information Systems by additional providers, additional populations, or types of information exchanged). (Completion no later than DY 4, Q4.)
- Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)

- Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)

REQUIRED PORTFOLIO NARRATIVE

HCA is seeking a deeper understanding of ACH implementation planning across ACHs' portfolio of projects for Medicaid Transformation. The questions below are intended to assess ACHs' preparation and current activities in key implementation areas that span the project portfolio. ACHs must provide clear explanations of the activities to be completed, timing of activities, and how they intend to progress the implementation of projects from DY 2, Q3 through DY 3, Q4. ACHs are required to provide responses that reflect the regional transformation efforts by either:

- The ACH as an organization,
- The ACH's partnering providers, or
- Both the ACH and its partnering providers.

ACHs should read each prompt carefully before responding.

Partnering Provider Project Roles

HCA is seeking a more granular understanding of the Medicaid Transformation work being conducted by partnering provider organizations. Imagine the Independent Assessor is conducting a site visit with your partnering providers; how would a partnering provider organization explain its role in the transformation work. What does the provider need to be successful?

Using at least four examples of partnering provider organizations, respond to the questions and provide a detailed description of each organization, and what each organization has committed to do to support of the transformation projects from DY 2, Q3 through DY 3, Q4.

In total, examples must reflect:
- A mix of providers traditionally reimbursed and not traditionally reimbursed by Medicaid.[2]
- All projects in the ACH's portfolio.

ACH Response
Responses must cover the following: • What is the name of the partnering provider organization? • What type of entity is the partnering provider organization? • In which project/project(s) is the partnering provider organization involved? • What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?

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[2] Traditional providers are those traditionally reimbursed by Medicaid (e.g. primary care providers, oral health providers, mental health providers, hospitals and health systems, nursing facilities, etc.). Non-traditional providers are those not traditionally reimbursed by Medicaid (e.g. community-based and social organizations, corrections facilities, Area Agencies on Aging, etc.).

> - What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?

INTRO:

On August 1st, BHT Partnering Providers in primary care and behavioral health settings completed Transformation Plans detailing their capacity and plan to implement Transformation projects. Plans are currently under review by BHT, and will be finalized for January Cohort participants in DY3 Q1 for, and August Cohort participants in DY3 Q3, preparing them to be ready to enter into contract with BHT for execution of Transformation projects. The following description of project activities comes directly from Partnering Provider Transformation Plans. Providers will carry out activities as described, and report on progress semi-annually. All Partnering Providers will continue to participate in monthly Collaborative meetings for shared learning, TA, and alignment.

Partnering Provider Project Roles – Lake Roosevelt Community Health Center

Lake Roosevelt Community Health Centers (LRCHC) is a tribally owned Federally Qualified Health Center (FQHC) comprised of two clinics serving the communities of Inchelium and Keller in Ferry County, Washington. LRCHC is located on the Colville Indian Reservation and in Ferry County, WA. LRCHC provides primary health services either directly, through Medicaid, Medicare and Private Pay contractual arrangements, or through cooperative agreements with the Tribe. LRHC also provides optometry, pharmacy, dental, and chronic disease management and is also participating in the statewide Indian Health Care Provider (IHCP) project that is working to increase behavioral health access. The service delivery model is a free-standing primary care clinic. LRCHC is a traditional Medicaid provider.

LRCHC is participating in Project 2A, Bi-directional Integration of Care, and Project 2B, Community-Based Care Coordination (not addressed in this profile). Beginning in DY2 Q4, LRCHC will provide patient access to the Collaborative Care Model of integrated services. Patients will be able to receive behavioral health and primary care services without having to surmount the challenge of traveling between multiple appointments. Also beginning DY2 Q4, LRHCH will provide psychiatric consultation to primary care providers for all patients accessing Collaborative Care Model services.

LRCHC will partner with the University of Washington AIMS Program to develop a plan for implementing the Collaborative Care Model into each clinic and will develop a sustainability plan in consideration of both the patient and provider experiences. They will provide staff training in the Collaborative Care Model and recruit a behavioral health team Case Manager to assist in developing the model. LRCHC will develop a Behavioral Health Registry (in conjunction with the Indian Health Services RPMS Behavioral Health package) with the ability to track clinical outcomes for their target population.

Partnering Provider Project Roles – NEW Alliance Counseling Services

Northeast Washington Alliance Counseling Services (NEWACS) offers behavioral health services to people in Stevens, Lincoln, and Ferry County, and participates in the Collaboratives in all three of these counties. NEWACS is a traditional Medicaid provider.

Bi-Directional Integration of Care
NEWACS will utilize aspects of both the Bree Collaborative and the Collaborative Care models—with an

emphasis on the Bree Collaborative. In most instances NEWACS will focus on procedures to create an "Off-Site: Enhanced Collaboration" system of care with behavioral health partners. NEWACS will outstation behavioral health clinicians on a part-time basis at the Republic and Curlew clinics within Ferry County Public Hospital District, and at the Lake Roosevelt Community Health Center. Similarly, NEWACS will outstation behavioral health clinicians one day a week at the Odessa Memorial Healthcare Center in Lincoln County Public Hospital District #1 and a master's level Mental Health Counselor at the Davenport Medical Clinic 3-days per week in Hospital District #3. In Stevens County, they will outstation Designated Crisis Responders at the Mount Carmel Hospital with Providence and behavioral health clinicians at the NEW Health Programs health centers. Protocols for on-site care team coordination will be developed, as will protocols for on-site and off-site care coordination for complex cases.

NEWACS's Plan emphasizes upgrading their electronic health record (EHR) to allow systematic tracking of patient outcomes, and earlier identification of non-responders for care management. By DY3 Q3, NEWACS will replace its current EHR system at all locations and programs with a new, more robust system that includes data analytics and outcome tracking necessary to track and plan care, identify groups of patients needing additional care, and facilitate performance monitoring and quality improvement efforts. System enhancements with the NEWACS EHR will result in enhanced off-site collaboration between with partners listed above (e.g., enhanced referral pathways, direct-trust messaging with CCD exchanges, standardized assessments for screening depression/substance use etc., as discussed throughout this Plan). The Plan also includes goals for increasing the use of telemedicine collaboration within NEWACS and with external partners.

Chronic Disease
NEWACS Chronic Disease project will target clients with behavioral health conditions who would be ineligible for Health Homes services based on their PRISM scores. By DY3 Q4 the "Physical Health Status" section of the MH and SUD assessments at NEWACS will be revised to add screening questions for chronic disease risk factors including Body Mass Index (BMI) and the known presence of diabetes, liver disease, kidney disease, asthma, and hepatitis. All clients seen for either a MH or SUD assessment will be screened for BMI at the time of the assessment, with those at risk referred for further evaluation by their primary care provider. Current functionality within the EHR will be utilized to track BMI changes over time, with those screened as "at risk" at any time referred for further evaluation.

NEWACS will develop pathways for referring patients with chronic health conditions and/or whose BMI suggests risks for diabetes and other chronic diseases to NEWHP primary medical providers including: Providence Health and Services (Mt Carmel & St Joseph's Hospital), NEWMG Clinic, Spokane Tribe of Indians Health & Human Services, Ferry County Public Hospital, Lake Roosevelt Community Health Center and Colville Tribe HHS. NEWACS will refer patients who would benefit from the Stanford Chronic Disease Self-Management Program to Rural Resources to access this program. NEWACS will coordinate with Rural Resources to identify NEWACS patients who are enrolled in Health Homes Programs with Rural Resources to avoid duplication of services.

Opioid
Working closely with a Northeast Tri County Opioid Workgroup convened by Northeast Tri County Health Department, NEWACS will largely focus on obtaining state certification to become a Medication Assisted Treatment (MAT) Facility and to expand access to MAT services for Medicaid enrollees accessing behavioral health services at NEWACS. NEWACS will also implement the systematic use of the PDMP, enhance Substance Use Disorder assessment and treatment services to substance abusing

inmates in the county jail, and enhance care coordination with our primary care partners for substance abusing pregnant women.

By DY3 Q4, NEWACS will develop policies and procedures, which shall be approved by DBHR/DOH, and thereby receive DBHR/DOH certification to become a Certified MAT Program, allowing patients enrolled in their Substance Use Disorder Treatment Program to received MAT Interventions, including Suboxone and naloxone (Narcan).

Additionally, each of the two psychiatric ARNPs employed at NEWACS in Lincoln and Ferry County will complete required certifications to become Suboxone prescribers, and each ARNP will provide MAT services (including prescribing/monitoring of Suboxone) to no fewer than 10 Medicaid individuals.

Partnering Provider Project Roles - SNAP

Spokane Neighborhood Action Partners (SNAP) is a community action organization, whose mission is to increase the human potential of our community by providing opportunities for people in need. SNAP offers services to primarily low-income individuals related to transportation, housing, finances, and other social services. SNAP is a non-traditional Medicaid provider.

SNAP is partnering with CHAS to implement Project 3D, Chronic Disease Prevention and Control. Launching in DY2 Q4, SNAP will be partnering with CHAS for a non-emergent patient transportation and home visit program. CHAS will issue a warm hand-off of patients diagnosed with Diabetes to SNAP. SNAP has hired a dedicated Community Health Worker (CHW) who will conduct an assessment and do a home visit. This CHW will help the patient with transportation to and from appointments, addressing one of the biggest barriers to health improvement identified in our community needs assessment. SNAP and CHAS will implement and monitor the project, and report updates to the ACH, through DY3.

CHAS and SNAP have a signed contract in place to formalize this partnership. SNAP has hired a CHW. The referral and assessment tool are in development between CHAS and SNAP, along with the procedures to ensure warm hand offs and bi-directional communication. The referral and assessment process will be finalized by DY Q3, and the project will launch DY3 Q4. Both partners are active participants in the Spokane County Collaborative and provide regular updates on project. Both CHAS and SNAP will continue to attend the Spokane County Collaborative on a monthly basis to give updates on their project, access TA, request resources, and participate in shared learning.

Partnering Provider Project Roles - CHAS

CHAS Health is a non-profit, Federally Qualified Health Center providing integrated primary care services, including medical, dental, behavioral health, pharmacy, nutrition, health education, pediatrics, and OB/Gyn. They are the primary care home for more than 75,000 patients, of whom over 60% have Apple Health insurance. CHAS is a traditional Medicaid provider.

Bi-directional Integration
CHAS has been a long-time participant in the Collaborative Care Model through CHPW's Mental Health Integration Program (MHIP), but with a subset of clinics and behavioral health providers. In 2019, CHAS will seek to expand this program to all clinics and all patients whenever clinically appropriate. By

increasing the number of patients engaged with and tracking in a Collaborative Care registry they expect improved outcomes such as adherence to depression medication, faster improvement in behavioral health measures (such as PHQ and GAD), an increase in successful referrals to community mental health, and a reduction in hospital admissions for behavioral conditions. 2019 will be a ramp-up year so that by early 2020, all CHAS primary care clinics will use the Collaborative Care model and use MHIP.

The other focus for CHAS will be on improving coordination with outside behavioral health and social service organizations, focusing on expanding and enhancing their collaboration with Frontier Behavioral Health. Specifically, CHAS and Frontier plan to expand staffing in their Care Connector program, which provides short-term case management to get patients connected to behavioral health care.

Chronic Disease
CHAS is currently developing a wellness program with the YMCA called "Pathways to Wellness" where CHAS clinical staff will meet with their patients at the YMCA. This program, launching DY2 Q4, aims to improve the health of patients with chronic conditions by providing support and education for patients regarding exercise, nutrition, and healthy living habits. They will bring on Care Coordinators and additional Community Health Workers in 2019 to help support with connecting patients to this program.

As noted above, launching in DY2 Q4, CHAS will be partnering with SNAP for a non-emergent patient transportation and home visit program for patients diagnosed with diabetes.

Opioid
CHAS Health offers MAT in combination with comprehensive OUD psychosocial services. Currently, this program is offered at five CHAS clinics. CHAS plans to expand the program to four additional sites throughout Spokane County. As the program continues to expand, it will impact the region's opioid treatment penetration rate.

However, at this time CHAS does not anticipate using Transformation funds to address opioid use specifically, aside from improving care coordination for BH/SUD providers to refer their MAT patients to CHAS primary care. Instead, they will be deploying available state and federal funding.

CHAS plans to bring on several new staff related to their projects, primarily in DY3. They intend to hire one FTE in DY3 to manage their Transformation project work, coordinating work across Quality Improvement, Utilization Management, and the Integrated Services departments. In Q2, they expect to hire a Coordinated Referrals Specialist as part of their expansion of the Collaborative Care and Chronic Disease models. In collaboration with Frontier, CHAS also plans to add one to two additional staff to their Care Connector Program. Pending Waiver funding, they expect to hire an Integrated Care Manager/Clinician in DY3 Q1/2 who would provide centralized clinical BH support via telehealth and manage the overall telehealth program. CHAS also plans to bring on additional care coordinators/Community Health Workers in DY3 to support elements of the Chronic Care model.

In the first half of DY3, CHAS has several training activities planned for their care teams, including training on:
- o MHIP, with the intention of all BH providers using MHIP for their collaborative care patient registries by the end of 2019
- o DATA waiver to prescribe buprenorphine
- o Warm-handoffs and utilizing Care Connectors and other care coordination

CHAS already utilizes robust HIT and QI practices but plans to implement a population health management tool available in their EHR (Athena) in Q1 of 2019. CHAS will continue to attend the Spokane County Collaborative on a monthly basis, to give updates on their project, access TA, request resources, and participate in shared learning.

Partnering Provider Project Roles - The Spokane County Reentry project

Through the Spokane Regional Law and Justice Council, Spokane County received grant funding through the Department of Justice, Bureau of Justice Assistance (BJA) Second Chance Act of 2007. The funding is intended to address the significant challenges individuals face when returning to communities from jail.. The goals of the BJA's *Smart Reentry: Focus on Evidence-based Strategies for Successful Reentry from Incarceration to Community program* is to support jurisdictions to develop and implement comprehensive and collaborative strategies that address the challenges posed by reentry to increase public safety and reduce recidivism for individuals reentering communities from incarceration who are at medium to high risk for recidivating. Within the context of this initiative "reentry" is not envisioned to be a specific program, but rather a process that begins when the individual is first incarcerated (pre-release) and ends with his/her successful reintegration into the community and reduction in risk of recidivism (post-release). Spokane County's goals regarding this grant funding are: to increase effective communications, coordination, and collaboration for the reentry population; increase the use of evidence-based practices; adhere to risk and needs principles; and engage families and/or mentors; to provide on-going education to the community, attorneys, jail staff, judiciary, and reentry task force; and to improve access to resources in the community for reentry support.

This pilot and set of partners aligns perfectly within the community-based care coordination Transformation project, utilizing the Pathways Community Hub model and Care Coordination Systems platform. Partners directly involved in the project are Spokane County, District Court, Probation, Mental Health Court, and the Community Services Department, along with Better Health Together and several community organizations and activists.

During DY2 Q3, Spokane County will contract with Better Health Together to be The Hub. In DY2 Q4, BHT (as the Community Based Care Coordination Hub) will contract with two care coordinating agencies to provide direct care coordination services. The Reentry Project Team will customize, test, and refine the Care Coordination Systems platform, train the two care coordinators along with supervisors, and begin referring clients to The Hub. Through DY3 Q1 – Q4, the Reentry Project Team will evaluate referral flows, outcomes, and provide overall quality assessment input as the care coordinating agencies build and maintain their respective case load capacity.

Partnering Provider Engagement
Explain how the ACH supports partnering providers in project implementation from DY 2, Q3 through DY 3, Q4.

ACH Response
Responses must cover the following:

- What training and/or technical assistance resources is the ACH facilitating or providing to support partnering providers in implementation from DY 2, Q3 through DY 3, Q4?

  BHT received Transformation Plans from 45 of our Partnering Providers in August. Based on gaps identified from these Plans and information from previously requested capacity Assessments, BHT will develop a Technical Assistance curriculum and funding allocation for DY3 to ensure provider readiness for Implementation. This curriculum is still under development, to be finalized in DY2 Q4, but tentatively will include topics related to:
  - Collaborative Care and Bree models of integrated healthcare
  - Change Management
  - Addressing the "culture" of bi-directional care
  - Billing and documentation in an integrated practice
  - Clinical workflow in an integrated practice
  - Care Management
  - Screening for SDoH and community resource integration
  - Risk assessment and stratification
  - Transitions of care
  - Information Exchange
  - Chronic Care Model
  - Chronic conditions and care paths
    - Diabetes
  - Interdisciplinary team development
  - Patient Self-Management (Patient Activation, Health literacy, Models)
  - Program tracking and Quality Measurement
  - Trauma Informed Care

- How is training and/or technical assistance resources being delivered within that timeframe?

  Partnering Providers in primary care and behavioral health who submitted Transformation Plans were assigned into one of two cohorts based on their readiness to implement Plans. The January Cohort will complete a request for more information in order to finalize their project plan and begin Implementation in Q1 2018. The January Cohort will participate in quarterly Technical Assistance. The August Cohort will participate in a learning cohort to prepare for final submission of their Transformation Plan by August 1, 2019, to increase foundational readiness and capacity for project success in DY3 Q1 and Q2. The August Cohort providers will begin Implementation in DY3Q. We expect to develop pay-for-participation incentives for all providers.

- How is the ACH engaging smaller, partnering providers and community-based organizations with limited capacity?

  Based on our assessment of Partnering Provider Transformation Plans, partners who have limited capacity and need additional support to be ready to implement Projects successfully will participate in the August Cohort. This Cohort will receive TA specifically to support

growing their foundational readiness and capacity. Provider teams will receive financial support to offset the time and lost revenue it takes to prepare for Transformation Projects as they participate in this Cohort.

- What activities and processes are coordinated/streamlined by the ACHs to minimize administrative burden on partnering providers (e.g., coordination of partnering provider contracts/MOUs)?

  BHT has established, and secured MOUs from all partners to participate in, six county-based Community Health Transformation Collaboratives which serve as the activation network for projects. Each Collaborative has nominated a Lead who takes on a project management role for the Collaborative Members. The Collaborative Lead agency communicates with the ACH, and is responsible for all Collaborative deliverables, which helps reduce administrative burden and ensures alignment for providers and the ACH. The Collaborative Lead agency in our Rural Counties earns $50,000 to support this role. In Spokane, this role is split between a 12-person Collaborative Connection Team, who earns $400,000 to support the much larger Spokane Collaborative. It is expected that the Collaborative Lead agency will lead communication and deliverables to ensure coordination between Partnering Providers, community organizations, and the ACH, with the intent to increase collaboration and reduce burden.

- How is the ACH coordinating with other ACHs in engaging partnering providers that are participating in project activities in more than one ACH?

  BHT continues to engage weekly with North Central ACH (NCACH) and Greater Columbia ACH (GCACH) in regular cross-ACH calls to explore opportunities for alignment and troubleshoot any issues our shared Partnering Providers are experiencing. BHT's Director of Integration maintains a standing monthly call with NCACH staff for shared learning and to discuss opportunities to align Technical Assistance and avoid duplicating activities. In DY3 Q4, we intend to schedule meetings with GCACH and NCACH to discuss opportunities for shared TA and learning across our shared partners in Adams County and in the Colville Reservation. The Confederated Tribes of the Colville Reservation fits in the boundaries of both NCACH and BHT, and BHT has Partnering Providers in Adams county that serve patients or operate in NCACH and GCACH. We intentionally waited to convene this conversation until our Partnering Providers completed their Transformation Plans for each ACH.

Partnering Provider Management

Explain how the ACH ensures partnering providers are driving forward project implementation from DY 2, Q3 through DY 3, Q4.

ACH Response

Responses must address both traditional and non-traditional Medicaid providers and cover the following:

- What are the ACH's project implementation expectations for its partnering providers from DY 2, Q3 through DY 3, Q4?

BHT expects Partnering Providers to finalize their Transformation Plans in the coming months and to begin Implementation in 2019. Partnering Providers will be expected to report regularly on progress against their own Implementation milestones and goals, as well as HCA's pay-for-reporting (P4R) metrics, and potentially a small number of indicators selected by BHT. Specific expectations will differ by Cohort:

- **January Cohort** Partnering Providers (all of whom are 'traditional' Medicaid primary care or behavioral health providers) will finalize their Transformation Plans by mid-January 2019. Partnering Providers will receive individual feedback, by BHT staff and consultants, to refine their plans in order to meet the specific requirements of the toolkit and include concrete timelines and milestones. It is an expectation that all primary care and behavioral health Partnering Providers include actionable plans to establish partnerships with non-traditional Medicaid and social determinant providers, as well as equity statements, and specific equity related milestones. The milestones will serve as the basis for our contracting with individual Partnering Providers and future reporting requirements on Implementation progress. The Transformation Manager at each Partnering Provider organization will be accountable for progress reporting.

- **August Cohort** Partnering Providers (also all 'traditional' Medicaid primary care or behavioral health providers) will be participating in a learning cohort in the first three quarters of 2019 in order to further prepare for Transformation Project Implementation. In addition to content designed to help build foundational capacity for Transformation, a primary goal of this Cohort is to ensure that each Partnering Provider has a well-developed Transformation Plan to meet the specific requirements of the toolkit and include concrete timelines and milestones. It is an expectation that all primary care and behavioral health Partnering Providers include actionable Plans to establish partnerships with non-traditional Medicaid and social determinant providers, as well as equity statements, and specific equity related milestones by August 2019. As with the January Cohort, the milestones will serve as the basis for our contracting with individual partners and future reporting requirements on Implementation progress. And a Transformation Manager at each Partnering Provider organization will be accountable for progress reporting.

- BHT has not required 'non-traditional' Medicaid providers to prepare individual Transformation Plans but expect that our 'non-traditional' Partnering Providers are participating in Transformation planning and projects via the six county-based Collaboratives, and should be included in behavioral health and primary care Partnering Provider Transformation Plans. Collaboratives submitted initial Transformation Plans in July 2018, and will update their Plans in the coming months, informed by approved primary care and behavioral health Transformation Plans. It is expected that Collaboratives will focus on further development around Community-

based Care Coordination and Opioids project efforts. Collaboratives may also develop work plans around locally-identified priorities. The expectation is that each county Collaborative will participate in design sessions for expansion of care coordination[3], and implement activities across all four levels of the Opioid project in 2019.

- What are the key indicators used by the ACH to measure implementation progress by partnering providers within that timeframe?

In addition to tracking how Partnering Providers are meeting their own milestones and collecting data for official HCA P4R metrics, BHT intends to monitor and provide incentives for key indicators that speak to Implementation progress and achievement of milestones that are connected to desired Transformation outcomes and P4P metrics.

Partnering Providers will be eligible to earn funding in DY3 by reporting demonstrated progress on their own Transformation milestones, and by showing improvements in an increasing number of BHT milestones. BHT will designate a list of incentive measures from which Partnering Providers will select a set of targets to focus on, and be expected to add more targets each year. The Incentive milestones are currently in draft form, awaiting review by BHT's Technical Councils and Collaboratives, and then approval from the BHT Board. Metrics will be finalized by DY3 Q1.

- What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?

BHT intends to establish semi-annual progress reporting for both Partnering Providers and Collaboratives. Reports will consist of an online tool that supports narrative reporting as well as quantitative data or survey-type questions (as required for several for P4R metrics). BHT will select a reporting tool based on several criteria: ease of access (i.e. no membership or complex registration required); document upload functionality (to reduce data entry requirements); ability to carry data over from one reporting period to the next to minimize response time if information has not changed; and capacity to provide summary information back to partners. BHT will also conduct a small number of site-visits and in-person meetings with Partnering Providers in each Collaborative to verify self-reported information.

BHT aims to integrate progress reporting with the data collection required for HCA's P4R metrics, and so anticipates requiring twice-yearly reporting. Specific due dates will be finalized in the coming months and included in the Partnering Provider contracts. Outside of this formal reporting cycle, BHT will maintain ongoing communication with Partnering Providers via the county-based Collaboratives, Technical Council activities, Learning Cohorts or other technical assistance, and ad-hoc events. These contact points will enable BHT to monitor Implementation progress at more frequent intervals.

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[3] Note that a small Pathways project is already active in Ferry County, focusing on individuals transitioning out of jail and a larger project is expected to launch in Spokane County—also with the jail transition population—by the end of 2018.

- How will the ACH support its partnering providers (e.g., provide technical assistance) if implementation progress to meet required project milestones is delayed?

  BHT believes our Collaborative and Learning Cohort model, which is a platform for shared learning and technical assistance, will help insure Partnering Providers have the resources, support network, and education they need to be successful. If Partnering Providers encounter obstacles or delays in Implementation, BHT is ready to assist with a variety of strategies including: technical assistance and capacity building; peer coaching; or assistance with addressing regulatory barriers. BHT's Collaboratives will also have a role in supporting Partnering Providers through Implementation challenges by providing a venue for communication and collaborative problem-solving. At BHT, the Director of Clinical Integration and the Pathways HUB Manager will monitor Implementation progress in their respective areas and identify, communicate, and address challenges with Partnering Providers. BHT may also involve its Provider Champions Council and/or our other Technical Councils in reviewing progress and developing support strategies for course corrections as needed.

Alignment with Other Programs

Explain how the ACH ensures partnering providers avoid duplication while promoting synergy with existing state resources from DY 2, Q3 through DY 3, Q4.

ACH Response

Responses must cover the following:

Project 2A

- What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other bi-directional integration efforts in the state?

  BHT has hosted many community meetings and conversations related to bi-directional integration to ensure we have a comprehensive understanding of the current health systems landscape and don't duplicate efforts. The Collaborative structure brings together participants from multiple sectors and creates a platform for alignment among partners.

  BHT is attending and supporting a local IMC Collaborative convened by Excelsior Youth Center, which is exploring alignment of local EHR adoption for behavioral health providers. We are supporting this collaborative to continue this work rather than co-opting the conversations they have already started. Similarly, we are keenly interested in supporting adoption and scale of telemedicine as a bi-directional integration strategy, and are closely monitoring statewide efforts related to expansion and training for these services.

  BHT's Executive Director will serve on the Spokane County convened Interlocal table to ensure alignment with the ACH bi-directional efforts. This platform will provide a structure for Spokane County Regional Authorities will plan, design and implement the IMC model for the Spokane County RSA, to assure clients are at the center of care delivery. The SCRA will work jointly to overcome barriers to access, incorporate goals of the new local law and justice council into behavioral health systems expectations, connect fully integrated managed care

and the Foundational Community Supports into homeless housing efforts, collaborate with emergency management systems and hospital emergency departments, and align shared planning across all counties with the Spokane County region.

BHT is actively working with the Spokane Teaching Health Consortium, comprised of Providence Health Care, WSU, and Empire Health Foundation to expand team-based, integrated-care training opportunities in the region.

Project 3A
- What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports?

    BHT's Provider Champions Council is tasked with regularly monitoring statewide, and other community efforts to check for opportunities to align and not duplicate efforts. BHT participates in the Spokane Regional Health District's Opioid Taskforce, and intentionally aligned our ACH Opioid efforts with this taskforce to avoid duplicating their efforts. Taskforce members participate in the Spokane Collaborative, allowing cross-communication and alignment of efforts. Each of the Rural Collaboratives have slightly different strategies, however the Collaborative structure ensures a mechanism for alignment between a broad group of partners.

    BHT and several of our Tribal Partners participate in a bi-weekly call convened by Olympic ACH's tribal liaison. The call provides technical assistance and information sharing of various opioid use disorder resources and models that Tribes use, or could adapt, to provide culturally appropriate care to their members We'll continue to stay informed of statewide Tribal opioid efforts, especially where our regional Tribal Partners are involved, in order to support them.

For ACHs implementing Project 2B
- How does the ACH align referral mechanisms and provider engagement strategies with the Health Homes and First Steps Maternity Support Services program?

    BHT contracted with Care Coordination Systems to develop a tool utilizing the CCS technology for Pathways for Health Homes Care Coordinators. We intend to reduce duplicative technology systems for Care Coordinators by building out CCS capabilities. This will also align assessment and eligibility tools, to ensure patients who are referred to the Care Coordination Hub, are referred to the most appropriate program for their set of needs and eligibility. This new technology will be implemented as a pilot with Rural Resources in DY2 Q4. We intend show an increase in access and coordination between Health Homes and other care coordination programs in the region.

    As BHT looks toward developing a Care Coordination pilot with a focus on high-risk pregnancies, we will first conduct an environmental scan of programs with a similar focus in

the region. This effort will be led by our HUB council, with the goal of inventorying the capacity and expertise of existing programs and resources. Conversations with existing Nurse Family Partnership providers in Spokane makes it clear there is a significantly more demand for pregnancy and motherhood related support services than regional programs can currently meet. BHT will look for opportunities to align, support and scale. It is important to ensure appropriate referrals are occurring across the population to maximize the resources available. Additionally, we will learn from Pierce County ACH on working with First Steps Maternity Support Services and expect to utilize the CCS improvements they have incorporated.

- What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?

    BHT has leveraged the existing 211 resource network as a directory of services. We are in the process of further developing the CCS platform to "push and pull" resource information from 211 to support Care Coordinators looking for resources for their clients. Multiple agencies and community groups have requested a centralized resource directory (or started their own). This is one area where the ACH will support an alignment of efforts. We intend to use our county-based Collaboratives, and wide reach of participants, to grow momentum and accessibility for the resources. As the project expands, we will work with other community care coordination programs, such as Hotspotters and Spokane CARES, to explore opportunities to expand buy-in and use of this resource.

    In addition, BHT is actively engaged in a statewide resource directory project working toward a Shared Community Inventory. In DY2 Q3, BHT will continue to work with convened statewide agencies and community organizations to map and design a directory of resources and services to further help in direct care coordination activities. In DY2 Q4, the group intends to write a legislative brief outlining a case statement toward the design elements and return on investment, which will focus on lowering state expenditures, aligning activities, and improving client outcome data.

- How is the ACH's approach aligned with MCO care coordination contract requirements?

    BHT has enjoyed a very productive relationship with all five of the Medicaid Managed Care Organizations (MCOs) operating in our region. Each MCO has participated in our ACH Leadership Council, Technical Councils, and most in our county-based Collaboratives. Additionally, since the announcement of the successful bidders for Integrated Managed Care, BHT has committed to developing an individual plan with each MCO. To this end, we have been working for 15 months to develop contracts with MCOs to support the Pathways program. While we have made progress with two of the three MCOs that will be active in our region, there continues to be a lot of concern that Pathways is not sustainable without changes to current MCO contracts. BHT is pleased to be coordinating a discussion around this topic in October with HCA, MCOs, and all ACH Pathways leaders. We are optimistic that joint design efforts could result in an agreed upon model for shared savings and long-term sustainability.

For ACHs implementing Project 3D

- What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve chronic disease management and control?

    One of the key areas of alignment has been coordination with our Partnering Providers who are also Health Homes Care Coordinating agencies. As Health Homes continues to gain traction in the region as a successful high utilizer model, often because of chronic disease management, we intend to build on this capacity for both our community-based care coordination and chronic disease management and control. Additionally, we expect that a more robust system for centralization of resources will aid providers in making referrals to chronic disease programs. This has been a consistent request from our partners to assist in smart referrals to available community resources. As a precursor to launching these efforts, we will conduct an environmental scan of current capacity for resources, which will help us be more informed about what services are available, to avoid duplication.

Regional Readiness for Transition to Value-based Care

Explain how the region is advancing Value-based Care objectives.

ACH Response

Responses must cover the following:

- What actionable steps are partnering providers taking from DY 2, Q3 through DY 3, Q4 to move along the VBP continuum? Provide three examples.

    The BHT ACH is focused on moving the region to whole-person care and value-based payments (VBP). Shifting to whole-person, integrated care will improve the quality of care people receive and improve outcomes for the most vulnerable populations and all Medicaid beneficiaries. This shift will also allow for a more efficient use of dollars, freeing up funds for increased investments in upstream health, including population health, prevention, and addressing social determinants of health. Infrastructure investments and clinical care redesign will be among the lasting impacts for the region's overall Medicaid population, including investments in HIE/HIT and workforce to support integrated care; establish efforts for providers to develop new evidence-based models of care/proof of evidence; implementation of clinical screening tools to new populations; and facilitated/shared learning across collaborative providers. These investments will pave the way for lasting change in health care delivery and prepare providers in the BHT region for value-based payment. Three examples of these efforts are:

    - **Collaborative-level Transformation Plans:** The BHT region's six county-based Transformation Collaboratives are designed to support the formation of the partnerships needed to support geographically based systems of care in a value-based environment. The linkages created to support the Medicaid Transformation Projects will translate to the relationships necessary to succeed in a value-based model and improve population health. The support from the ACH, MTP dollars, and local investment will create an

environment to test new processes and implement new practices to ensure readiness for VBP and improved care delivery. Partnering Providers are required to participate in their local Collaborative in order to receive Waiver funding for Transformation projects. These Collaboratives were required to develop a Collaborative-level Transformation Plan and submit an initial draft to BHT over the summer. These plans require that each Collaborative consider how project plan strategies contribute to the achievement of the value-based care metrics/targets. The plans will also develop shared goals and new partnerships across providers, a cornerstone for moving to value-based and whole-person care.

- **Improving EHR Capacity:** BHT intends to use the remainder of its Year 1 FIMC incentive funds (approximately $1 million) to help providers acquire the EHR systems and/or capacity they need to be successful in 2019 and beyond. In our assessment of providers in the region, we found that lack of interoperable data or access to comprehensive or timely data on patient populations to be the most frequently mentioned barrier to moving to value-based payment. In addition to supporting the transition to a new billing environment, a primary goal of this investment is to help behavioral health and Tribal partners prepare for working bi-directionally with primary care. To earn FIMC Incentive funds for EHR investments, providers must attest to:

  1. A functioning EHR system must be implemented by August 1, 2019
  2. The current or planned EHR is either ONC Certified, or at a minimum has the existing functionality / ability to establish data sharing interfaces with established Health Information Exchanges (HIEs).
  3. The BH Provider's current or planned EHR must possess existing functionality/ability to establish data sharing interfaces with the major primary care provider in their county collaborative to support bi-directional integration
  4. Describe necessary steps to ensure that current or planned EHR has functionality that can be implemented to promote the sharing of data and/or the development of data analytics in support of improved clinical outcomes
  5. Describe expected allocation of funds to support Integrated Managed Care and bi-directional integration

- **Improving Quality Improvement & Change Management Capacity:** Moving to value-based payment requires organizations to develop or enhance their skills, capacity, and systems for managing clinical, financial, and operational performance and risk. The learning Cohorts BHT is establishing for Partnering Providers for DY3 will require interdisciplinary teams from each organization to build capacity to understand and act on organizational performance and increase their knowledge of quality improvement processes.

- What is the role of the region's provider/practice champions as it relates to providing guidance to regional partners in support of value-based care goals?

  The **Provider Champions Council** will play a leadership role, in promoting and supporting necessary changes to move toward value-based care, serving as key champions for whole-person, value-based care in the region. It is expected Providers on this council and throughout the region will serve as faculty for the learning Cohorts BHT will launch during DY3. Provider/practice leaders in the January Cohort will also share their expertise with providers and practice staff in the August Cohort for peer-to-peer learning.

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Regional Readiness for Health Information Technology (HIT) / Health Information Exchange (HIE)

Explain how the region is advancing HIT/HIE objectives.

ACH Response
Responses must cover the following: • What actionable steps are the ACH taking to facilitate information exchange between providers at points of care? Provide three examples. • How is the ACH leveraging Transformation incentives, resources, and activities to support statewide information exchange systems? BHT is taking steps to ensure that Partnering Providers—particularly behavioral health providers—have the foundational HIT and HIE capacity needed to support integration. In its initial steps, BHT has taken a broad view of HIT and HIE readiness, rather than focusing exclusively on point-of-care information exchange. Following are three examples of how BHT is supporting regional readiness: 1. BHT assisted primary care (PC) and behavioral health (BH) providers in the region to assess and document their baseline HIT and HIE capacity and barriers via two assessments: a broad Medicaid Transformation Project (MTP) Capacity Assessment; and 2) a fully integrated managed care (FIMC) readiness assessment with BH partners only, using Qualis Health's Behavioral Health Agency Billing Survey tool. Key contacts at each participating agency or clinic received a PDF copy of their responses and overall results were made available to partners, as well as BHT's Collaboratives and Technical Councils for planning purposes. Assessment results suggested that PC and BH providers in BHT's region do commonly exchange information but that exchange is typically *not* electronic, as shown in the table below:

	Clinics exchanging info with this provider type	At least some of the info exchange is electronic
Primary care	95% (61)	38% (24)
Hospitals and/or EDs	92% (59)	24% (15)
Mental health	95% (61)	23% (15)
Substance use disorder	89% (57)	23% (15)

Oral health	61% (39)	16% (10)	
Long-term care	78% (50)	5% (3)	
Community-based organizations	88% (56)	8% (5)	

Commonly reported barriers to increased use of HIT and HIE included: lack of interoperability of different systems (55% noted this as a barrier); cost (48%); technical issues with hosting or performance (44%); workflow constraints and privacy/confidentiality concerns (42% each). Thirteen clinics, all in rural counties, noted insufficient broadband capacity as a barrier.

2. With support from HCA, BHT contracted with Xpio Health, a business and technology consulting firm, to provide technical assistance to BHT's behavioral health providers to prepare for Integrated Managed Care. Xpio met individually with provider organizations to assist in documenting IT needs and answer questions. XPIO will make recommendations to BHT for further funding or technical to support clinical and operational improvements. Echoing the earlier assessments, Xpio has found that IT systems are generally less robust among smaller, rural, and behavioral-health only providers.

3. BHT intends to use the remainder of its Year 1 FIMC incentive funds (approximately $1 million) to assist providers to acquire the EHR systems and/or capacity they need to be successful in 2019 and beyond. In addition to supporting the transition to a new billing environment, a primary goal of this investment is to assist behavioral health and Tribal partners to prepare for working bi-directionally with primary care. To that end, BHT approved an investment in partner EHR systems or upgrades with the expectation that those systems will possess capacity to enable electronic information exchange with primary care. As described in the previous section, Partnering Providers will earn IMC incentive dollars for hitting milestones that support integration.

4. BHT continues to participate the state's effort to build a state HIE system and is following the guidance issued by the Health Care Authority in August 2018. BHT stands ready to partner with the IGT Contributors to further develop a workable solution that acknowledges providers that work across ACH boundaries.

BHT is monitoring developments in statewide information exchange resources such as OneHealthPort and the Clinical Data Repository, as well as resources like EDIE/PreManage and the state Prescription Monitoring Program data system. Along with other ACHs, BHT has been working with CCS to develop application programming interfaces (API) with many of these systems.

Technical Assistance Resources and Support

Describe the technical assistance resources and support the ACH requires from HCA and other state agencies to successfully implement selected projects.

ACH Response

Response should cover the following:

- What technical assistance or resources have the ACH identified to be helpful? How has the ACH secured technical assistance or resources?

    BHT contracted with Providence CORE for data and analytics support. CORE has provided extensive TA on data, monitoring, evaluation, quality improvement, and reporting.

    BHT also contracts with HMA for subject matter expertise consulting and benefits from TA provided by their team of practicing clinicians related to bi-directional integration, opioid, and chronic disease management. BHT has requested that HMA staff provide content rich webinars on the opioid and chronic disease project areas. The HMA team also includes people who have worked in practice transformation, quality improvement, funds flow, and equity strategy development in Oregon and New York Medicaid Transformation efforts, and share helpful perspectives from those lessons learned.

    Ann Shields from the AIMS Center provided a webinar on bi-directional integration to our Partnering Providers, and has made herself and staff available to attend BHT meetings when needs or questions arise.

    BHT has benefited from work with Qualis Health, who have provided two trainings to our region, one specific to billing and another on quality improvement and value propositions. Qualis is also providing clinical support to partners in East Adams, Republic, and Washtucna. To promote cross ACH engagement, we have also invited Greater Columbia ACH providers to participate in these trainings.

    We have contracted with Xpio to provide TA support for Behavioral Health providers transitioning to IMC. Xpio offered one-on-one TA meetings with all of our Partnering Providers throughout DY2 Q2 and Q3.

    Finally, we have hosted two trainings with Adam Falcone on managed care Contracting, with content that supports an expanding complexity of negotiating contracts with both Medicaid and Medicare payers.

- What technical assistance or resources does the ACH require from HCA and other state agencies?

    BHT believes it is best to collaborate with other ACH partners and the HCA on shared TA as much as possible. The ACHs collectively developed the chart below, which highlights recommended areas for support:

Health System Capacity Building	Technical Assistance	Administrative
Strong partnerships with Washington Association of Public Hospital Districts	HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE.	Approving general behavioral health integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings.
Strong partnerships with Washington Hospital Association	Support from HCA for guidance on the ACHs' role in moving towards whole-person care and VBP.	Streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring.
Stronger collaboration between HCA and MCOs	ACH's would benefit from additional training to fully understand our role in supporting VBP contracts between HCA, MCOs, and provider organizations.	Streamline informational requests from our partners. This will enhance continued assessment and planning.
ACH and HCA continued collaboration to find interoperability solutions	ACH also seeks greater clarity on the state's ongoing role in the Practice Transformation Support Hub, the P-TCPi Practice Transformation Network, and its vision for continuity after January 2019.	Regular communication and access to results from state-level health system capacity surveys such as the VBP survey, the Washington State Health Workforce Sentinel Network and the Medicaid EHR Incentive Program.
HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Clear timelines and transparency about the extent of continued support planned—and needed—for practice transformation resources and initiatives	Engagement of ACH staff and key partners in design and dissemination of these and other surveys will also limit redundancy and increase response rates to data collection processes.

In collaboration with stakeholders, identify solutions for provider shortages, increasing access and expanding the scope of practice for current providers and allowing for reimbursement on additional codes	Support from the state on VBP, specifically understanding how we can advance VBP to support project implementation and sustainability of health system Transformation. This support can be facilitated through the MVP Action Team or other technical assistance from the state.	ACHs want to ensure that information held in these data repositories (*All-Payers Claims Database and Clinical Data Repository*) is accurate, accessible, timely, and useful to our Transformation work and to our partners.
Systems for Population Health Management support for: •Data governance •Interoperability •HIE •Disease registries •Telehealth •PreManage/EDIE •Centralized registries	Training and TA for key workforce positions within required projects (e.g., CHWs, peer support specialists, care coordinators BH specialists)	MCO VBP and quality improvement requirements as well as VBP models to support CHWs, peers and other positions not reimbursed by Medicaid
Stronger recruitment and tuition support at the state level for primary care, behavioral health, nursing and licensed social workers	Training and TA for common training needs: MAT, PMP, 6 Building Blocks, Transitional Care models, trauma-informed practices, cultural sensitivity	Establishing a career path for rural nursing and workforce needs, from high school, through four-year programs
Support for dental health aide therapists and other dental professions that expand scope of practice will improve dental access	Increased capacity for practice transformation support directly to participating providers-i.e. practice transformation coaches, clinical subject matter expertise, change management expertise, workforce training and collaborative tools needed to work across ACH regions	Improved coordination with DOH to ensure coordinated opioid prevention efforts

	Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) so they truly understand the types of VBP arrangements and rural multi-payer models, how it will impact them and what steps they should take to be prepared	Help bring more alignment to measures and incentives across payers. Reducing variability in how providers are rewarded for performance would allow providers to focus on the actual work of providing better care.
	Resources tailored to behavioral health providers who are having to build capacity around quality improvement and measurement as they look ahead and adapt to a landscape where they are rewarded for quality, not quantity	Advocate for increased Medicaid rates in Washington State. Providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation Projects.
	Best practices and strategies specific to billing/coding for healthcare providers that align payments with the intent behind bi-directional integration (i.e. DOH's Practice Transformation Hub is coordinating with the UW AIMS Center to provide guidance around collaborative care codes)	Taking leadership role around regulations that are a barrier to MTP goals. Specifically, behavioral health information exchange (42 CFR, Part 2). These laws prevent some of the ideals of healthcare reform and health information exchange from happening.

- What project(s)/area(s) of implementation would the ACH be interested in lessons learned or implementation experience from other ACHs?

  We continue to find that lack of safe and affordable housing stock is a big barrier to improved health in our region, especially for the most vulnerable and highest utilizers of the health and social determinant of health systems and would value any opportunities for lessons learned on innovation related to addressing this barrier.

  We will work closely with Providers and MCOs to ensure better access to and use of patient population data if we'll achieve success in VBC. We value the chance to learn from our colleagues who have made this kind of collaboration successful. Providers in our region are

keenly interested in hearing from non-traditional providers who have successfully identified and marketed their value proposition to large health systems or payers.

ACHs have a good track record of cross collaboration and communication. We think it is important to continue to engage in regular discussion on topics related to the movement building aspect of health transformation, best practices of engaging community/beneficiary voices, collective impact, and equity, which will be fundamental to success and sustainability.