



**Medicaid Transformation  
Accountable Communities of Health (ACH)**

**Implementation Plan Template:  
Work Plan Instructions & Portfolio Narrative**

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## TABLE OF CONTENTS

ACH CONTACT INFORMATION	3
SUBMISSION INSTRUCTIONS	3
PROJECT WORK PLAN REQUIREMENTS	5
Instructions	5
MINIMUM REQUIRED TOOLKIT MILESTONES	7
Project 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	7
Project 2B: Community-Based Care Coordination	9
Project 2C: Transitional Care	11
Project 2D: Diversion Interventions	13
Project 3A: Addressing The Opioid Use Public Health Crisis	14
Project 3B: Reproductive and Maternal/Child Health	16
Project 3C: Access to Oral Health Services	18
Project 3D: Chronic Disease Prevention and Control	20
REQUIRED PORTFOLIO NARRATIVE	22
Partnering Provider Project Roles	22
Partnering Provider Engagement	48
Partnering Provider Management	59
Alignment with Other Programs	69
Regional Readiness for Transition to Value-based Care	72
Technical Assistance Resources and Support	81

## ACH CONTACT INFORMATION

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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](mailto:WADSRIP@mslc.com).

## PROJECT WORK PLAN REQUIREMENTS

### Instructions

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**<sup>1</sup> 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](mailto: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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<sup>1</sup> 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.).

- Beyond the milestones, ACH work plans must address additional, self-identified milestones and associated work steps to convey the work happening in their regions.
- 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.
  - *Health Systems and Community Capacity Building.* Work steps should include the collaborative work between HCA, the ACHs and statewide providers (e.g., UW, AWP/PHD) on health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment).
  - *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.
  - *Health Systems and Community Capacity Building.* Key deliverables/outcomes should reflect the collaborative work between HCA, the ACHs and statewide providers (e.g., UW, AWP/PHD) on health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment).
  - *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.)
- Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities.
  - Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities. (Completion no later than DY 3, Q4.)
- 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.)

Please refer to document GCACH.IP.Work Plan. 2A. 2C. 3A. 3D. 10.1.18. Tab: Work Plan Template – 2A Final.

## 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.)

GCACH is not participating in this project area.

## Project 2C: Transitional Care

### 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/pathways. (Completion no later than DY 3, Q2.)
- Implement project, including the following core components across each approach selected:
  - Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)
  - Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the electronic shared care plan). (Completion no later than DY 3, Q4.)
  - Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs. (Completion no later than DY 3, Q4.)
  - Incorporate activities that increase the availability of POLST forms across communities/agencies (<http://polst.org/>), where appropriate. (Completion no later than DY 3, Q4.)
  - Develop systems to monitor and track performance. (Completion no later than DY 3, Q4.)

### Stage 3: Scale & Sustain Milestones

- Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. (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.)

Please refer to document GCACH.IP.Work Plan. 2A. 2C. 3A. 3D. 10.1.18. Tab: Work Plan Template – 2C Final.

## Project 2D: Diversion Interventions

### 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/pathways. (Completion no later than DY 3, Q2.)
- Implement project, including the following core components across each approach selected:
  - Ensure participating partners are provided with, or have access to, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)
  - Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure team members, including client, have access to the information appropriate to their role in the team). (Completion no later than DY 3, Q4.)
  - Establish mechanisms for coordinating care management plans with related community-based services and supports such as those provided through supported housing programs. (Completion no later than DY 3, Q4.)

### Stage 3: Scale & Sustain Milestones

- Expand the model to additional communities and/or partner 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. (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.)

GCACH is not participating in this project area.

## 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.)

Please refer to document GCACH.IP.Work Plan. 2A. 2C. 3A. 3D. 10.1.18. Tab: Work Plan Template – 3A Final.

## Project 3B: Reproductive and Maternal/Child Health

### 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 project, including the following core components across each approach selected:
  - Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)
  - Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the care plan). (Completion no later than DY 3, Q4.)
  - Establish mechanisms, including technology-enabled, interoperable care coordination tools, for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs. (Completion no later than DY 3, Q4.)
  - Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes. (Completion no later than DY 3, Q4.)

### Stage 3: Scale & Sustain Milestones

- Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. (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.)

GCACH is not participating in this project area.

## Project 3C: Access to Oral Health Services

### 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 project, including the following core components across each approach selected:
  - Implement bi-directional communications strategies/interoperable HIE tools to support the care model. (Completion no later than DY 3, Q4.)
  - Establish mechanisms for coordinating care with related community-based services and supports. (Completion no later than DY 3, Q4.)
  - Develop workflows to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed. (Completion no later than DY 3, Q4.)
  - Establish referral relationships with dentists and other specialists, such as ENTs and periodontists. (Completion no later than DY 3, Q4.)
  - Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)
  - Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes. (Completion no later than DY 3, Q4.)
  - Engage with payers in discussion of payment approaches to support access to oral health services. (Completion no later than DY 3, Q4.)

### Stage 3: Scale & Sustain Milestones

- Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. (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.)

GCACH is not participating in this project area.

## 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.)

Please refer to document GCACH.IP.Work Plan. 2A. 2C. 3A. 3D. 10.1.18. Tab: Work Plan Template – 3D Final.

## 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.<sup>2</sup>
- 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?

<sup>2</sup> 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?

**How would a partnering provider organization explain its role in the transformation work?  
What does the provider need to be successful?**

Partnering provider organizations in the Greater Columbia ACH play numerous roles in the transformation work. They serve on GCACH workgroups, committees, and Boards. They act as subject matter experts, clinicians, and administrators. Partnering providers lead Local Health Improvement Networks, and run multi-million organizations, and small rural hospitals. They are leaders in the communities that they serve and are part of the bigger vision to transform our healthcare delivery system. They provide services to over 85% of the regional Medicaid population across a spectrum of sectors. Many of these providers will be implementing projects in the four project areas and becoming Patient-Centered Medical Homes between now and 2021.

Many of the GCACH Board of Directors are also partnering providers, giving them a unique opportunity to shape transformation efforts in their communities. Using the Transformation Project as a catalyst for change, Greater Columbia ACH partnering providers are embracing the Patient-Centered Medical Home model of care to transform the delivery system. Three of them are exemplar organizations, achieving NCQA recognition as excellent examples of team base, integrated, coordinated care.

Broadly speaking, partnering provider organizations advance the planning, implementation, and monitoring of the Medicaid Transformation Project. Whether at the 30,000-foot level (Board of Directors), adding clarity to working details of a program (Provider Readiness Committee), or delivering direct services, each partnering provider contributes to the understanding, progress and path towards health care transformation, and its numerous components.

In order to be successful in the transformation work, partnering provider organizations will need to mentor, lead, and engage with each other, and with other community organizations. They will need to adopt a “team-based approach” to serving their patients and adapt to new workflows and processes. They will need to offer physical and behavioral health as part of a person’s care and provide 24/7 access.

Organizations desiring to certify as PCMH will follow a structured program of change concepts leading to PCMH certification. PCMH organizations will receive the support and assistance of the GCACH Practice Transformation Team, funding for population health management and reporting tools, access to Learning Collaboratives, and incentives for completed milestones. They may be selected for special demonstration projects, or act as mentors to other organizations.

**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.**

Twenty-three provider organizations are receiving technical assistance to advance or adopt the Patient Centered Medical Homes model of care. Seventeen behavioral health providers are receiving technical assistance for transitioning to fully integrated managed care by January 2019. Please refer to the Project schedules following the examples of partnering provider organizations to view the specific milestones that each organization will be undertaking between DY2, Quarter 3 and DY3, Quarter 4.

Name and type of the Partnering Organization	Involvement in Project Areas	Roles and Responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?
<p><b><u>Astria Sunnyside Hospital</u></b>  <i>Hospital</i>  <b>Traditional Medicaid Provider</b></p> <p>Astria Sunnyside Hospital is a Level 1 Cardiac facility, offering 24-hour emergency room services, intensive care unit, cancer care, laboratory services and diagnostic imaging. The Astria Health Affiliate specializes in General Surgery, Orthopedics, Neurosurgery, Urology, Interventional Radiology and Otolaryngology. Astria’s vision is to build sustainable healthcare organizations that deliver comprehensive quality-care to improve health in the communities they serve.</p>	<p>Bi-Directional Integration</p> <p>Transitional Care</p> <p>Opioid Use</p> <p>Chronic Disease</p>	<p>Participation in the Leadership Council or Board of Directors, or Opioid, Chronic Disease, Bi-directional Integration, or Transitional Care Project Team, or participation in the Practice Transformation Workgroup, or participation in a Learning Collaborative, or participating in at least one learning webinar per month.</p> <p>Working with GCACH staff to identify clinics willing to become Patient-Centered Medical Homes (PCMH).</p> <p>Working with identified clinics to develop and implement the necessary steps in becoming PCMH recognized including:</p> <ul style="list-style-type: none"> <li>• Contracting with GCACH, Budgeting, HIT, MeHAF, EHR, Training and PCMH Assessments, Visioning and Goal Setting,</li> <li>• Creation of a Quality Improvement (QI) Team to developing Workflows, Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> </ul>

		<ul style="list-style-type: none"> <li>• Creation of policies to provide 24/7 access for patients, and 24/7 access for providers for remote access to organization’s EHR, implementation of decision-making tools, and proactively manage empanelment to providers</li> <li>• Implementing population health management tools to enable clinic to risk stratify patients, provide patient portals, provide secure messaging to care partners, receive daily updates on emergency department and hospital admissions</li> <li>• Conduct patient and family engagement on a regular basis</li> <li>• Report on clinical quality metrics, pay-for-reporting metrics, and practice transformation process measures</li> </ul> <p>Use an ONC-certified EHR</p> <p>Provide care management to at least 80% of highest risk patients which will include:</p> <ul style="list-style-type: none"> <li>• Bi-Directional integration of behavioral Health and/or primary Care</li> <li>• Implementation of tools for screening and treatment</li> <li>• Collecting ED visit data through PreManage software on a daily basis</li> <li>• Collecting Inpatient data through PreManage on a daily basis</li> <li>• Implementing self-management support</li> </ul>
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		<ul style="list-style-type: none"> <li>Medication Management</li> </ul>
<p><b><u>Blue Mountain Heart to Heart</u></b>  <i>Community-Based Organization (CBO)</i>  <b>Traditional Medicaid Provider</b></p> <p>Blue Mountain Heart to Heart is a Community-Based Organization (CBO) whose mission is to promote public health with advocacy, education, harm reduction, and support for individuals across a spectrum of chronic conditions, with a special emphasis on HIV prevention and care. The organization hopes to encourage an environment of dignity and improved quality of life for the entire community. Blue Mountain Heart to Heart has been serving clients and providing prevention education to communities in Walla Walla, Dayton, and the Tri-Cities since 1991.</p>	Opioid Use	<p>Participation in the Opioid Project Team, Chronic Disease or Bi-directional Integration Project Team, or participation in the Practice Transformation Workgroup, or participation in a Learning Collaborative.</p> <p>Provision of services that might include syringe exchange, substance use treatment, recovery supports, education on prevention, case management, insurance enrollment, housing assistance, legal services, support groups, and other services that would be in a community’s network of care.</p> <p>Willingness to make connections with GCACH staff, Local Health Jurisdictions, primary care providers, local government, landlords, hospitals, judicial system, law enforcement, support groups, and faith-based institutions wanting to be a part of the community-wide effort to address the opioid crisis.</p>
<b>Name and type of the Partnering Organization</b>	<b>Involvement in Project Areas</b>	<b>Roles and Responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?</b>
<p><b><u>Community Health of Central Washington (CHCW)</u></b>  <i>Federally Qualified Health Center (FQHC)</i></p>	Bi-Directional Integration	Participation in the Leadership Council or Board of Directors, or Opioid, Chronic Disease, Bi-directional

<p><b>Traditional Medicaid Provider</b></p> <p>Community Health of Central Washington is a Federally Qualified Healthcare Provider (FQHC), and awarded Patient Centered Medical Home Certification by NCQA for five clinic sites in the Greater Columbia ACH service area. They provide medical, behavioral and oral health services to 30,000 residents of all ages regardless of their ability to pay. Their patients receive preventive services, care for acute and chronic illness, and care in their clinics, hospitals and other sites. They provide prenatal and obstetric services in Yakima and Kittitas Counties, pharmacy services, senior residential care, and oral health. CHCW has a family medicine residency program that has operated since 1993 and is responsible for graduating nearly 30 family doctors who practice in the area which has helped ease the primary care shortage. They also participate in training many other health care professions.</p>	<p>Transitional Care</p> <p>Opioid Use</p> <p>Chronic Disease</p>	<p>Integration, or Transitional Care Project Team, or participation in the Practice Transformation Workgroup, or participation in a Learning Collaborative, or participating in at least one learning webinar per month.</p> <p>As an exemplar organization, CHCW will collaborate and provide mentoring to the other partnering providers that are adopting the PCMH model of care. They will also be implementing projects in the four project areas.</p> <p>Working with exemplar clinics to develop and implement the necessary steps to support continued progress with PCMH:</p> <ul style="list-style-type: none"> <li>• Contracting with GCACH, Budgeting, HIT, MeHAF, EHR, Training and PCMH Assessments, Visioning and Goal Setting,</li> <li>• Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> <li>• Report on clinical quality metrics, pay-for-reporting metrics, and practice transformation process measures</li> </ul> <p>Provide care management to at least 80% of highest risk patients which will include:</p> <ul style="list-style-type: none"> <li>• Bi-Directional integration of behavioral Health and/or primary Care</li> </ul>
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<p><b><u>Comprehensive Healthcare</u></b>  <i>Behavioral Health Provider</i>  <b>Traditional Medicaid Provider</b></p> <p>Since the 1970's, Comprehensive Healthcare has been providing services to children, adults, and families throughout Eastern Washington. Comprehensive is a private nonprofit organization that offers a full range of behavioral health and substance use disorder treatment services, with special programs for veterans, victims of crime, parents and employees. The organizations core values include integrity, quality, diversity, openness, teamwork, creativity, accountability, collaboration, respect and stewardship. More than 700 highly trained and qualified professional staff provide behavioral healthcare services to over 20,000 individuals each year.</p>	<p>Bi-Directional  Integration  Transitional Care  Opioid Use</p>	<p>Comprehensive Healthcare will be transitioning to fully integrated managed care (IMC) by the end of 2018. This requires completing the MeHAF and Toolkit assessments, purchasing software that can report data to the Managed Care Organizations, Developing a Transition Plan, Contracting with GCACH, and testing billing prior to January 2019.</p> <p>Once they have successfully transitioned to managed care, Comprehensive will go through the same process to become PCMH excluding those steps that they have already taken during the IMC phase:</p> <ul style="list-style-type: none"> <li>Contracting with GCACH, Budgeting, Training and PCMH Assessments, Visioning and Goal Setting</li> <li>Creation of a Quality Improvement (QI) Team to developing Workflows, Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> <li>Creation of policies to provide 24/7 access for patients, and 24/7 access for providers for</li> </ul>

		<p>remote access to organization’s EHR, implementation of decision-making tools, and proactively manage empanelment to providers</p> <ul style="list-style-type: none"> <li>• Implementing population health management tools to enable clinic to risk stratify patients, provide patient portals, provide secure messaging to care partners, receive daily updates on emergency department and hospital admissions</li> <li>• Conduct patient and family engagement on a regular basis</li> <li>• Report on clinical quality metrics, pay-for-reporting metrics, and practice transformation process measures</li> </ul> <p>Use an ONC-certified EHR</p> <p>Provide care management to at least 80% of highest risk patients which will include:</p> <ul style="list-style-type: none"> <li>• Bi-Directional integration of behavioral Health and/or primary Care</li> <li>• Implementation of tools for screening and treatment</li> <li>• Collecting ED visit data through PreManage software on a daily basis</li> <li>• Collecting Inpatient data through PreManage on a daily basis</li> <li>• Implementing self-management support</li> <li>• Medication Management</li> </ul>
<p><b><u>Consistent Care-</u></b> <i>Case Management and Care Coordination Agency</i></p>	<p>Transitional Care</p>	<p>Participation in the Opioid Project Team, Chronic Disease or Bi-directional Integration Project Team, or</p>

<p><b><i>Traditional Medicaid Provider</i></b></p> <p>Consistent Care is a care coordination and case management organization. They have locations across Washington State that focus on engaging resources of the entire community limits of the traditional health care setting to reduce the amount of frequent Emergency Department (ED) users. Each Consistent Care patient receives the tools they need (i.e. transportation, a home and food) beyond the to become successful contributors in their community.</p>	<p>Opioid Crisis</p> <p>Chronic Disease</p>	<p>participation in the Practice Transformation Workgroup, or participation in a Learning Collaborative.</p> <p>Provision of care management services that might include the development of a care plan including substance use treatment, home visits, recovery supports, education on prevention, case management, medicine reconciliation, insurance enrollment, housing assistance, employment assistance, legal services, support groups, and other services that would be in a community’s network of care. Emergency department diversions is Consistent Care’s core competency. They use community-based care coordination, outreach and provider/patient education to address moderate to high users of the hospital ED.</p> <p>Willingness to make connections with GCACH staff, Local Health Jurisdictions, primary care providers, local government, landlords, hospitals, judicial system, law enforcement, workforce specialists, support groups, and faith-based institutions wanting to be a part of the community-wide effort to address the opioid crisis.</p>
<p><b><u>Kadlec Regional Medical Center</u></b> <i>Hospital</i> <b><i>Traditional Medicaid Provider</i></b></p>	<p>Bi-Directional Integration</p> <p>Transitional Care</p>	<p>Participation in the Leadership Council or Board of Directors, or Opioid, Chronic Disease, Bi-directional Integration, or Transitional Care Project Team, or participation in the Practice Transformation</p>

<p>Kadlec Regional Medical Center opened in 1944 and was established to care for the Hanford area workers and their families. As a nonprofit, private corporation governed by local volunteer trustees, the Kadlec hospital is home to a growing open-heart surgery and interventional cardiology program, the region’s only level III neonatal intensive care unit, and a world-class all digital outpatient imaging center.</p>	<p>Opioid Use</p> <p>Chronic Disease</p>	<p>Workgroup, or participation in a Learning Collaborative, or participating in at least one learning webinar per month.</p> <p>Working with GCACH staff to identify clinics willing to become Patient-Centered Medical Homes (PCMH).</p> <p>Working with identified clinics to develop and implement the necessary steps in becoming PCMH recognized including:</p> <ul style="list-style-type: none"> <li>• Contracting with GCACH, Budgeting, HIT, MeHAF, EHR, Training and PCMH Assessments, Visioning and Goal Setting,</li> <li>• Creation of a Quality Improvement (QI) Team to developing Workflows, Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> <li>• Creation of policies to provide 24/7 access for patients, and 24/7 access for providers for remote access to organization’s EHR, implementation of decision-making tools, and proactively manage empanelment to providers</li> <li>• Implementing population health management tools to enable clinic to risk stratify patients, provide patient portals,</li> </ul>
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		<p>provide secure messaging to care partners, receive daily updates on emergency department and hospital admissions</p> <ul style="list-style-type: none"> <li>• Conduct patient and family engagement on a regular basis</li> <li>• Report on clinical quality metrics, pay-for-reporting metrics, and practice transformation process measures</li> </ul> <p>Use an ONC-certified EHR</p> <p>Provide care management to at least 80% of highest risk patients which will include:</p> <ul style="list-style-type: none"> <li>• Bi-Directional integration of behavioral Health and/or primary Care</li> <li>• Implementation of tools for screening and treatment</li> <li>• Collecting ED visit data through PreManage software on a daily basis</li> <li>• Collecting Inpatient data through PreManage on a daily basis</li> <li>• Implementing self-management support</li> <li>• Medication Management</li> </ul>
<p><b><u>Kittitas County Public Hospital District #1 Kittitas Valley Healthcare</u></b></p> <p><i>Public Hospital District</i>  <b>Traditional Medicaid Provider</b>  Kittitas Valley Healthcare is a public hospital district that is governed by a five-member elected Board of</p>	<p>Bi-Directional Integration</p> <p>Transitional Care</p> <p>Opioid Use</p> <p>Chronic Disease</p>	<p>Participation in the Leadership Council or Board of Directors, or Opioid, Chronic Disease, Bi-directional Integration, or Transitional Care Project Team, or participation in the Practice Transformation Workgroup, or participation in a Learning Collaborative, or participating in at least one learning webinar per month.</p>

<p>Commissioners and almost entirely supported by revenue from generated patient services. KVH provides care through clinics including family medicine, internal medicine, orthopedics, general surgery, women’s health and urgent care. KVH also provides specialty services through home health, hospice, physical therapy, speech therapy and occupational therapy.</p>		<p>KVH is testing an IT integrate care coordination pilot project (the Health Commons) in Kittitas that incorporates a use case which also includes behavioral health, EMS, primary care and social service providers. The Health Commons seeks to provide e-referrals and shared care plans.</p> <p>Working with GCACH staff to identify clinics willing to become Patient-Centered Medical Homes (PCMH).</p> <p>Working with identified clinics to develop and implement the necessary steps in becoming PCMH recognized including:</p> <ul style="list-style-type: none"> <li>• Contracting with GCACH, Budgeting, HIT, MeHAF, EHR, Training and PCMH Assessments, Visioning and Goal Setting,</li> <li>• Creation of a Quality Improvement (QI) Team to developing Workflows, Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> <li>• Creation of policies to provide 24/7 access for patients, and 24/7 access for providers for remote access to organization’s EHR, implementation of decision-making tools, and proactively manage empanelment to providers</li> </ul>
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<p><b><u>Lourdes Health Network</u></b></p> <p><i>Hospital</i></p> <p><b><i>Traditional Medicaid Provider</i></b></p>	<p>Bi-Directional Integration</p> <p>Opioid Use</p>	<p>Participation in the Leadership Council or Board of Directors, or Opioid, Chronic Disease, Bi-directional Integration, or Transitional Care Project Team, or participation in the Practice Transformation Workgroup, or participation in a Learning</p>

<p>Since 1916, Lourdes Health Network has had a rich history of being called to respond to the health care needs of the local community with a Christian spirit. The hospital believes that health care should be effective, safer and more available to all people. The organization provides an array of services including cardiology, counseling, pain management, pediatrics, rheumatology and more!</p>	<p>Chronic Disease</p>	<p>Collaborative, or participating in at least one learning webinar per month.</p> <p>Working with GCACH staff to identify clinics willing to become Patient-Centered Medical Homes (PCMH). Since LHN was the initial provider to successfully proceed through the GCACH Practice Transformation process, we expect that they will provide academic detailing to other organizations who also go through the process.</p> <p>Working with identified clinics to develop and implement the necessary steps in becoming PCMH recognized including:</p> <ul style="list-style-type: none"> <li>• Contracting with GCACH, Budgeting, HIT, MeHAF, EHR, Training and PCMH Assessments, Visioning and Goal Setting,</li> <li>• Creation of a Quality Improvement (QI) Team to developing Workflows, Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> <li>• Creation of policies to provide 24/7 access for patients, and 24/7 access for providers for remote access to organization’s EHR, implementation of decision-making tools, and proactively manage empanelment to providers</li> </ul>
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<p><b><u>Pullman Regional Hospital</u></b></p> <p><i>Public Hospital District</i></p> <p><b><i>Traditional Medicaid Provider</i></b></p>	<p>Bi-Directional Integration,</p> <p>Transitional Care</p>	<p>Participation in the Leadership Council or Board of Directors, or Opioid, Chronic Disease, Bi-directional Integration, or Transitional Care Project Team, or participation in the Practice Transformation Workgroup, or participation in a Learning</p>

<p>Pullman Regional Hospital is in Pullman, Washington at the heart of the Palouse. Pullman Regional provides an array of treatment and prevention services, each at the forefront of the medical industry and is designed to provide the most comprehensive benefits to their patients including: 24-hour emergency medicine care, 24-hour access to stroke neurologists, occupational, massage, speech and physical therapy, 4 state-of-the-art operating rooms, and more!</p>	<p>Chronic Disease</p>	<p>Collaborative, or participating in at least one learning webinar per month.</p> <p>Working with GCACH staff to identify clinics willing to become Patient-Centered Medical Homes (PCMH).</p> <p>Working with identified clinics to develop and implement the necessary steps in becoming PCMH recognized including:</p> <ul style="list-style-type: none"> <li>• Contracting with GCACH, Budgeting, HIT, MeHAF, EHR, Training and PCMH Assessments, Visioning and Goal Setting,</li> <li>• Creation of a Quality Improvement (QI) Team to developing Workflows, Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> <li>• Creation of policies to provide 24/7 access for patients, and 24/7 access for providers for remote access to organization’s EHR, implementation of decision-making tools, and proactively manage empanelment to providers</li> <li>• Implementing population health management tools to enable clinic to risk stratify patients, provide patient portals, provide secure messaging to care partners,</li> </ul>
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		<p>receive daily updates on emergency department and hospital admissions</p> <ul style="list-style-type: none"> <li>• Conduct patient and family engagement on a regular basis</li> <li>• Report on clinical quality metrics, pay-for-reporting metrics, and practice transformation process measures</li> </ul> <p>Use an ONC-certified EHR</p> <p>Provide care management to at least 80% of highest risk patients which will include:</p> <ul style="list-style-type: none"> <li>• Bi-Directional integration of behavioral Health and/or primary Care</li> <li>• Implementation of tools for screening and treatment</li> <li>• Collecting ED visit data through PreManage software on a daily basis</li> <li>• Collecting Inpatient data through PreManage on a daily basis</li> <li>• Implementing self-management support</li> <li>• Medication Management</li> </ul>
<p><b><u>Tri Cities Community Health</u></b></p> <p><i>Federally Qualified Health Center (FQHC)</i></p> <p><b><i>Traditional Medicaid Provider</i></b></p> <p>Tri-Cities Community Health (TCCH) began as a modest-sized clinic in Pasco, Washington in 1981. The clinic was founded by a small group of women in the Pasco community who saw the need to serve low-income community members who could not afford to</p>	<p>Bi-Directional Integration</p> <p>Transitional Care</p> <p>Opioid Use</p> <p>Chronic Disease</p>	<p>Participation in the Leadership Council or Board of Directors, or Opioid, Chronic Disease, Bi-directional Integration, or Transitional Care Project Team, or participation in the Practice Transformation Workgroup, or participation in a Learning Collaborative, or participating in at least one learning webinar per month.</p>

<p>pay for health care. In 1992, the clinic met the requirements to become a designated Federally Qualified Health Center (FQHC), which made the clinic eligible to obtain financial support from the federal and state governments to expand services.</p>		<p>Working with GCACH staff to identify clinics willing to become Patient-Centered Medical Homes (PCMH).</p> <p>Working with identified clinics to develop and implement the necessary steps in becoming PCMH recognized including:</p> <ul style="list-style-type: none"> <li>• Contracting with GCACH, Budgeting, HIT, MeHAF, EHR, Training and PCMH Assessments, Visioning and Goal Setting,</li> <li>• Creation of a Quality Improvement (QI) Team to developing Workflows, Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> <li>• Creation of policies to provide 24/7 access for patients, and 24/7 access for providers for remote access to organization’s EHR, implementation of decision-making tools, and proactively manage empanelment to providers</li> <li>• Implementing population health management tools to enable clinic to risk stratify patients, provide patient portals, provide secure messaging to care partners, receive daily updates on emergency department and hospital admissions</li> </ul>
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<p><b><u>Yakima Neighborhood Health Services</u></b></p> <p><i>Federally Qualified Health Center (FQHC)</i>  <b><i>Traditional Medicaid Provider</i></b></p> <p>Established in 1975, Yakima Neighborhood Health Services (YNHS) today serves more than 23,000 patients annually. The Federally Qualified Healthcare Center (FQHC) is the first Health Center in Washington State to achieve the highest level of</p>	<p>Bi-Directional Integration</p> <p>Transitional Care</p> <p>Opioid Use</p> <p>Chronic Disease</p>	<p>Participation in the Leadership Council or Board of Directors, or Opioid, Chronic Disease, Bi-directional Integration, or Transitional Care Project Team, or participation in the Practice Transformation Workgroup, or participation in a Learning Collaborative, or participating in at least one learning webinar per month.</p> <p>As an exemplar organization, YNHS will collaborate and provide mentoring to the other partnering providers that are adopting the PCMH model of care.</p>

<p>recognition possible as a Patient-Centered Medical Home and are accredited by the Joint Commission. The organization’s mission is to provide affordable, accessible, quality health care, promote learning opportunities for students of health professions, end homelessness and improve quality of life in local communities.</p>		<p>They will also be implementing projects in the four project areas.</p> <p>Working with exemplar clinics to develop and implement the necessary steps to support continued progress with PCMH:</p> <ul style="list-style-type: none"> <li>• Contracting with GCACH, Budgeting, HIT, MeHAF, EHR, Training and PCMH Assessments, Visioning and Goal Setting,</li> <li>• Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> <li>• Report on clinical quality metrics, pay-for-reporting metrics, and practice transformation process measures</li> </ul> <p>Provide care management to at least 80% of highest risk patients which will include:</p> <ul style="list-style-type: none"> <li>• Bi-Directional integration of behavioral Health and/or primary Care</li> <li>• Collecting ED visit data through PreManage software on a daily basis</li> </ul>
<p><b><u>Yakima Valley College (YVC)</u></b></p> <p><i>Community College</i> <b>Non-Traditional Provider</b></p>	<p>Domain 1, Workforce</p>	<p>Dan Ferguson is the Director of the Washington State Allied Health Center of Excellence, and a Board member of GCACH. He is involved in numerous state agencies and activities in analyzing, understanding, and growing the healthcare workforce for the state of Washington. He has been</p>

<p>Yakima Valley College was founded in 1928, offering applied science degrees in business management, information technology, and dental hygiene. Over half of the students at YVC are Hispanic/Latino (55%), with the remainder of students being Caucasian, Native American, African American, or Asian/Pacific Islander. YVC is home to the Washington State Allied Health Center of Excellence, a flagship institution that is focused on the state’s health workforce industry. Centers are guided by industry representatives to lead collaborative and coordinated statewide education and training efforts to build a competitive workforce in a global economy.</p>		<p>instrumental in bringing expertise to the table with respect to workforce.</p> <p>He has acted as a broker of information and resources related to the healthcare industry for industry representatives, community-based organizations, economic development organizations, community and technical colleges, secondary education institutions, and four-year colleges and universities.</p> <p>Working with and through Dan and the resources he can bring to the table, GCACH hopes to create, develop and train a workforce that has the skills needed to perform under the PCMH model. Activities may include:</p> <ul style="list-style-type: none"> <li>• Legislation to address scope of licensing/practice issues</li> <li>• Creating healthcare pathways that allow entrance into healthcare industries along a continuum</li> <li>• Training for team-based care and workers to practice at top-of-license</li> <li>• Inter-professional training to promote and facilitate partnerships between Washington State University, Heritage University, Central Washington University and Pacific Northwest University of Health Sciences</li> </ul>
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<p><b><u>Yakima Valley Farmworkers Clinic</u></b></p> <p><i>Federally Qualified Health Center (FQHC)</i>  <b><i>Traditional Medicaid Provider</i></b></p> <p>Yakima Valley Farm Workers Clinic first opened in 1973 with a mission to provide migrant and seasonal farm workers healthcare, an initiative that was nearly non-existent at the time. Today, YVFWC has locations throughout Washington and Oregon and is known as the second largest community-based health center in the Pacific Northwest. The FQHC organization strives to embrace new technologies and systems that engage and empower patients to actively participate in personal care as well as meet the evolving needs of local communities.</p>	<p>Bi-Directional Integration</p> <p>Transitional Care</p> <p>Opioid Use</p> <p>Chronic Disease</p>	<p>Participation in the Leadership Council or Board of Directors, or Opioid, Chronic Disease, Bi-directional Integration, or Transitional Care Project Team, or participation in the Practice Transformation Workgroup, or participation in a Learning Collaborative, or participating in at least one learning webinar per month.</p> <p>As an exemplar organization, YVFWC will collaborate and provide mentoring to the other partnering providers that are adopting the PCMH model of care. They will also be implementing projects in the four project areas.</p> <p>Working with exemplar clinics to develop and implement the necessary steps to support continued progress with PCMH:</p> <ul style="list-style-type: none"> <li>• Contracting with GCACH, Budgeting, HIT, MeHAF, EHR, Training and PCMH Assessments, Visioning and Goal Setting,</li> <li>• Development of a Practice Transformation Implementation Workplan (PTIW), Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments</li> <li>• Report on clinical quality metrics, pay-for-reporting metrics, and practice transformation process measures</li> </ul> <p>Provide care management to at least 80% of highest risk patients which will include:</p>
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		<ul style="list-style-type: none"> <li>• Bi-Directional integration of behavioral Health and/or primary Care</li> <li>• Collecting ED visit data through PreManage software on a daily basis</li> </ul>
<p><b>Yakama Nation</b></p> <p><i>Tribal Nation</i></p> <p><b><i>Non-Traditional Medicaid Provider</i></b></p> <p>The Yakama Nation Reservation is 1,130,000 acres and shares borders with Yakima, Klickitat, Lewis and Skamania Counties. Their total service population is approximately 13,000 Native Americans. They are a sovereign nation governed by the Yakama Tribal Council, which consists of representatives of 14 tribes. The Nation operates 28 programs including Maternal Child Health, Mental Health, Substance Use Disorders Treatment, Housing, Human Resources, Dental, Diabetes, Energy Assistance, and Cultural Programs.</p>	Bi-Directional Integration	<p>The Yakamas have chosen to:</p> <p>(1) Develop Integrated Physical and Behavioral Health Care Team Approach for IHS Service Unit and YN 638 programs.</p> <p>(2) Incorporate Behavioral Health Aides and/or Community Health Aides into YN 638 programs.)</p> <p>2019 Steps for Project:</p> <p>(1) YNBHS will:</p> <ul style="list-style-type: none"> <li>• Develop an Advisory Board</li> <li>• Research other Tribes legal and protocol frameworks, cross-program patient consent mechanisms, and Collaborative Care Model</li> </ul> <p>(2) YNBHS will:</p> <ul style="list-style-type: none"> <li>• Consult with Alaska Native Tribal Health Consortium of implementing program to Washington State.</li> <li>• Consult with Washington State HCA, ACH, Kristi Woodward (IHS), and AIHC on developing a program in Washington State.</li> <li>• Research billing systems and submit Drafts to MCO for approval</li> </ul>

Table 1: Partnering Provider Organizations

Tasks	COHORT 1, PARTNERING PROVIDERS - PCMH									COHORT 2, PARTNERING PROVIDERS - PCMH								
	16-Jul	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
	DY2, Qtr 3			DY2, Qtr 4			DY3, Qtr 1			DY3, Qtr 2			DY 3, Qtr 3			DY 3, Qtr 4		
Call for Partnering Providers																		
Select Partnering Providers for PCMH																		
Kick off meeting																		
MeHAF Assessment																		
PCMH Assessment																		
2018 Cost Analysis																		
Practice Transformation Implementation Workplan (PTIW)																		
Contract with GCACH																		
Vision & Mission Statements																		
Assessment of Baseline Data																		
Initiated Mentoring																		
Assessment of Training Needs																		
Assessment of EHR																		
QI Team Developed																		
Premanage/EDIE																		
Direct Messaging																		
Patient Portal Tool																		
Risk Stratification																		
Capacity/Identify Community Partners																		
Access 24/7 by Patient																		
Implement Patient Portal																		
Patient & Family Engagement																		
ED & Follow up - A B C																		
Resources for Care Coordination A B C																		
Identify and Implement Shared decision making tools or aids in 2 health conditions																		
Participate in Learning Collaborative Training																		
Participate in 1 webinar per month																		
2019 Budget																		
Establish Opioid Resource Networks																		
Project Implementation																		
Learning Collaboratives																		
Quarterly Reports																		

Tasks	COHORT 1, PARTNERING PROVIDERS - BH - IMC						COHORT 2, PARTNERING PROVIDERS - BH - IMC									
	DY2, Quarter 3			DY2, Quarter 4			DY3, Quarter 1			DY3, Qtr 2			DY3, Qtr 3		DY3, Qtr 4	
Registration in Portal																
CSA Complete																
Billing Toolkit Assessment																
MeHAF Assessment																
MeHAF sent to MCOs																
Billing Toolkit sent to MCOs																
Provider Appointments																
Assessments Reviewed																
Follow-up Appts																
Transition Plan Development																
Contract with GCACH																
Contract executed																
Funds Released to Provider																
Billing Testing																
Additional Infrastructure Identified																
Go Live																

Figure 1: Practice Transformation Status Tracker

## 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?
- How is training and/or technical assistance resources being delivered within that timeframe?
- How is the ACH engaging smaller, partnering providers and community-based organizations with limited capacity?
- 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)?
- How is the ACH coordinating with other ACHs in engaging partnering providers that are participating in project activities in more than one ACH?

The GCACH is supporting partnering providers, big and small, in a variety of ways during DY2, Quarter 3 through DY 3, Quarter 4. As shown in the previous project schedule, there will be one-on-one technical assistance from the GCACH Practice Transformation staff through June of 2019 to help partnering providers receive Patient Centered Medical Home recognition and certification, and to get ready for integrated managed care. GCACH staff will also be able to assist partnering providers with technical assistance in selecting population health management tools that complement their electronic health record systems, perform cost analysis and develop 2019 budgets, identify and link with community-based partners, and help develop the necessary protocols and workflows that provide linkages with their partners to provide continuity of care for of their patients.

Direct technical assistance from GCACH staff will include conducting the MeHAF, PCMH, and Billing Toolkit assessments, and assessments of partnering provider training needs, electronic health records system and reporting needs, performing a cost analysis of their 2018 operations and developing a 2019 budget, developing a Practice Transformation Implementation Workplan (PTIW) for their project areas, creating or confirming their vision and mission statements, building their care management capacity through analysis of workflows, training staff in using population health management tools so that they can run reports to manage patient care and communicate with their patients and partners, training on how to maximize reimbursements for the project areas, and assistance identifying community partners that will be part of their care team. The level of technical assistance will be dependent on the partnering providers'

existing population health management infrastructure, level of PCMH certification, and willingness to implement projects, however, all partnering providers will receive specific population health management tools to enable secure messaging to patients and partners, if needed.

While there is much expertise in health information technology with the GCACH staff, it is expected that the individual vendors will also provide technical assistance in selecting and installing population health management tools and infrastructure. Collective Medical Technologies, for example, can assist providers in implementing EDIE and PreManage to help manage high risk patients and to create the digital network to share care plans. Mike Hindmarsh of Hindsight Healthcare Strategies has provided technical assistance for implementing chronic disease management programs in primary care and was a featured speaker for the Leadership Council in August 2018. GCACH expects to retain his services to help set up the Learning Collaboratives in 2019.

Other assistance may have to be contracted with outside vendors to supplant partnering provider project specific needs.

The following table of common training needs has been developed by the nine Accountable Communities of Health (ACH) Health Systems and Community Capacity Building Partnership to support partnering providers in a variety of topical areas. The hope is that the training can be coordinated between ACHs to reduce costs, and to provide consistent training for all partnering providers.

Potential training partners by topic	
Topics	Possible Vendors/Trainers
<b>Change Management: Structured approach for ensuring changes are smoothly implemented and sustained. Impact on individuals and teams as they move from current to new state.</b>	NUKA system of care – Southcentral Foundation
	AIMS Center
	Qualis Health
	MacColl Institute
	Camden Coalition
	IHI Science of Improvement
	Hindsight Healthcare Strategies (Mike Hindmarsh)
<b>Collaborative Care Model   Bree Model   Z codes/collaborative care codes</b>	NUKA system of care – Southcentral Foundation
	AIMS Center
	Qualis Health
	MacColl Institute
<b>Cultural Competency   Community Engagement   CLAS   Equity Tool   Health Literacy   Working with Interpreters</b>	NUKA system of care – Southcentral Foundation
	Tacoma Pierce County Health Department - Jacques Colon

	AHRQ Health Literacy Universal Precautions Toolkit Second Edition
	CDC
	American Indian Health Commission of WA (cultural competency, health literacy)
	WSHA
	Haas Institute
	Healthy King County Coalition
	OHSU
	Teach back and Patient Activation
	Legacy Health System Annual Health Literacy Conference
	Interpreter Services Program, HCA
<b>Equity, Diversity and Inclusion</b>	john a. powell (Haas Institute)
	Tacoma Pierce County Health Department - Jacques Colon

	American Indian Health Commission of WA (Government to Government Training and historical trauma)
	CDC
	Pride Foundation
	Bridging Health & Community (Tamber)
	Children of the Setting Sun (Tribal)
	Healthy King County Coalition
<b>Managing Chronic Disease (BHA audience)</b>	Qualis Health
	MacColl Institute
	WA State Department of Health
	Hindsight Healthcare Strategies, PCMH (Mike Hindmarsh)
	WSU Extension Service-Diabetes Prevention
<b>Motivational Interviewing   Self Management Support   Harm Reduction</b>	NUKA system of care – Southcentral Foundation
	IHI

	Camden Coalition
	t3 <a href="http://us.thinkt3.com/">http://us.thinkt3.com/</a>
	Hindsight Healthcare Strategies (Mike Hindmarsh)
	CCSI
<b>Opioid Prescribing   Opioid Overdose Education   Opioid/ODU Screening   Six Building Blocks   MAT</b>	<a href="#">Six Building Blocks development team is Seattle-based (UW, MacColl Center, KPWHRI)</a> <a href="https://www.improvingopioidcare.org/about-us/">https://www.improvingopioidcare.org/about-us/</a>
	Camden Coalition
	t3 <a href="http://us.thinkt3.com/">http://us.thinkt3.com/</a>
	SAMHSA
	University of WA, Dr. Charissa Fotinos
	WA State Department of Health
<b>Population Health Management   Registries   Data Collection &amp; Analytics</b>	NUKA system of care – SouthCentral Foundation
	AIMS Center
	Qualis Health
	Camden Coalition

	IHI
	King County
	Health IT Analytics, Jennifer Bresnick
	CORE
	XPIO
	Quad Aim Partners (Information Exchange)
<b>Quality Improvement</b>	NUKA system of care – SouthCentral Foundation
	Qualis Health
	IHI
	Life QI
<b>Team Based Care   Care Planning, Management, Coordination   Working with Peers &amp; CHWs   Community Health Navigation &amp; Resources Training</b>	NUKA system of care – SouthCentral Foundation
	AIMS Center
	Qualis Health
	WA Department of Health (Community Health Workers)
	Kathy Burgoyne, contractor

	Oregon Community Health Worker Association (ORCHWA)
<b>VBP Contracting   Understanding NEW VBP World (Payment Integration, Working with MCOs, etc.)</b>	Qualis Health
	Feldesman Tucker Leifer Fidell, LLP (Adam Falcone)
<b>Trauma Informed Care</b>	Camden Coalition
	NAMI
	t3 <a href="http://us.thinkt3.com/">http://us.thinkt3.com/</a>
	Centers for Social Innovation (CRI)
	Darryl Tonemah, (American Indian health psychologist and musician)
	Kitsap Strong
<b>Oral Health Integration</b>	Arcora Foundation
	Qualis Health
<b>Reproductive Health</b>	Upstream
	Planned Parenthood
	One Key Question
<b>PreManage (BHA perspective)</b>	CMT

	Qualis
	Consulting support TBD
<b>Workforce Development</b>	WA DOH
	Weitzman Institute
	NUKA
	Interprofessional Practice & Education Pacific Northwest University of Health Sciences

*Table 2: Potential Training Partners by Topic*

In addition to the common trainings, the ACHs are coming together to address scope-of-practice, financing and regulatory barriers to providing whole person care, developing strategies to collect and report on data, supporting expanded site of service and scope for telehealth, advocating for reimbursement policies that align with the project areas, and coordinating strategies to address state-level training programs for Community Health Workers, and workforce shortages. The five ACHs that have contracted with OHSU (North Central, North Sound, Olympic Community of Health, Cascade Pacific Action Alliance, and Greater Columbia) are also working on an inventory and crosswalk to identify common measures that will align MCO contracts to ensure VBP alignment with providers.

Greater Columbia ACH is engaging smaller, partnering providers and community-based organizations with limited capacity in a variety of ways. All organizations receive GCACH’s monthly newsletter and special announcements, many attend the monthly Leadership Council meetings, or attend meetings within their Local Health Improvement Networks, and GCACH sent out almost 600 letters of interest in September of 2017 to any provider wishing to contract for services.

GCACH has contracted with Local Health Improvement Coalitions to bring more community-based organizations (CBO) into the delivery system, and all the CBOs will be eligible to apply for projects in their local communities through the Community Health Fund (CHF). The purpose of the CHF is to help mitigate the effects of Social Determinants in the communities which vary from county to county. Because of the feedback from the local health network partners and based on the Robert Wood Johnson’s data on social determinants of health by County, rural LHINs received more funding per Medicaid consumer than the ACH regional average. Garfield County, the least populated County in the State of Washington, for example, is receiving \$6.38/Medicaid beneficiary through the CHF due to their number of social determinants that are worse than the state average. The timeline for the CHF distribution is reliant on the LHIN’s selection of a third-party administrator (TPA), and finalization of the contract between GCACH and the TPA, however, all contracts are projected to be in place by January of 2019.

Local Health Improvement Network Abbreviation	Local Health Improvement Network Full Name
BFCHA	Benton-Franklin Community Health Alliance
BMRCHP	Blue-Mountain Regional Community Health Partnership
KCHN	Kittitas Community Health Network
SE WA RHN	Southeast Washington Rural Health Network
WCHN	Whitman County Health Network
YCHCC	Yakima County Health Care Coalition

Table 3: Local Health Improvement Abbreviations

LHIN	Total Population	Medicaid Population	% Medicaid	% GCACH Medicaid	WTSA Measures (worse than State Average)	WTSA %	Population Funds	WTSA Funds	Total Funding	Per Consumer
BFCHA	279,170	94,605	33.9%	37.0%	25	16.2%	\$185,191	\$32,078	\$217,269	\$2.30
BMRCHP	60,730	17,155	28.2%	6.7%	29	18.8%	\$33,581	\$37,210	\$70,792	\$3.86
KCHN	43,710	10,436	23.9%	4.1%	23	14.9%	\$20,429	\$29,512	\$49,940	\$4.79
SE WA RHN	28,400	8,705	30.7%	3.4%	30	19.5%	\$17,040	\$38,494	\$55,534	\$6.38
WCHN	47,940	8,392	17.5%	3.3%	18	11.7%	\$16,427	\$23,096	\$39,524	\$4.71
YCHCC	250,900	116,133	46.3%	45.5%	29	18.8%	\$227,332	\$37,210	\$264,542	\$2.28
<b>Totals</b>	<b>710,850</b>	<b>255,426</b>		<b>100%</b>	<b>154</b>	<b>100%</b>	<b>\$500,000</b>	<b>\$197,600</b>	<b>\$697,600</b>	<b>\$2.73</b>

Table 4: Local Health Improvement Network (LHIN) Dollars Outlined

Another way in which GCACH is engaging with smaller, partnering providers has been through a contract with the Health Care Authority to provide technical assistance for the Behavioral Health agencies (BHAs) transitioning to Integrated Managed Care (IMC). Several of these agencies are very small requiring a lot of technical support. All BHAs receive direct assistance with filling out the Current State Assessments, MeHAF, Billing Toolkit, Transition Plan, and Contingency Plans. The GCACH Project Manager for IMC organizes monthly meetings for three IMC workgroups, Provider Readiness, Early Warning System, and IMC Communications of which the smallest agencies have been attending. The one-on-one technical assistance has also resulted in new partnerships between Substance Use Disorder and Mental Health agencies. Finally, all non-Medicaid Providers will be receiving funding for Direct Secure Messaging to ensure that they can communicate with their partner organizations to share care plans, client information and referrals.

### **How is GCACH aligning with other ACHs who share providers?**

In order to coordinate the activities, processes and providers across the state, the ACHs have developed common trainings, held joint meetings, and shared MOUs and contract templates. Several of the ACHs are purchasing the same population health management software and reporting tools (e.g. CMT PreManage for ADT data and CSI Solutions for provider reporting). There are pilot projects relating to IT-driven care coordination that span the ACHs (e.g. Health Commons project, led by Quad Aim Partners). The Pathways Community HUB model for care coordination is being adopted by six ACHs, who are utilizing the same software reporting platform. ACH executive directors, along with Association of Washington Public Hospital Districts, University of Washington, the Department of Health and HCA, have formed a strategic partnership to identify common gaps and opportunities statewide for health system capacity building. The Health Capacity Building Partnership workgroup has met over several months to align strategies across organizations that advance value and system transformation. In part, they have come together to outline a common set of training topics and initiatives along with corresponding organizations providing training and assistance.

Members of the GCACH Practice Transformation Workgroup (PTW) include clinical leaders from organizations that span multiple ACHs. For example, Mark Wakai is the Chief Population Health Officer for Providence Health & Services, Brian Sandoval is the Director for Primary Care Behavioral Health for Yakima Valley Farmworkers and Lily Gonzalez performs diabetes education and community health awareness and education for Virginia Mason Memorial. These and others share the work of the GCACH with their respective organizational leaders and bring back to the GCACH work those same organizations are performing in other ACHs.

### **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?
- What are the key indicators used by the ACH to measure implementation progress by partnering providers within that timeframe?
- What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?
- How will the ACH support its partnering providers (e.g., provide technical assistance) if implementation progress to meet required project milestones is delayed?

The GCACH has been explicit with its partnering providers regarding project implementation through the distribution of the PCMH Efforts tracker. Through December 31, 2018, the following 23 partnering providers selected for PCMH will be expected to complete the tasks as bulleted below.

- Tri-Cities Community Health
- Catholic Charities Serving Central Washington
- Providence St. Mary Medical Center
- Palouse Medical
- Yakima Valley Farm Workers Clinic
- CHAS Health
- Astria Sunnyside Hospital
- Prosser Memorial Health
- Yakima Neighborhood Health Services
- Columbia County Health System

- Comprehensive Healthcare
- Lourdes Health
- Quality Behavioral Health
- Garfield County Hospital District/Pomeroy Medical Clinic
- Memorial Physicians
- Kittitas Valley Healthcare
- Community Health of Central Washington
- Columbia Basin Health Association
- Kadlec Regional Medical Center
- Student Health Options
- Astria - Yakima Hospital
- Pullman Regional Hospital
- Astria Toppenish Hospital

**The following activities and tasks will be required of all 23 PCMH partnering providers by the end of DY2, Quarter 4**

- Kick off meeting
- MeHAF Assessment
- PCMH Assessment
- 2018 Cost Analysis
- Practice Transformation Implementation Workplan (PTIW)
- Contract with GCACH
- Vision & Mission Statements
- Initiated Mentoring
- Assessment of Training Needs
- Assessment of EHR
- QI Team Developed

**The additional activities and tasks will be required of the PCMH partnering providers in the blue box by the end of DY2, Quarter 4**

- PreManage/EDIE
- Direct Messaging
- Training for Medication-Assisted Treatment, Prescription Monitoring Program, and Oral Health assessment and Fluoride Treatments
- Patient Portal Tool
- Risk Stratification
- Build Care Management Capacity
- Access 24/7 by Patient
- Current Patient Portal
- Patient & Family Engagement
- ED & Follow up           A B C (Provider choose 3 P4P measures)
- Resources for Care Coordination           A B C (Providers choose 3 P4P measures)
- Identify and Implement Shared decision-making tools or aids in 2 health conditions
- Participate in Learning Collaborative
- Participate in 1 webinar per month
- Creation of policies to provide 24/7 access for patients, and 24/7 access for providers for remote access to organization's EHR,
- Implementation of decision-making tools, and proactively manage empanelment to providers
- Implementation of population health management tools to enable clinic to risk stratify patients, provide patient portals, provide secure messaging to care partners, receive daily updates on emergency department and hospital admissions
- Conduct patient and family engagement on a regular basis
- Report on clinical quality metrics, pay-for-reporting metrics, and practice transformation process measures
- Use an ONC-certified EHR
- Provide care management to at least 80% of highest risk patients which will include:
  - Bi-Directional integration of behavioral Health and/or primary Care
  - Implementation of tools for screening and treatment

- Collecting ED visit data through PreManage software on a daily basis
- Collect Inpatient data through PreManage on a daily basis
- Implement self-management support
- Medication Management

*Table 5: List of the Initial Cohort of Partnering Providers*

**Generally, both traditional and non-traditional Medicaid providers will be expected to engage in the following activities from DY2, Q3 through DY 3, Q4:**

- Participate in a GCACH led committee, board, workgroup, Learning Collaborative
- Participate in the Leadership Council or GCACH sponsored trainings and webinars
- Share data and program information
- Participate with other community organizations like the Local Health Improvement Coalitions
- Support and assist PCMH partner organizations to provide community-based care to include the social determinants of health, and to provide whole-person care for their patients
- Provide additional supports and services for care management such as home visits, employment connections, legal services, navigation through the judicial system, and support groups
- Identify gaps in population management tools, and coordinating care
- Take advantage of the technical assistance provided by GCACH
- Obtain Direct Messaging Platform using funding provided by GCACH
- Participate in surveys generated by HCA, GCACH, or other State partners
- Identify gaps in current service structure and work towards implementing or collaborating to provide those services
- Organizations identified as exemplar to provide technical assistance, mentoring and share best practices

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

It is critical that patient-centered medical home adoption be measured so that payment can be linked to achievement. The PCMH assessment (PCMH-A) is one of the first milestones of the partnering providers. Completed by a multidisciplinary team, and conducted by the Practice Transformation Navigators, the PCMH-A captures the various perspectives of the practice and establishes a baseline for each organization. The PCMH-A is reviewed at six-month intervals to track improvement and progress toward practice transformation. The Practice Transformation Navigators use this tool to assess partners against these key progress indicators, and track progress through their individual Practice Transformation Implementation Workplan (PTIW) (see attached sample PTIW).

The PTIW is a living document that guides each of the PCMH organizations through eight change concepts of the Safety Net Medical Home model:

- Laying the Foundation: Engaged Leadership and Quality Improvement Strategy
- Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships
- Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions
- Reducing Barriers to Care: Enhanced Access and Care Coordination

The PTIW will also be used for each project area that the partnering provider is implementing to keep track of goals, metrics, baseline, action steps, start date and target completion dates.

Another tool for assessing partners against implementation progress indicators is the PCMH Efforts Tracker. This document is kept up to date by the Practice Transformation Navigators as milestones are completed by the Partnering Provider. (See Figure 2). As milestones are reached, payment for milestones will be made to the partnering providers as detailed in their contracts. Copies of the DRAFT Milestone Deliverables for Practice Transformation/PCMH Contracting, and the IMC contract are attached to this document.

While the exact funding formula will not be determined until the achievement values from the Semi-Annual report have been released in mid-October, and vetted by the Board of Directors, an example of the funds flow model is included below for the PCMH organizations.

Finally, each partnering provider will be required to report out quarterly on their progress using an electronic reporting tool or provider portal. GCACH staff is finalizing the software and vendor contract. The portal will be a web-based interface that allows for the upload of performance data (i.e. metrics) and will act as a landing page for program and provider specific documentation (e.g. PTIW's).

## PCMH EFFORTS TRACKER

Provider	Kick off meeting	MeHAF Assessment	PCMH Assessment	2018 Cost Analysis	PTW	Contract with GCACH	Vision & Mission Statements	Assessment of Baseline Data	Initiated Mentoring	Assessment of Training Needs	Assessment of EHR	QI Team Developed	Premanage/EDIE	Direct Messaging	Patient Portal Tool	Risk Stratification	Build Care Management Capacity/Identify Community Partners	Access 24/7 by Patient	Implement Patient Portal	Patient & Family Engagement	ED & Follow up A B C	Resources for Care Coordination A B C	Identify and Implement Shared decision making tools or aids in 2 health conditions	Participate in Learning Collaborative	Training	Participated in 1 webinar per month	2019 Budget
Tri-Cities Community Health	X	X	X		X		X		X	X	X	X			N/A												
Catholic Charities Serving Central Washington	X	X	X																								
Providence St. Mary Medical Center	X																										
Palouse Medical	X	X	X																								
Yakima Valley Farm Workers Clinic	X	X	X																								
CHAS Health																											
Astria Sunnyside Hospital																											
Prosser Memorial Health	X																										
Yakima Neighborhood Health Services	X																										
Columbia County Health System																											
Comprehensive Healthcare																											
Lourdes Health		X	X		X		X		X	X	X	X															
Quality Behavioral Health	X	X			X																						
Garfield County Hospital District/Pomeroy Medical Clinic	X		X		X																						
Memorial Physicians																											
Kittitas County Public Hospital District #1 dba Kittitas Valley Healthcare	X																										
Community Health of Central Washington																											
CBHA Columbian Basin Health Association	X	X	X																								
Kadlec Regional Medical Center	X																										
Student Health Options, dba The Health Center	X																										
Astria SHC Medical - Yakima dba Astria Regional Medical Center																											
Pullman Regional Hospital	X																										
Astria Toppenish Hospital	X	N/A	X																								

Figure 2: PCMH Efforts Tracker

Provider	Registration in Portal	CSA Complete	Billing Toolkit	MeHAF	MeHAF Sent to MCOs	Billing Toolkit Sent to MCOs	Scheduled Appointment to meet	Met to go over Assessments	Follow up Appointments	Transformation/ Transition Plan Contract Sent	Signed by both parties	Amount Paid	Contract Complete	
Barth Clinic	X	X	8/20/18	8/20/18	8/21/18	8/21/18	8/20/18	8/20/18	8/27/18 9/4/18 9/18/18	X	X	X	\$ 20,000	
Blue Mountain Counseling	X	X	8/14/18	8/14/18	8/15/18	8/15/15	8/30/18	8/30/18	10/11/18	X	X			
Catholic Charities	X	X	9/25/18	9/25/18	9/26/18	9/26/18	9/25/18	9/25/18		X	X			
Comprehensive Healthcare	X	X	7/9/18	5/16/18	7/20/18	7/20/18	9/28/18	9/28/18			X			
First Steps	X		8/8/18	8/8/18	8/10/18	8/10/18	8/8/18	8/8/18	8/17/18 8/29/18	X	X			
Ideal Balance	X	X	7/27/18	7/19/18	7/20/18	7/30/18	7/27/18	7/27/18	8/3/18 8/27/18	X	X	X	\$ 20,000	
Lourdes Counseling Center/Cri	Need Contract	X	7/13/18	5/16/18	7/20/18	7/27/18	8/10/18	8/10/18	9/27/18	X				
Lutheran Community Services	X	X	7/3/18	7/3/18	7/20/18	7/20/18	7/6/18	7/6/18	7/31/18 8/14/18	X	X	X	\$ 20,000	
Merit Resources - Valley Alcohol Council	X	X	7/13/18	7/13/18	7/20/18	7/20/18	7/27/18	7/27/18	8/27/18 9/17/18	X	X	X	\$ 20,000	
Palouse River Counseling	X	X	9/21/18	3/23/17	7/20/18	9/24/18	9/21/18	9/21/18		X	X			
Quality Behavioral Health	X	X	7/26/18	7/31/18	8/3/18	7/26/18	8/21/18	8/21/18	9/11/18	X	X			
Serenity Point Counseling	X	X	7/13/18	7/18/18	7/24/18	7/26/18	8/2/18	8/2/18	8/30/18	X	X	X	\$ 20,000	
Somerset Counseling	X	X	7/10/18	7/10/18	7/20/18	7/20/18	7/10/18	7/10/18	7/19/18 7/23/18 8/7/18 9/13/18	X	X	X	\$ 20,000	
Sundown M Ranch	X	X	7/26/18	7/11/18	7/20/18	7/26/18	8/13/18	8/13/18	8/20/18	X	X	X	\$ 20,000	
Tri-Cities Community Health	X	X	7/30/18	5/29/18	7/24/18	7/30/18	8/14/18	8/14/18	8/22/18 8/31/18 9/6/2018	X	X			
Triumph Treatment Services - Yakima Valley Council on Alcoholism	X	X	Working with Triumph to schedule time to meet									X		
Yakima Valley Farmworkers	X	X	8/13/18	7/30/18	7/30/18	8/13/18	8/13/18	8/13/18	9/25/18	X	X	X	\$ 20,000	

Figure 3: Integrated Managed Care Behavioral Health Provider Status Tracker

Greater Columbia Accountable Community of Health  
 Revenue Sharing Model for Medicaid Transformation Partners - 2019 and Beyond

2019 Transformation Incentive Allocation Weights and Values - Stage 1 Capacity Building & Readiness						
Component	Weight	Available Funding	Rank	Points	\$/IPP (45)	Award per Point
Assessments (HIT/EHR)	6%	\$489,796	1	3	\$ 10,884	\$163,265
Bi-Directional Integration	6%	\$489,796	1	3	\$ 10,884	\$163,265
Empanelment of Patients	6%	\$489,796	1	3	\$ 10,884	\$163,265
Risk Stratification	4%	\$326,531	2	2	\$ 7,256	\$163,270
Care Management	6%	\$489,796	1	3	\$ 10,884	\$163,265
Reporting	6%	\$489,796	1	3	\$ 10,884	\$163,265
ED and Hospital Follow-Up	6%	\$489,796	1	3	\$ 10,884	\$163,265
Hospital Utilization	6%	\$489,796	1	3	\$ 10,884	\$163,265
Shared Decision-Making	2%	\$163,265	3	1	\$ 3,628	\$163,300
Health Information Technology	6%	\$489,796	1	3	\$ 10,884	\$163,265
Cost Analysis & 2019 Budget	2%	\$163,265	3	1	\$ 3,628	\$163,300
Practice Transformation Learning Collaboratives	6%	\$489,796	1	3	\$ 10,884	\$163,265
Implementation Workplan (PTIW) Quality Improvement	6%	\$489,796	1	3	\$ 10,884	\$163,265
Training/Mentoring	4%	\$326,531	2	2	\$ 7,256	\$163,270
Implementation of PM/EDIE	6%	\$489,796	1	3	\$ 10,884	\$163,265
Access and Continuity	6%	\$489,796	1	3	\$ 10,884	\$163,265
Patient & Family Engagement	6%	\$489,796	1	3	\$ 10,884	\$163,265
<b>Total 2019 Transformation Incentives</b>	<b>92%</b>	<b>\$8,000,000</b>			<b>\$ 177,778</b>	
		Score 1	13			39
		Score 2	2		\$554,555.56	4
		Score 3	2			6
						<b>49</b>

**DRAFT**

Figure 4: Revenue Sharing Model for Medicaid Transformation Partners- DY 2, Q3, Q4

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

The GCACH is prepared to provide additional one-on-one technical assistance from the Practice Transformation Navigators, or from contracted PCMH experts to meet the required project milestones if progress is delayed. While the steps to become PCMH are prescriptive, three of the organizations in the first cohort are exemplar, and several are well down the path of becoming exemplar (e.g. Yakima Neighborhood Health Services), which allows some flex time in the schedule. Exemplar organizations will be expected to be available for academic detailing, one-on-one assistance, and in-person educational outreach visits to the other organizations. Academic detailing is an interactive communication approach, used by the pharmaceutical

industry, to share a reliable and continuous source of current data regarding the comparative effectiveness, safety, and cost of therapies.

Our exemplar organizations will also be involved in Learning Collaboratives which are meant to assist in meeting milestones. Collaborative learning opportunities are critical for developing engaged leadership skills during the initial phase of transformation and will offer opportunities for providers to conduct periodic learning sessions.

If necessary, GCACH is prepared to contract with vendors that are qualified to provide PCMH assistance. One of these organization, Hindsight Healthcare Strategies is under consideration for such assistance.

### **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?

The GCACH will minimize duplication of programs and services by providing direct technical support to its Partnering Providers through its Practice Transformation Team. We will also be minimizing the use of outside vendors for the major body of work relating to bi-directional integration. In addition, the Learning Collaboratives are meant to streamline and share best practices developed through the Partnering Provider QI teams across the GCACH service area. The sharing of evidence-based approaches and best practices will help align each organization's approach to bi-directional and reduce the duplication of programs and services.

The MCOs have been active participants in the Bi-Directional Project Team since its inception. They understand the different approaches that other ACHs have used toward implementation. This has benefited us as we learn from the practice of others. There is also MCO participation on the GCACH Board, PTW, and other project teams.

The GCACH Director of Practice Transformation is a former employee of Qualis and is also familiar with the state's resources, and their related services, available in Project 2A (e.g.

Qualis, AIMS Center at University of Washington, MacColl Center). This information around state resources is being passed on to our partnering provider organizations, which helps create alignment across the state. These programs have technical resources, trainings and presentations that will be made available to our Partnering Providers as they go through Practice Transformation for Project 2A. Working alongside these state agencies and partners will support alignment and help reduce duplication efforts.

#### 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?

The GCACH conducted a broad and detailed Current State Assessment in May 2018. This analysis highlighted the current programs and services being offered by 56 Participating Providers – including primary care, behavioral health, EMS, hospital, care coordination, public health, and community-based organizations – within our delivery system. This informed us about what was happening and where gaps still exist.

The GCACH has aligned with several statewide agencies. Our Director of Practice Transformation comes from Qualis and understands the services provided and personnel still affiliated with that organization. We have also worked with Department of Health and the Washington Hospital Association. We also look to partner with Department of Behavioral Health and Recovery, DSHS and the Washington State Medical Association. The Practice Transformation Team is being trained on the Six Building Blocks (6-BBs) decision tool through the Department of Health. This training will allow the Practice Transformation Navigators to become themselves on this model. However, most of the GCACH providers are using the CDC opioid prescribing guidelines.

Another way the GCACH is aligning with providers is through the regional recovery coalition affiliated with the Washington Recovery Alliance. The regional coalition includes stakeholders from a variety of sectors: SUD providers, housing, care coordination, law enforcement, EMS, social supports, fire department, public health, community health centers, and consumers.

The GCACH Community and Tribal Engagement Specialist is sharing the Department of Health's media campaign regarding its Rx opioid abuse awareness campaign. We are sharing the Partner Toolkit with our Local Health Improvement Networks with the expectation that they will participate in the media campaign at the community level. We have tied this to a deliverable within the signed LHIN contract.

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?
- What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?
- How is the ACH's approach aligned with MCO care coordination contract requirements?

For ACHs implementing Project 2C

- How does the project align with or enhance related initiatives such as Health Homes or other care/case management services, including those provided through the Department of Corrections?
- What additional programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve transitional care services?

The GCACH's Transitional Care Project furthers the work of our State Innovation Model (SIM) project that was accomplished through a partnership with Aging and Long-Term Care, WSU Nursing, Meals on Wheels, Kadlec Regional Medical Center, Trios Health, and Consistent Care Services. One of the most important findings of the SIM project was the need to perform home visits immediately after discharge from the hospital by clinical personnel (RNs) who engaged the family in the patient's follow-up care. This has prompted the GCACH to include other care partners, such as Community Para-medics in the planning and implementation of the Transitional Care model. While we have not focused as much on transitions from the jail system, we have worked with skilled nursing facilities to help manage post-discharge care from the hospital.

The GCACH is also partnering with Chaplaincy Healthcare, a palliative care provider to expand the network of the Transitional Care Model. Following the SIM project, Qualis contacted GCACH to charter a cohort of providers that would address hospital readmissions. The cohort included skilled nursing facilities, the Benton-Franklin Community Health Alliance, Kadlec, Aging and Long-Term Care that have continued to meet with the goal of reducing hospital readmissions.

Trish Anderson, Director of Quality and Performance Improvement with WSHA/WSMA, has reached out to participate in their Preventable Readmissions and Care Transitions Program.

For ACHs implementing Project 2D

- What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to promote appropriate use of emergency care services and person-centered care? (e.g., the Washington State Hospital Association’s “ER is for Emergencies” and “Seven Best Practices” initiatives.)

For ACHs implementing Project 3B

- How do the ACH’s partnering providers align with and avoid duplication of Maternal Support Services? How will the project strengthen or expand current implementation of Home Visiting Models?
- What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve access to high quality reproductive and maternal/child health care?

For ACHs implementing Project 3C

- What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve access to oral health services?

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?

The GCACH is implementing the PCMH model of care corresponding to the AHRQ and Safety Net Medical Home implementation models and guides, which are the national training standards. It has been noted to us by Dr. Mike Hindmarsh, who was a co-developer of the Chronic Care Model with Dr. Ed Wagner at the MacColl Institute, that the Chronic Care Model has been integrated into the Patient-Centered Medical Home model. Implementing the PCMH model of care ensures alignment with the Chronic Care Model. The director of SE Washington Aging and Long-Term Care sits on the GCACH Board and their organization has submitted a Letter of Interest (LOI) and a Current State Assessment (CSA) with the desire to contract for care coordination services that relate to chronic care management.

Several EMS provides from across our region have expressed to us and submitted both LOIs and CSAs with the desire to contract for Community Para-Medicine services. We currently have a pilot project in place in Kittitas that utilizes Community Para-Medicine as part of a “use case” to manage high-risk, high utilizing chronically ill patients.

**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.
- 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?

Given the GCACH's large Medicaid population (more than 255 thousand subscribers), it became clear from the beginning that to leverage its limited DSRIP Project Incentive Funds, the ACH would need to focus on the segments of the population that would most directly benefit from the GCACH's efforts. This led to researching the available evidence (e.g. through the work of the Healthcare Transformation Taskforce) relating to proactively identifying and managing high-cost patient populations. This subsequently led to further research relating to provider-led population health management approaches. Presentations around both these subject areas drove conversations within the GCACH Leadership Council and Board and helped shape our initial overall strategy.

In February 2018, the GCACH hired a former consultant who had extensive knowledge and years of experience with implementing the Patient-Centered Medical Home (PCMH) model in academic and private practice settings. Through her guidance, we began to create a unifying model of change management that incorporated the above as well including the elements of the Chronic Care Model and bi-directional integration. This model was the PCMH, which also integrated aspects of transitional care and management of opioid use disorder. Given its successes elsewhere with improving outcomes, increasing quality and lowering costs, the PCMH provides probably the best opportunity for primary care to build provider capability as it relates to being successful under Value-Based Payment.

Therefore, a major objective for the GCACH is to move its primary care delivery system – whether these practices are part of a hospital system, an FQHC, or embedded in a behavioral health agency – toward PCMH model. Without a true primary care medical home that commits to a longitudinal relationship with the patient and assumes effective oversight over the patient's entire care, the probability that the patient receives recommended and coordinated care drops significantly.

The GCACH has created a Practice Transformation department that includes staff members who have been trained on the national standardized curriculum for implementing the PCMH model, including the Safety Net Medical Home Initiative's implementation guides and AHRQ's Primary

Care Practice Facilitation Curriculum. The Safety Net Medical Home Initiative covers several change concepts, which were then converted into six selection criteria categories:

- Leadership
- Transparency
- Collaboration
- Adaptability
- Value-driven mindset
- Equity

Added to this list was an additional category linked to Medicaid patient volume. Together these seven categories were used, in part, to develop the questions included within the ACH's Current State Assessment (CSA) survey tool that was implemented in May 2018 and sent to Medicaid provider billing and non-billing organizations within our system, including public health, EMS, hospitals, FQHCs, care coordination, CBOs, syringe exchange and other providers. Questions within the CSA were grouped into the seven selection criteria categories. Each organization was then scored, and organizations were then sorted in order by their total score. This process led to the selection of our initial cohort of 23 partnering organizations who would undergo Practice Transformation, leading to PCMH.

The partnering provider organization list was split into two groups. The first group of ten provider organizations will begin initial engagement with the GCACH by the end of October 2018, while the second group of 13 organizations would receive engagement by the end of December 2018. Engagement will include an initial organizational assessment using the Safety Net Medical Home Initiative PCMH Assessment tool or the Maine Health Access Foundation (MeHAF) assessment tool. Subsequently, the practice will receive months of extensive technical assistance from the GCACH's Practice Transformation Navigators (PTNs), who will support the following:

- **Leadership buy-in:** Working with organizational leadership to influence the practice's culture to move it toward population health management
- **Workforce development:** Assessing the current and prospective roles of MAs, RNs, care coordinators, behavioral health coordinators, and pharmacists. This will include expanding the roles of some functions (e.g. medical assistants) and facilitating team-based care
- **Revenue cycle management:** There are a number of billing codes that many provider organizations don't currently use which could support Medicaid reimbursement under PCMH.

- **Performance management:** PTNs will help provider organizations with the development of performance metrics at the practice level (e.g. Diabetes metrics) that support Demonstration pay-for-performance measures and other objectives. Navigators will also support the development of standardized processes and clinical workflows that support evidence-based practices and reduce unnecessary variation and waste.
- **Staff education:** With a host of education resources, the GCACH will support staff education across a variety of areas, such as patient engagement, cultural sensitivity, chronic disease management and opioid prescribing protocols.
- **Referral management:** Managing the full referral cycle – from initiation to follow-up visit by the PCP – is an essential part of care coordination. Understanding this process and assisting the provider organization with tools to manage this cycle will be an important component of engagement.
- **Provider network management:** Formal structures around provider network management – written agreement, referral protocols, formalized incentives for downstream providers and mechanisms for reporting back on performance – will be key to managing downstream utilization. With its current network of Medicaid and non-Medicaid provider organizations, the GCACH is in a unique position to provide support in this area.
- **Care coordination across specialties and service lines:** There are many opportunities here to inform provider organizations:
  - Health risk assessment and management
  - Health promotion, wellness and coaching strategies
  - Co-location of specialty services: behavioral health, pharmacy, nutrition
  - Post ED and inpatient discharge follow-up to reduce subsequent institutional utilization
  - Development and adherence to treatment plans
  - Identifying and managing perceived gaps in care
- **Patient-centered comprehensive care planning:** This would include creating links between the organization and independent care coordination organizations residing in the GCACH service area (e.g. Consistent Care Service, Signal Health, Aging & Long-Term Care). It would also include assisting the organization with the creation of care management platforms and population health management systems.
- **Patient engagement:** A variety of tools and guides exist to assist the organization with implementing simple strategies to enable and enhance patient engagement. This is particularly important given the ethnic and socio-economic mix of the Medicaid patient population within the GCACH.

- **Evidenced-based case management:** The PTNs have numerous common clinical protocols – including chronic and acute disease management, medication management, and links to supportive services – within their toolbox that might be used to assist the organization.
- **Links to social determinants of health:** Providers will need to develop assessments that identify patients’ social needs, linking social service needs into the care plan. It will also mean helping the provider organization create more sophisticated care management agreements that link patients to social support services.
- **Creating a robust social service resource directory:** The GCACH is actively pursuing strategies that will make community social service resources more readily available to patients and provider organizations. This might include the development of an app that links to such services.
- **Supporting data aggregation, exchange and reporting:** Supporting this will be implementation of CMT PreManage, direct secure messaging, and population health management software. It will also include integration of the state’s prescription monitoring database into the clinical EMR.

All primary care practices identified in the initial cohort of partnering providers (see Efforts Tracker) will be receiving support and technical assistance from the GCACH PTNs that may last several months per practice. Following initial practice transformation, PTNs will maintain an ongoing relationship with each of partnering provider practices. As well, each of these practices will undergo follow-up assessments using the assessment tools described above and will submit metric to the GCACH through an online portal, which is currently being researched.

The GCACH has preliminarily identified high-performing or “exemplar” practices. These organizations include Community Health of Central Washington (CHCW), Yakima Valley Farm Workers Clinic (YVFWC) and Yakima Neighborhood Health Services. These FQHCs have already achieved great success under the PCMH model. CHCW has previously been recognized by the Safety Net Medical Home Initiative for its outstanding work. YVFWC has already provided consultative services around bi-directional integration for Better Health Together in Spokane. The GCACH expects to contract with these organizations to further their work and implementation of the PCMH model. However, we also expect to use them as models of best-practices that other organizations may learn from and consult with to better their own operations. These organizations may help the GCACH’s prospective learning collaboratives or they may provide one-on-one consultation with individual provider organizations.

### **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?

GCACH success under the Medicaid Transformation Project will lead to provider success under value-based contracting arrangements. This will require providers to incorporate data from multiple sources to focus clinical and care coordination resource on high-risk and high-utilizing patients and to monitor performance and population health. Providers will need the ability to aggregate, use and share data from various sources, across the continuum of care. They will need to capabilities to carry-out patient risk stratification, pre-visit planning, and patient registries through IT tools that integrate with their organizations EMR and possibly claims feeds coming in from MCOs. They will also need to establish electronic links with other organizations, including specialists, mental health, SUD providers and social service organizations.

To support this, the GCACH will be making several strategic investments in HIT, including the following:

- **CMT PreManage:** PreManage makes use of Admission, discharge, transfer (ADT) notifications, which are widely regarded as a keystone to improving patient care coordination through health information exchange. ADT notifications are sent when a patient is admitted to a hospital, transferred to another facility, or discharged from the hospital. Notifications are then sent through PreManage to update physicians and care management teams on a patient's status, thus improving post-discharge transitions, prompting follow-up, improving communication among providers, and supporting patients with multiple or chronic conditions. ADT notifications also help to identify patients who are frequent or high users of the healthcare system. This allows providers to steer those patients toward clinical and non-clinical interventions, reducing overutilization by preventing avoidable emergency department visits and hospital readmissions. All hospitals within the state currently have CMT's EDIE system. At a minimum, the GCACH will ensure that all provider organizations that are undergoing Practice Transformation and PCMH implementation have PreManage. This will allow for information exchange between hospitals and the provider organization, creating real-time access to information on patient ED visits and inpatient admissions.
- **Direct Secure Messaging:** Direct Secure Messaging is a standard to facilitate secure electronic communication of patient related data between Healthcare providers and

Healthcare IT systems. It also has the potential to exchange information between healthcare providers and social service agencies to facilitate care coordination activities. Some of the types of patient data that can be transmitted are patient visit summaries, prescription histories, general communications between providers and communication on transitions of care (e.g. from hospital to nursing home or from primary care to community-based organization). The GCACH has received presentations and bids from three Direct Secure Messaging vendors – EMR Direct, UpDox, and Data Motion – will be receiving a presentation from Surescripts within the near future. We plan on creating an agreement with one of these vendors to install the application programming interface (API) that does the formatting and transmission of the data. Only those providers who do not now have this technology will be receiving the interface.

- **Population Health Management tools:** EMRs currently on the market are designed for a fee-for-service world, running entirely on encounter-based medicine. This makes it difficult to manage the health of populations—and difficult to understand the cost of care. Fundamentally, in a population health environment, a health system is managing to margin on a per-member, per-month (PMPM) basis. And in this environment, everyone must be aware of the cost of care, at the point of care; something not possible without major changes to the software of current EMRs. To help support population health efforts at the practice level, the GCACH will be financing the implementation of population health management software for each practice undergoing Practice Transformation. Such software already exists within some practices. For example, most of the FQHCs within the GCACH currently employ Arcadia, a popular PHM that allows for quality improvement, patient management, patient outreach, patient risk stratification, pre-visit planning, and patient registries. However, some organizations may choose to use another PHM, such as i2i or another product. The GCACH will provide enough funding to ensure that the practice uses or implements a PHM product suitable to meeting their Practice Transformation needs.
- **Investments to enhance existing EHRs:** The GCACH will also be making investments to existing EHR implementations, where suitable to activate features or make enhancements, such as the creation of workflow templates. These enhancements will be made where they support the efforts of Practice Transformation. However, the GCACH will not be financing replacement EMRs for its primary care practice undergoing PCMH implementation.
- **Online social services resource:** Providing providers at the point-of-care with information about community-based social resource and providers is essential for care coordination and for addressing the social determinants of health, which will lead to better population health and outcomes. The GCACH has looked at several applications –

1degree.org, WIN211, Healthify, Aunt Bertha – but has not found an application that includes all the components needed to fully address the needs of clients. An optimal application will have a robust underlying database that is continually updated; it will be extremely user friendly and rely upon a graphic user interface for searching rather than using free text queries; it will group all the necessary resources together around a particularly chronic care condition (e.g. diabetes, substance use disorder); and it will be relatively inexpensive to build and operate, which ensure its financial sustainability. The GCACH is currently talking with two “app” developers to determine whether a product could be built from the ground up that utilizes an existing database of social resources. We realize no social services resource database is completely exhaustive, nor will it ever be. For example, local libraries offer an array of services that are not readily posted or available to an online search engine. So we will be relying upon our Local Health Improvement Networks to help augment any database we identify. There has been some discussion across the ACHs about developing a statewide resource in this area. This may be difficult as some ACHs are carrying out the Community Pathways HUB, which has its own unique and embedded social services directory.

- **Prescription Monitoring Program:** Washington State Department of Health’s Prescription Monitoring Program (PMP) is an essential tool for prescribing providers’ use when managing a patient’s opioid or sedative prescriptions. The PMP was created with the purpose to improve patient care and stop prescription drug misuse by collecting dispensing records for Schedule II, III, IV and V drugs and making the information available to medical providers and pharmacists as a patient care tool. Although providers understand the PMP’s importance and understand the impact of the current opioid use crisis, many are reluctant to login and use the system because of its challenging nature. While the GCACH cannot pay for the restructuring of the PMP interface, we will be investigating how useful it will be to invest in integrating the PMP into practices’ EMRs. At the least, this could lead to a single sign-on solution. Or it could include full real-time integration of the PMP into practice’s EMR. Either way, we expect to identify a way to make the PMP more accessible to prescribing providers.

- **Digital Health Commons:** Based upon the success experienced with Olympic Community of Health (OCH), the GCACH consulted with Quad Aim Partners (HIT consultant) to develop and pilot test in Kittitas County an integrated HIT solution that connects healthcare and social service providers together to improve patient/client care transitions into one e-referral network. This is leading to the development of a low-cost, easy-to-use web-based portal with EHR integration. The Kittitas collaborative effort includes Kittitas Valley Healthcare, Comprehensive Healthcare, and Ellensburg Community Paramedicine. The pilot project is on track, on budget and about to implement their first test e-referral. The GCACH is very satisfied with the current success of this project and the response from local stakeholders tied to it. We are now planning another implementation of the model in one of our other Local Health Improvement Networks. We also recently signed a cross-ACH agreement with OCH to come together to cover the costs for ongoing cloud-based server capacity needed to maintain the system.

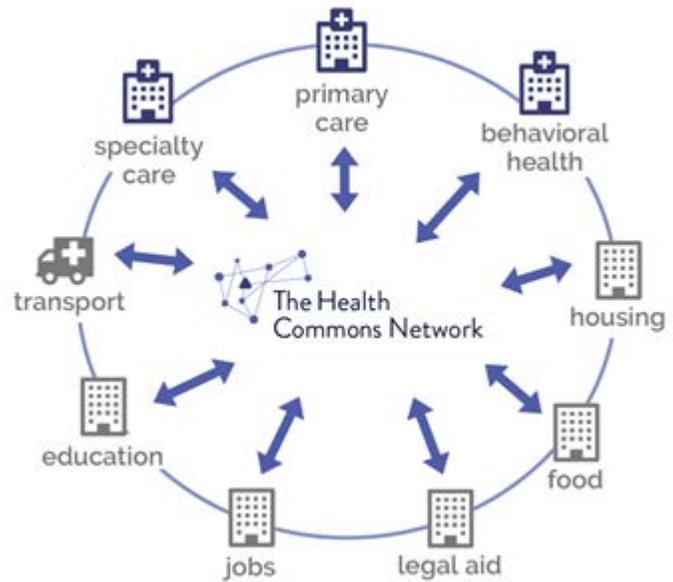


Figure 5: The Health Commons Network

- **Online Provider Portal:** The GCACH has reviewed several proposals for online portals and integrated reporting tools, including LifeQI, Azara, Cipherhealth and SpectraMedix. While each of these had beneficial features, each also had shortcomings, mainly tied to cost of implementation. Given the success implementation we have observed in North Central ACH and OCH, we will be reviewing a presentation from CSI Solutions within the very near future. This software may potentially provide an online tool for provider reporting as well as a landing page for our organizations undergoing Practice Transformation or tied to our project areas in some capacity.
- **All Payers Claims Database (APCD):** The GCACH recently negotiated and signed an agreement with Seattle King County Public Health to act in an analytical capacity to extract, analyze and provide data reports from the state's APCD. These reports will be used to help our provider organizations identify high cost, high utilizing patient and target populations corresponding to our four project areas.

- **Statewide HIE:** The GCACH continues to support the adoption and implementation of the state’s HIE system and the Clinical Data Repository. We would like all our provider organizations to come onto the state’s HIE/CDR.

**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
<p>Response should cover the following:</p> <ul style="list-style-type: none"> <li>● What technical assistance or resources have the ACH identified to be helpful? How has the ACH secured technical assistance or resources?</li> <li>● What technical assistance or resources does the ACH require from HCA and other state agencies?</li> <li>● What project(s)/area(s) of implementation would the ACH be interested in lessons learned or implementation experience from other ACHs?</li> </ul>

Throughout the MTP, the GCACH has relied upon technical assistance from several different sources, which have aided and guided our work:

- **Manatt:** The presentations and PowerPoints made available by Manatt were very helpful and instructive to the GCACH during the initial phases of the MTP. We have saved and printed some of these materials and continue to rely upon them.
- **Dr. Patrick Jones:** The GCACH has contracted with Dr. Patrick Jones, Executive Director, Institute for Public Policy & Economic Analysis at Eastern Washington University. He has helped with overall strategy and planning, effectively facilitated our Leadership Council meetings, and helped us conduct a regional survey during 2017 of stakeholder interest across the MTP project areas.
- **Oregon Health Sciences University (OHSU):** Individuals at OHSU were contracted by the GCACH to help with strategic planning, the creation and implementation of our Current State Assessment (CSA) survey, and the initial scoring of the CSA, which led to the identification of the initial cohort of partnering providers.
- **Tenfold health:** This small consultancy was an initial sub-contractor to Manatt and became our regional representatives with them. They have provided us with ongoing strategic planning and guidance. Following the end of the initial Manatt contract with HCA, tenfold health joined with OHSU in its current contract with the GCACH and a few other ACHs across the state.

- **Health Management Associates (HMA):** HMA is a large, national consultancy that the GCACH contracted with during 2017. We relied upon them heavily to do strategic planning and support our drafting of key reporting deliverables, such as the 2017 Project Plan. Their work helped us reduce the number of project areas we ended up focusing on from eight down to four. They also assisted with identifying our key target populations and provided guidance on consolidating our project areas into a portfolio.
- **Technical Advisory Committee (TAC):** Along with HMA, this committee included outside consultants we contracted with to assist us in determining the final project areas we chose to focus on. The TAC included:
  - Mike Bonnetto, MPH, PhD., partner at 10-Fold Health, former chief of staff & health policy advisor in office of the Oregon Governor
  - Robert Burden, retired Director, Group Health; 20 years in leadership with Benton/Franklin Community Health Alliance
  - John Kitzhaber, MD, former governor of the state of Oregon; founder, Center for Evidence-based Policy at OHSU founder of the Archimedes Group
  - Lee Ostler, DDS, Richland-based; clinical instructor, Las Vegas Institute for Advanced Dental Studies
  - Hugh Straley, MD, past president, Group Health Cooperative; chair, Dr. Robert Bree Collaborative
- **Quad Aim Partners:** This small consultancy, led by Rob Arnold, was hired to conduct the Digital Health Commons pilot project in Kittitas County.
- **Hindsight Consulting:** This small consultancy is led by Mike Hindmarsh, an established healthcare improvement consultant offering strategic planning, project direction, practice coaching and technical assistance for implementing quality improvement programs in primary, specialty and ancillary care settings. Mike began as the Managing Director of Clinical Improvement under the guidance of Ed Wagner, MD, MPH of the MacColl Institute in Seattle, Washington. Along with Dr. Wagner, Mike and his colleagues created the Chronic Care Model. He is being hired by the GCACH to provide the keynote address the PCMH Kick-off event and will assist us in refining our implementation plan.

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

The GCACH would like granular, ongoing and timely utilization and cost data relating to particular project areas and sub-geographical units, even down at the individual provider level; e.g. Yakima Neighborhood Health Services (an FQHC in Yakima). Also, the Health Systems Capacity Building Partnership will rely on the leadership of HCA and state partners (e.g. AWP/PHD, UW) to convene the ACHs to work toward statewide issues; e.g. workforce capacity,

telehealth, matters requiring legislative policy changes (e.g. reimbursing services that support ACH project areas, such as reimbursement for transitional care follow-up services). We would also like to have ongoing support with the tribes in terms of obtaining health data and interfacing with them as a large state agency to assist in contracting requirements within the financial executor portal. We would also appreciate continued funding to support the monthly convening of ACH leaders and staffs and the associated trainings and learnings. Continuous learnings require sharing best practices which will benefit standardization and alignment across the ACHs.

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

Every ACH has confidence with the work they are doing in certain areas. The GCACH feels confident that our project approaches for Bi-Directional Integration and Chronic Disease Prevention and Control are enough to create sustainable change within the project areas. The Patient Centered Medical Home is an evidence-based model that has a proven track record at achieving quality improvement and better patient outcomes. The successes of other ACHs in achieving gains relating to the Transitional Care and Addressing the Opioid Use Public Health Crisis project areas would be of interest to us as we continue to refine these projects going forward.

THIS CONTRACT IS AN AGREEMENT  
BETWEEN  
IDEAL BALANCE  
AND  
GREATER COLUMBIA ACCOUNTABLE COMMUNITY OF HEALTH

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This is a Contract between the Greater Columbia Accountable Community of Health (hereinafter "GCACH") and Ideal Balance (hereinafter "Contractor") which sets out the parties' agreement of obligations listed in the responsibilities section.

**1. PURPOSE**

This Contract is a binding agreement between GCACH and the Contractor to collaborate, design, develop and implement a fully integrated managed care plan to be ready for financial integration of Medicaid benefits, "Mid-Adopter" by January 1, 2019 using Medicaid Transformation Integration Incentive Funding (IIF). It represents a description of the roles and responsibilities of each party. By clearly defining and understanding the expectations of each party, the parties have a greater potential to ensure a successful experience, and to be prepared for the billing processes, datasets, and electronic transactions required by the managed care organizations.

The goal of integrated managed care is to meet the legislative direction under E2SSB 6312 to fully integrate behavioral health benefits into the Apple Health managed care program (FIMC) so that clients have access to the full complement of medical and behavioral health services through a single managed care plan. Counties that commit to implementing fully integrated managed care before 2020 are "mid-adopter" regions and the Accountable Communities of Health in these regions are eligible for integration incentive funding through the Healthier Washington Medicaid Transformation. All regions statewide must fully integrate no later than 2020. The Board Members of Greater Columbia Behavioral Health (GCBH) declared their unanimous intent for GCBH to become Mid-Adopters of Fully Integrated Managed Care in January 2019 and signed a legally binding document that was submitted to the HCA on October 16, 2017.

Integration Incentive Funding will be provided to partnering providers in regions that implement fully integrated managed care before January 1, 2020. These incentives are complementary to but separate from funds for specific transformation projects. This funding is to be used to assist providers and the region with the process of transitioning to fully integrated managed care. This could include using funds to assist with the uptake of new billing systems or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with managed care plan business processes. Additionally, the incentive payments can further support and build upon the region's work to implement integrated clinical models.

The incentives for integrated managed care will be distributed in two phases: delivery of binding letters of intent and implementation. This contract refers to the first phase of funding, the achievement of the binding letter of intent.

## 2. DEFINITIONS

The following terms are used as defined below throughout this Contract:

The integration of billing and administrative processes is referred to financial integration, or fully Integrated Managed Care (IMC).

“Integration Incentive Funding” refers to the incentive payments earned by GCACH through two achievements:

1. Submission of a binding letter of intent signed by the county authority or authorities in the region to the Washington State Health Care Authority by October 16, 2017.
2. Implementation of integrated managed care effective January 1, 2019.

## 3. PERIOD OF PERFORMANCE

The Contract shall remain in full force and effect until the completion date of December 31, 2018. The completion date may be extended by mutual written agreement of both parties.

## 4. FUNDING DISTRIBUTION & DELIVERABLES

Payments shall be made to the Contractor upon satisfactory completion of the items shown in table below. Payments made to the Contractor shall not exceed \$116,862.63.

Item	Amount
1. Completion of the Maine Health Access Foundation (MeHAF)	\$10,000.00
2. Completion of Qualis Behavioral Health Agency Self-Assessment Tool (Billing Toolkit)	\$10,000.00
3. Contractor shall develop a plan that transitions their organization to a financially integrated model. Contractor shall complete the Practice Transformation Implementation Workplan (Appendix “A”) and Business Continuity Plan (Appendix “B”). Contractor shall provide a thorough description of the planned use of funding.	Not to exceed \$96,862.63

All deliverables shall be received by GCACH by December 31, 2018. GCACH will be the approver for all deliverables and will ensure prompt payment once the plan has been approved. GCACH ensures that all funds transferred to the Contractor are public funds that are not federal funds and are otherwise eligible to be used as the non-federal share of Medicaid expenditures consistent with 42 CFR 433.51, by providing funds only from sources that GCACH has approved as allowable sources. Pursuant to GCACH instruction, the Contractor shall maintain records to document the source of transferred funds and furnish those records to GCACH as requested.

**5. ALLOWABLE COSTS**

Washington State Health Care Authority (HCA) and GCACH expects regions to prioritize the use of integration incentive funding to assist Medicaid behavioral health providers with the process of transitioning to integrated managed care. HCA issued their expectations on March 29, 2018 in a document titled Expectations Regarding Use of Medicaid Transformation Integration Incentive Funding (Appendix "C").

The Contractor shall utilize the HCA's document as guidance when developing their budget. However, the GCACH Board of Directors has determined Nonallowable Expenditures (Appendix "D") that are consistent with Federal guidelines.

GCACH reserves the right to review all transaction expenses in result of use of this funding. The Contractor shall maintain complete financial records relating to this Contract and the services rendered. If unallowable costs are identified in the process or within ninety (90) days of the end of the Contract, those costs shall be identified and excluded from any billing, claim, or proposal applicable to this Contract. GCACH reserves the right to offset funding that has been used on unallowable costs and re-allocate to the Contractor upon receiving a new budget. All expenditures shall be reviewed by GCACH.

**6. ACCESS TO ADDITIONAL FUNDS**

GCACH will hold 12% of the total funding for those organizations in "extra need". To access this funding providers will need to show that their funding allocations are not sufficient to purchase the necessary investments to be ready for fully integrated managed care by January 1, 2019. Extra need funds that have not been used by December 31, 2018 will be allocated according to a methodology as recommended by a 60% majority of the provider organizations and approved by the GCACH Board.

**7. RESPONSIBILITIES OF CONTRACTOR**

For participation as a Mid-Adopter and use of integration incentive funding the Contractor will be responsible for:

- a. All deliverables outlined in this Contract under Section 4 FUNDING DISTRIBUTION & DELIVERABLES.
- b. All use of funding to meet one or more of the categories listed within this Contract under Section. 5 ALLOWABLE COSTS.
- c. Register in the Washington Financial Executor (WAFE) Portal.

**8. RESPONSIBILITIES OF GCACH**

As a healthcare quality improvement organization, GCACH will be responsible for:

- a. Distributing FIMC dollars through the WAFE Portal.
- b. Maintaining contingency funds in the amount of 12% for use in organizations requiring additional help.
- c. Provide project management support to assist Providers including self-assessments.
- d. Working with HCA and Managed Care Organization's to convene three (3) provider workgroups:
  - Provider Readiness Work Group
  - Early Warning System Work Group
  - Integrated Managed Care Communications Work Group

**9. CHANGE IN STATUS**

In the event the Contractor has a change in the legal status, organizational structure, or fiscal reporting the Contractor shall notify GCACH of the change. The Contractor shall provide written notice within thirty (30) days after such a change takes effect.

**10. AMENDMENT & TERMINATION**

This Contract may be amended at any time by mutual written agreement of the parties.

Either party may terminate this Contract with fourteen (14) day of written notification to the other party. If this Contract is so terminated, the Contractor may be liable for the return of funds awarded by the GCACH, less costs incurred in accordance with the terms of this Contract prior to the effective date of termination.

Unless otherwise specified within this Contract, all expenses incurred by the parties over the course of the Contract are the responsibility of the individual entity.

**11. CONFLICT OF INTEREST**

GCACH may, in its sole discretion, by written notice to the Contractor terminate this Contract if it is found, after due notice and examination by GCACH, that there is a violation of GCACH Conflict of Interest Policy No. 2016-003; or any similar statute involving the Contractor in the procurement of, or services under this Contract.

In the event this Contract is terminated as provided above, GCACH shall be entitled to pursue the same remedies against the Contractor as it could pursue in the event of a breach of the Contract by Contractor. The rights and remedies of GCACH provided for in this clause shall not be exclusive and are in addition to any other rights and remedies provided by the law.

**12. GOVERNING LAW**

This Contract shall be construed and interpreted in accordance with the laws of the State of Washington, and the venue of any action brought hereunder shall be in the Superior Court for Franklin County. The prevailing party is entitled to recover all attorney fees and costs.

**13. ASSURANCES AND CONFORMANCE**

The Contractor represents that it is familiar with, and shall be governed by and comply with, all Federal, State and local statutes, laws, ordinances, and regulations including amendments and changes as they occur.

**14. DEBARMENT AND SUSPENSION**

The Contractor certifies, to the best of his or her knowledge and belief, that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency; has not been convicted or had a civil judgement rendered against him/her for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; are not presently indicted or otherwise criminally or civilly charged by a government entity (federal, state, or local) with commission of any of the offenses enumerated above, and have not, within a three-year period preceding this application/proposal, had one or more public transactions (federal, state, or local) terminated for cause or default.

**15. INDEMNITY**

Each party shall indemnify, defend, and hold the other party harmless from and against any and all claims, actions, suits, demands, assessments, or judgments asserted, and any and all losses, liabilities, damages, costs, and expenses (including, without limitation, attorney's fees, accounting fees, and investigation costs to the extent permitted by law) alleged or incurred arising out of or relating to any operations, acts, or omissions of the indemnifying party or any of its employees, agents, and invitees in the exercise of the indemnifying party's rights or the performance or observance of the indemnifying party's obligations under this Contract. Prompt notice must be given of any claim, and the party who is providing the indemnification will have control of any defense or settlement.

**16. INSURANCE**

Each party agrees to maintain insurance during the term on this Contract at its own expense with a minimum limit of \$1,000,000 per occurrence to protect itself and the other party of this Contract from all claims of any kind or nature for damage to property or personal injury, including death, made by anyone, that may arise from activities performed or facilitated by this contract, whether these activities are performed by that company, its employees, agents, or anyone directly or indirectly engaged or employed by that part or its agents.

The Contractor shall provide a Certificate of Insurance to GCACH within ten (10) days after receipt of the Contract award showing the Insuring Companies, policy numbers, effective dates, limits of liability.

The Contractor shall comply with all applicable local, state, and federal licensing, accreditation, and registration requirements/standards, necessary for the performance of this Contract.

**17. NONDISCLOSURE**

The Contractor and GCACH shall maintain this Contract in a confidential manner. Therefore, the Parties agree not to divulge to third parties, without the written consent of the other Party, any information which relates to the technical or business activities of the disclosing Party in connection with the performance of this Contract

This Contract represents all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Contract shall be deemed to exist or to bind any of the parties hereto.

**APPROVAL**

This Contract is executed by the persons signing below, who warrant that they have the authority to execute it.

GREATER COLUMBIA  
ACCOUNTABLE COMMUNITY OF HEALTH

IDEAL BALANCE

DocuSigned by:  
*Carol Moser*  
F08CE9DA9ECC0499...  
\_\_\_\_\_  
Authorized Representative

DocuSigned by:  
*Penny Bell*  
5A360DF6DA5347D...  
\_\_\_\_\_  
Authorized Representative

Executive Director  
\_\_\_\_\_  
Title

Administrator  
\_\_\_\_\_  
Title

APPENDIX "A"

PRACTICE TRANSFORMATION IMPLEMENTATION WORKPLAN "SAMPLE"

The document shall be attached as a separate file in pdf format.

APPENDIX "B"  
BUSINESS CONTINUITY PLAN "SAMPLE"

The document shall be attached as a separate file in pdf format.

APPENDIX "C"

EXPECTATIONS REGARDING USE OF MEDICAID TRANSFORMATION INTEGRATION INCENTIVE FUNDING

The document shall be attached as a separate file in pdf format.

## APPENDIX "D"

## NON-ALLOWABLE EXPENDITURES

The following list of non-allowable expenditures is subject to change. Contractor is not permitted to duplicate or supplant other federal or state funds from this Contract. Several sources were reviewed to develop this list of non-allowable expenditures, including current state and federal funding guidance and other program guidance.

- Alcoholic Beverages
- Debt restructuring and bad debt
- Defense and prosecution of criminal and civil proceedings, and claims
- Donations and contributions
- Entertainment
- Capital expenditures for general purpose equipment, building and land, except for:
  - Costs for ordinary and normal rearrangement or alteration of facilities
- Fines and penalties
- Fund raising and investment management costs
- Foods or services for personal use
- Idle facilities and idle capacity
- Interest expense
- Lobbying
- Memberships and subscription costs
- Patent costs

All costs must be considered reasonable. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. In determining reasonableness of a given cost, consideration must be given to:

- a. Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the entity or the proper and efficient performance of the award.
- b. The restraints or requirements imposed by such factors as: sound business practices; arm's-length bargaining; Federal, state and other laws and regulations; and terms and conditions of the award.

**SAMPLE Practice Transformation Implantation Plan**

**Site Name:**

**Practice Transformation Team Members:** *Martin Sanchez, Diane Halo, Jenna Shelton*

**Date:**

Physical and Behavioral Health Integration Assessment overview
<b>Strengths:</b>
<ul style="list-style-type: none"> <li>•</li> </ul>
<b>Gaps:</b>
<ul style="list-style-type: none"> <li>•</li> </ul>

Transformation Assessment Overview
<b>Strengths:</b>
<p><b>Care Coordination</b> – <i>Link patients with community resources to facilitate referrals and respond to social service needs. Integrate behavioral health and specialty care into care delivery through co-location or referral agreements. Track and support patients when they obtain services outside the practice. Follow up with patients within a few days of an emergency room visit or hospital discharge. Communicate test results and care plans to patients.</i></p> <ul style="list-style-type: none"> <li>• XXX</li> </ul> <p><b>Leadership</b> – <i>Provide visible and sustained leadership to lead overall cultural change as well as specific strategies to improve quality and spread and sustain change. Ensure that the PCMH transformation effort has the time and resources needed to be successful. Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model. Build the practice’s values on creating a medical home for patients into staff hiring and training processes.</i></p> <ul style="list-style-type: none"> <li>• XXX</li> </ul> <p><b>Organized Evidence Based Care</b> - <i>Use planned care according to patient need. Identify high risk patients and ensure they are receiving appropriate care and case management services. Use point-of-care reminders based on clinical guidelines. Enable planned interactions with patients by making up-to-date information available to providers and the care team prior to the visit.</i></p> <ul style="list-style-type: none"> <li>• XX</li> </ul>
<b>Opportunities:</b>
<p><b>Quality Improvement Strategy</b> – <i>Choose and use a formal model for quality improvement. Establish and monitor metrics to evaluate routinely improvement efforts and outcomes; ensure all staff members understand the metrics for success. Ensure that patients, families, providers, and care team members are involved in quality improvement activities. Optimize use of health information technology to meet Meaningful Use criteria.</i></p> <ul style="list-style-type: none"> <li>• XX</li> </ul>

**Empanelment** - Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis. Assess practice supply and demand, and balance patient load accordingly. Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need.

- XX

**Continuous Team Based Healing Relationships** - Establish and provide organizational support for care delivery teams that are accountable for the patient population/panel. Link patients to a provider and care team so both patients and provider/care teams recognize each other as partners in care. Assure that patients are able to see their provider or care team whenever possible. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

- XX

**Enhanced Access** - Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail, or in-person visits. Provide scheduling options that are patient and family-centered and accessible to all patients. Help patients attain and understand health insurance coverage.

- XX.

<b>Goal:</b>		
<b>Domain:</b> <i>IMC, QI</i>		
<b>Action steps:</b>	<b>Person responsible</b>	<b>Due date</b>
x		
x		

<b>Goal:</b> Improve the coordination of care for patients through the addition of data sharing systems.		
<b>Domain:</b> <i>IMC</i>		
<b>Action steps:</b>	<b>Person responsible</b>	<b>Due date</b>
x	x	

Practice Transformation Involvement	
Name of PTN:	Name of Contact:
Plan for alignment with Hub activities:	

Qualis Health Supportive Activities:

Action Steps for the Next (insert timeframe)	Responsible Team Member

Monthly Updates/Achievements:

# SAMPLE Business Continuity

## Section I: General

The function of the Business Continuity Plan (BCP) is to assist Behavioral Health Agencies (BHAs) with the transition to Integrated Managed Care (IMC). The IMC transition will heavily impact data and IT systems. This plan will help ensure that crucial business functions are maintained and clear communication is kept with Managed Care Organizations (MCOs). This BCP will detail how to mitigate the impact for the following areas: billing, data reporting/data tracking, care coordination, and MCO relationships. Each of these areas will contain a contingency plan in the event the initial transition plan is not effective.

With the IMC transition the following structure will be put in place for the MCOs and BH-ASO:

- a. The county is able to contract with MCO and BH-ASO to continue providing treatment, services just as any other behavioral health provider agency in the region.
- b. The Health Care Authority (HCA) requires the same services be provided through contracted MCOs and BH-ASO. HCA will monitor use to ensure that services will not be negatively affected.
- c. Early Warning System and Communication workgroups will provide opportunity for input on monitoring activities and performance measures.
- d. IMC funding will support transition regarding billing/payment infrastructure (e.g. setting up 837P for claims reporting, testing claims submission process, training BHA staff, and assistance with EHR via consultant and/or directly with the MCO representative and GCACH).
- e. There will be coordination with MCO and BH-ASO representatives on individual clearing houses and platforms used for billing. Each MCO and BH-ASO should provide contact information with their employees' photos, email addresses, phone numbers, and areas of expertise.
- f. The MCOs and BH-ASO will provide the amount of data required in order to satisfy their contracts with HCA and what requested actions BHAs will need in order to manually track and report.
- g. The MCOs are required in contract with HCA to establish a sub-contract with the BH-ASO to pay for Medicaid covered crisis services for their members.
  - a. If a Medicaid client is committed to treatment as a result of their encounter with the crisis system the MCOs are contractually required to pay for services. MCOs are not able to do prior authorization or deny a service that has been court ordered.

- h. The MCO and the BH-ASO must coordinate with the criminal justice system and treatment providers to ensure their members are engaged in treatment and diverted from jail whenever possible. I.e. the expectation is the MCO and BH-ASO hire jail liaisons and are actively engaged in jail diversion activities.
- i. Clients rights – MCOs are required to provide information on grievances and appeals to clients. The ombuds function will continue within the region and can assist the client should they feel they have been wrongly terminated or denied services.
- j. The MCOs and BH-ASO will develop an allied system coordination plan that outlines partnership agreements including MOUs when appropriate to ensure ongoing relationships with allied system partners.
- k. The Department of Health and Human Services through the Transformation Hub will develop a full toolkit and roadmap that will complement the survey tool that clearly defines the MCO billing expectation for providers and provide guidance and clear timelines on what they need to do to be ready for implementation.
- l. In the event of server outage or infrastructure system failure, Contractor in conjunction with the MCOs, BH-ASOs will develop a process and timeframe to facilitate revenue continuity.
- m. Contractor will maintain an inventory of all services provided in order to facilitate reimbursement for these services under a contractual agreement. See Exhibit B.

The following structure will be put in place for Contractor.

- a. Contractor will use the Qualis self-assessment toolkit that was specifically designed to assess Washington state BHO providers capacity to transition to the MCO model.
  - a. If a new system is required as a part of the IMC transition the BHA will preserve historical clinical documents to meet Washington records retention regulations (up to 10 years).
    - i. Contractor is using Office Ally clearing house for private insurance and will transition to bill Medicaid.
    - ii. Considering using a cloud-based server or on-site server as opposed to storing data on individual “fat-clients”.
- b. Contractor will reference Best Practices/Lessons Learned in Preparing Behavioral Health Providers for Integrated Managed Care. <https://www.hca.wa.gov/assets/program/bp-ll-ta-nc-swwa.pdf>
- c. Contractor will conduct claims testing early so there is time to identify and correct claim rejections and reconfigure BHA/MCO data systems as needed (this is dependent upon the date the MCO providers reporting and configuring requirements).
- d. Contractor will ensure that they understand differences between submitting claims (requesting payment) and submitting encounters (reporting services).
- e. In agreement with the MCO billing coordination requirements, Contractor will stay in communication with the MCO and BH-ASO.

- f. Clients rights – MCOs are required to provide information on grievances and appeals to clients. The ombuds function will continue within the region and can assist the client should they feel they have been wrongly terminated or denied services.
  - a. Contractor will provide a grievance form that is readily available in the office.
- g. Contractor will work with GCACH to utilize the toolkit for behavioral health agencies
- h. Contractor will contract with all four (4) MCOs and BH-ASO to continue to provide current services. The contracts between providers and payers are proprietary and negotiated between the health plan and the provider.
- i. Contractor will reference Appendix “A “Practice Transformation Implementation Workplan” (PTIW) for additional information regarding funding budgets and IMC implementation.
- j. In the event of server outage or infrastructure system failure, Contractor in conjunction with the MCOs, BH-ASOs will develop a process and timeframe to facilitate revenue continuity.
- k. Contractor will maintain an updated inventory of software and infrastructure that is supportive of critical operations. See Exhibit A.
- l. Contractor will maintain an inventory of all services provided in order to facilitate reimbursement for these services under a contractual agreement. See Exhibit B.

#### Transportation and other Non-Medicaid support services

- a. Patients receiving Medicaid funded treatments may have support services that are not entirely covered, however supported by non-Medicaid funds (e.g. transportation from SUD residential treatment facilities and “flex” funds for outpatient providers).
  - a. Providers can assess HCAs transportation broker services to obtain Medicaid covered transportation. This applies regardless whether the training provider is in or out of the region. Concerns for access or timeliness contact the HCA.
  - b. Flex funds – the expectation is that the MCOs and BH-ASO would replicate, at least initially, their provider contracts and assume it is a value-add. It is likely that contracting arrangements will continue as agreed upon by providers and payers.
  - c. The MCOs are provided some GF-S dollars to support these types of wraparound supports.
  - d. Non-Medicaid support services may be available through Community Funds through GCACH.

In the event of a crisis, Contractor Counseling will make every effort to continue operations. This plan addresses organization-wide considerations for operations, finance, staffing, supplies, vital records and departmental specific needs/devolution of essential functions to continue operations. To ensure the continuity of essential services during an event that may interrupt the delivery of normal operations the following actions will be taken:

(E.g. Infrastructure not supportive of billing, clearinghouse incompatibility, timeliness of payments, etc.)

- a. Identify critical operation points, functions or skills necessary for continuity of operations (e.g., management staff; specific levels of expertise, training or experience; recording or documentation requirements; health and safety concerns), which may be necessary for business to continue and for staff to provide patient care services.
- b. Identify the need for additional resources or support to maintain essential services/functions.
- c. Plan for service reduction based on need, critical nature of function as a support for organization or local population and other factors.
- d. Written notification to employees regarding business continuity strategies for the duration of the event and compensation provisions, if feasible.
- e. Activation of continuity and emergency operations procedures as determined by the individual authorized to operate Contractor Counseling facilities.

## Section II: Overview

This plan defines the mission critical services and processes and procedures to ensure they can be continued and/or recovered when normal operations are not viable.

This BCP was developed in conjunction with the Contractor emergency planning effort and Greater Columbia Accountable Community of Health (GCACH). In developing this plan and all associated procedures, checklists and forms, the continuity between the Contractor, MCOs, BH-ASO and the associated departments can be ensured. Note that in order for the plan to be effective Contractor will conduct claims testing early so there is time to identify and correct claim rejections and reconfigure BHA/MCO data systems as needed (this is dependent upon the date the MCO providers reporting and configuring requirements).

Additionally, updates to the plan and all associated checklists, forms and procedures will be updated as required in Section 10 AMDNEMNT & TERMINATION.

For purposes of this plan and all associated procedures, checklists and forms, an event is defined as any planned or unplanned situation that disrupts the normal operations of the department.

This plan describes the procedures for continuity or, if needed, contingencies for the recovery of services at an alternate location. Strategies for continuing operations when key services are unavailable are detailed in the departmental continuity plan.

## Section III: Activation

In an effort to prevent disruption from normal operations and that could impact essential Contractor billing operations and services provided, measures are to be taken to prepare and pre-position resources to ensure continuity of mission critical services and processes. Questions of consideration are shown below and answers from the HCA and MCOs will be provided as available. In addition, testing will begin immediate and upon response from the MCO on billing requirements. In the event of platform infrastructure issues other arrangements with the MCO and BH-ASO may be required (e.g. paper billing submission, logging into MCO system to bill, etc.)

Contractor is comprised of personnel with the knowledge and authority to provide support for Business Continuity, Emergency Response and Recovery activities.

The sample of questions below will be updated and given to the Contractor at the Provider Readiness Workgroup meetings.

<b>Issue/Question</b>	<b>Answer from MCOs</b>
1. When will CPT codes for billing be available?	
2. Will there be a sliding fee?	
3. MCO requirements and process for payment on dually eligible.	
4. Who are all of our points of contacts? Will I be coordinating with a different person for contracts, billing/claims, IT, care coordination, etc...	
5. What clearinghouse will your plan be using? We intend to continue using Office Ally, will this be compatible?	

<p>6. Will we be continuing to submit Native Data information from the Data Dictionary (demographics, client address, etc.) with your plan?</p>	
<p>7. What is your plan's process for pre-authorization for residential? What is the approved amount of time for getting the patient to the scheduled bed date? What is the approved amount of time for residential? Will your plan have its own authorization form or will it be standardized among the four chosen plans?</p>	
<p>8. In one region, the outpatient provider has 5 days once the authorization is in place to get the patient into residential, with a pre-scheduled bed date secured. What is your plan's policy going to be for residential agencies that do not give scheduled bed dates? For example, several residential agencies expect the patient and outpatient provider to call everyday to see about openings instead of giving an actual bed date. In these cases, a 5 day turn-around is not going to be feasible.</p>	
<p>9. How often does your plan want claims and encounters submitted? Weekly? Bi-monthly? Monthly?</p>	

<p>10. Will your plan accept 837p files for claims and encounters? Will your plan be using electronic remittances? Our EMR is AvailHealth's product KeyNotes. As of now, KeyNotes can accept 835s and is testing 270/1 eligibility request/responses.</p>	
<p>11. What is the expected turn-around time for payment? If there are issues with the claims submission or receiving, will we still be paid?</p>	
<p>12. Is there any additional forms or paperwork we need to be creating or that you will be providing for claims submission, authorizations, or any other services provided?</p>	
<p>13. Will there be state-only funds from your plan to reimburse for non-Medicaid services, such as outreach and interim services, for your Medicaid-covered patients?</p>	
<p>14. Will your plan be able to reimburse for Community Outreach (in the SERI)? This is an approved service that is not connected to a particular person so at this time there is difficulty being reimbursed for it, as there is no demographic or individual encounter to submit.</p>	
<p>15. All of the plans at the panel discussion mentioned "special projects" funding that is available to help with integration, innovation and whole-person care. Will there be language in the contract to help guide ideas for special projects and reimbursement?</p>	

<p>16. WISE Program – legal program; how will that be reimbursed? Fee for service could possibly limit open services and possibly not work.</p>	
<p>17. Currently billing Amerigroup via hard copy paper; will this change or will this continue with other MCO’s?</p>	
<p>18. MCO’s processes for outpatient services? Authorization required?</p>	
<p>19. What is the process for the HCA to transition and communicate changes for UHC clients?</p>	
<p>20. What is the process for reimbursement or will there be reimbursement available for refugee services?</p>	
<p>21. Currently reimbursed via check will EFT be available?</p>	
<p>22. What will be the process to submit Native Claims?</p>	



**Delegation of Authority Form**

Who from Contractor will be able to contact billing agencies.

The person named below will have full, unlimited authority to operate Contractor Counseling to the fullest extent possible until such person is relieved by the next highest-ranking officer. Delegation to successors other than Executive Director and/or owners extending beyond seven days will need approval by Contractor Counseling.

Name and Title of Person Delegated Authority: \_\_\_\_\_

Date and Event Triggering Delegation: \_\_\_\_\_

Authority is (circle one): Unlimited – No Restrictions    Limited – list limitations:

\_\_\_\_\_  
\_\_\_\_\_

Day/Date of Delegation Termination: \_\_\_\_\_

Date Authority Extended: \_\_\_\_\_

Name and Title Approving Extension: \_\_\_\_\_

Signature of Extension Authorization: \_\_\_\_\_

Name and Title of Person Assuming Authority: \_\_\_\_\_

Date of Authority Assumption: \_\_\_\_\_

# Departmental Plans and Devolution of Essential Functions

Each department has developed a plan that identifies their essential functions, applications, vital records, equipment and supplies. The devolution of essential functions identifies how the departments will conduct essential operations during crisis events that may adversely impact their department. This information is listed in the Strategy for Recovery and Interruption Impact section of their plan.

## Mission Critical Services and Processes

Tier	Criticality
Tier 0	Immediately needed, no later than September 30, 2018.
Tier 1	Needed no later than December 1, 2018.
Tier 2	Needed no later than January 1, 2019.
Tier 3	Needed after January 1, 2019

Department	Mission Critical Services and Processes
IT Department	To work with IT to identify cloud based server or local server to facilitate the capability of data restoration.
Billing	Medicaid billing will be moved to Office Ally clearing house and tested once billing requirements are received from the MCO.
Contractual Payer (MCO, BH-ASO)	Provide the billing requirements and assist with testing before go-live on January 1, 2019.
Contractual Payer (MCO, BH-ASO)	In the event billing processes and submittal are unsuccessful work with Contractor to identify ways to ensure revenue is not negatively impacted.
IT Department	In the event of a server outage or infrastructure system failure refer to MCO/BH-ASO and Contractor infrastructure outline ( ).

Department	Essential Function

**Additional considerations in a crisis during recovery.**

- Notify insurers and third-party administrators as needed.

## Vital Records

During any system failure personnel will be deployed during an emergency to ensure the protection and ready availability of electronic (via web-based offsite) and hardcopy documents in storage, references, records, and information systems needed to support essential functions under the full spectrum of emergencies. Personnel and locations of vital records have been identified before an emergency in order to have full access to use records and systems to conduct essential functions during a crisis event.

## Finance

Business continuity plans should address the considerations with respect to the continuation of essential services such as payroll, the insurance claims process for both losses and emergency protocols with payers and federal re-imbusement procedures following declared disasters.

During a service interruption event or emergency, the Executive Director and/or owners may appoint a staff member. The staff member should understand patient intake, insurance, coding and reimbursement.

Essential functions, at a minimum for finance should include:

- Payroll processing
- Financial recording and reporting
- Billing, Payment and Reimbursement
- Claims Processing

## Payroll Processing

- Modify process for approving time sheets in the event a supervisor is unavailable.
- Make provisions for alternate access to payroll systems in the event primary staff are unavailable.
- Ensure that payroll will be conducted from an alternate/remote site.
- Arrange for optional cash salary payments if needed.
- Distribute paper checks if needed. Document the process on how this will done including who has authority to write checks, location of distribution, who will distribute (manager vs. finance dept) etc.

## Financial Recording and Reporting

- Prepare and maintain cumulative income and expense report during the event.
- Set-up zero dollar cost centers (2 or more) to capture disaster related charges. Cost

codes within the cost center should include labor, supplies, pharmaceuticals, equipment, etc.

- Retain all invoices, time sheets, etc. to ensure all costs are captured and attributable to the event.
- Track, record and report all on-duty time for personnel who are working during the event.
  - Establish and maintain documentation of all payroll activities.
  - Ensure records are accurate and complete. All staff must be keeping time sheets (exempt or not) as their time may be reimbursable by insurance.
  - Provide instructions to all employees to ensure time sheets and travel expense claims are completed properly.
  - Ensure that time records, travel expense claims, and other related information are prepared and submitted to payroll.
- Develop financial reports and use forms that are easy to understand for use by staff and board members.
- Prepare and maintain an expense report for Contractor leadership. The report should include cumulative analyses and total expenditures for the event.
- Organize and prepare records for audit.

## Billing, Payment and Reimbursement

*Collect and maintain documentation on all disaster information for claims, payment and reimbursement from private insurance carriers, FEMA, SBA and other agencies.*

### Claims

- Investigation of injuries and property and equipment damage claims arising out of the event.
- Notify insurers and third party administrators.
- Prepare required documentation (insurance carriers and government agencies) as necessary to recover all allowable disaster response and recovery costs.
- Provide information regarding insurance coverage as necessary.
- Track the total inventory of equipment, supplies and other items that have been lost, impacted or damaged.
- Maintain a chronological log of property damage reported during the event.
- Coordinate the preparation of appropriate forms for damage claims and forward them to the insurers within the required time frame.

### Payers

- Review payer contracts to see if they include clauses that address utilization management and claims processing during emergencies.
- Address suspension of contractual obligations or establish memorandums of agreement with health plan providers regarding suspension of (or modifications to) the following processes to reduce interruptions in patient care:
  - Prior authorization
  - Precertification
  - Concurrent review
  - Referrals
  - Notice of admission
  - Claims submission deadlines
  - Retrospective medical necessity reviews
  - Provision of emergency department records
  - Medical record documentation
- Determine whether payers have modified requirements related to medical record documentation after a state of emergency has been declared.
- Determine whether specific coding will be required by commercial payers to reflect care that is provided at an alternate care site. Determine which code must be used.
- Prioritize claim submissions. Consider submitting high-dollar claims first, or those that

### Property Damage Documentation

- invoices
- purchase orders
- repair quotations
- time and material contracts with expenditures
- labor time sheets with corresponding payroll journals
- supply vouchers or requisitions
- inventory quantities with pricing

### Business Interruption Documentation

- reconstruction schedule
- past experience of business actual experience during the
- period of indemnity
- revenue forecasts
- additional expenses incurred to reduce the period of reconstruction
- purchase journals
- payroll journals
- general ledger
- profit and loss statements
- inventory records, quantities and values

do not require extensive documentation.

### **FEMA Reimbursement**

- Determine eligibility for compensation through state or federal funds due to financial losses attributed to a declared disaster or public health emergency.

FEMA may cover:

- Emergency medical care
- Temporary medical facilities
- Sheltering
- Storage and internment of unidentified human remains
- Mass mortuary services
- Overtime pay for regular employees
- Regular and overtime pay for extra hires

FEMA may not cover:

- Inpatient care
- Follow-up treatment
- Costs associated with loss of revenue
- Increased administrative and operational costs due to increased patient load
- Disaster-related recovery

- Submit Request for Public Assistance (RPA) within 30 days of the date that the affected area is designated a disaster area in a Presidential Disaster Declaration.
- Kickoff Meeting will be scheduled within one week of FEMA's receipt of the Request for Public Assistance.
- Damaged facilities and emergency work must be identified and reported to FEMA within 60 days of the Kickoff Meeting.

Completing Work:

- Time starts from the Date of the Declaration.
- Time frames may be adjusted depending on the type and extent of the disaster. Extension of times may be requested.

### **Forms**

- Claims Report
- Emergency Order Form
- Time Sheet





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## Expectations Regarding Use of Medicaid Transformation Integration Incentive Funding

Counties that commit to implementing integrated managed care before 2020 are “mid-adopter” regions and the Accountable Communities of Health in these regions are eligible for integration incentive funding through the Healthier Washington Medicaid Transformation.

This document describes expectations of the Washington State Health Care Authority (HCA) for how regions should prioritize the use of these integration incentives. In regions that are implementing integrated managed care in 2020, HCA’s expectation is that Project 2A funds be used to support the activities described in this document, as needed and as funding allows.

Each region’s Accountable Community of Health (ACH) makes decisions about fund distribution, and funding is distributed through the financial executor. The State expects the ACHs to use an inclusive process in which county authorities and behavioral health providers participate in decision-making.

ACH integration incentive payments should be prioritized to assist Medicaid behavioral health providers and the region with the process of transitioning to integrated managed care.

This could include:

- Using funds to assist Medicaid behavioral health providers with the uptake of new billing or electronic health record systems.
- Technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing.
- Technical assistance for providers to work within managed care business processes.
- Funding to support the hiring of temp staff, to assist with historical data conversion at Medicaid behavioral health agencies or re-configuration of billing systems.
- Providing Medicaid behavioral health providers with funds as an incentive for completion of the Qualis Behavioral Health Agency [Self-Assessment Tool](#).
- Providing funds to Medicaid behavioral health providers to cover operating expenses through the first quarter of IMC implementation, so that providers have adequate cash-flow during the initial transition months.
- Funding to support provider recruitment and retention.
- Incentive funding for provider participation/to improve provider network.
- Funding to support specialized provider training.
- Using funds to build/improve upon a quality improvement program.
- Funding to further support and build upon the region’s work to implement integrated clinical models.

- Support for behavioral health providers to attend trainings and collaborative meetings with medical providers and other off-site responsibilities (covering time loss from patient care).
- Funding for pilots at clinic locations e.g. for obtaining Substance Use Disorder consent and record sharing.

If you have questions about the use of integration incentive funding, please contact [Kali Klein](#), Health Care Policy Project Manager, or [Isabel Jones](#), Integration Policy Manager.

More resources:

- Information on the [Healthier Washington Medicaid Transformation](#)
- Information on the [transition to integrated managed care in Washington State](#)
- Access to the [Qualis Toolkit](#)

# Practice Transformation Implementation Workplan

Site Name: **Tri-Cities Community Health**

Practice Transformation Team Members: Sam Werdel, Martin Sanchez, Jenna Shelton, Veronica Gutierrez

Date:

Physical and Behavioral Health Integration Assessment overview
<b>Strengths:</b>
<i>Quality Improvement Strategy – 7.0/4.0</i> <i>Enhanced Access – 6.8/2.0</i> <i>Care Coordination – 6.8/4.0</i> <i>Patient Centered Interactions – 5.4/6.3</i>
<b>Opportunities:</b>
<i>Organized, Evidence Based Care – 5.4/4.0</i> <i>Continuous and Team Based Healing Relationships – 5.0/2.0</i> <i>Engaged Leadership – 5.0/6.3</i> <i>Empanelment – 1.5/2.0</i>

Transformation Assessment Overview
<b>Strengths:</b>
<p><b>Quality Improvement Strategy</b> – <i>Choose and use a formal model for quality improvement. Establish and monitor metrics to evaluate routinely improvement efforts and outcomes; ensure all staff members understand the metrics for success. Ensure that patients, families, providers, and care team members are involved in quality improvement activities. Optimize use of health information technology to meet Meaningful Use criteria.</i></p> <ul style="list-style-type: none"><li>Quality Improvement is a strength for TCCH. Currently QI activities are conducted by the practice teams supported by the Quality Department. There is the ability in NextGen to have comprehensive reporting for medical data and Meaningful Use data. There are opportunities to improve data collection within registries, patient satisfaction, and utilization data.</li></ul>

- Behavioral health at TCCH operates within the NextGen system. Similar to the medical departments, there are opportunities to enhance QI activities through further understanding of NextGen and enhancement of workflows.

**Enhanced Access** - *Promote and expand access by ensuring that established patients have 24/7 continuous access to their care teams via phone, e-mail, or in-person visits. Provide scheduling options that are patient and family-centered and accessible to all patients. Help patients attain and understand health insurance coverage.*

- Currently patients at TCCH are provided with the opportunity to have same-day visits and flexible visit times. If a patient has an issue with insurance that is addressed by the billing department. Although Enhanced Access is a strength for TCCH, there is opportunity to add structure to the scheduling system and create workflows around responding/triaging incoming calls for medical and behavioral health.
- Enhanced Access for Behavioral health patients is limited due to provider availability and scheduling constraints. There is opportunity to enhance workflows and scheduling templates within NextGen, specifically for behavioral health.

**Care Coordination** – *Link patients with community resources to facilitate referrals and respond to social service needs. Integrate behavioral health and specialty care into care delivery through co-location or referral agreements. Track and support patients when they obtain services outside the practice. Follow up with patients within a few days of an emergency room visit or hospital discharge. Communicate test results and care plans to patients.*

- Workflows have been systematically implemented for TCCH around care coordination. TCCH uses EDIE to track patients' visits to the Emergency Department and provide outreach to schedule follow up appointments. Patients are linked to community-based resources through targeted population outreach. Behavioral health services are available on site for patients needing a warm hand off. There are opportunities to improve the timeliness of referrals sent to and received from surgical specialists; possibly with the implementation of Premanage and/or Direct Secure Messaging.
- Although behavioral health and medical use the same EHR, there are barriers regarding integration and the coordination of treatment plans and referrals. Within practice transformation there is an opportunity to eliminate the silos of these departments and increase functionality. Moreover, creating workflows that ensure consistent follow up after referral, test, or treatment will also be beneficial. TCCH's Behavioral Health department has strong processes for linking patients to community resources and social supports.

**Patient Centered Interactions** - *Respect patient and family values and expressed needs. Encourage patients to expand their role in decision-making, health-related behaviors, and self-management. Communicate with patients in a culturally appropriate manner, in a language and at a level that the patient understands. Provide self-management support at every visit through goal setting and action planning. Obtain feedback from patients/families about their healthcare experience and use this information for quality improvement.*

- Valuing the patient and family’s culture and preferences is a pillar of TCCH. Patients are consistently involved in their decision making and care. These preferences are documented within NextGen. Patient comprehension is assessed and delivered to patients in their preferred language. Patients can be referred to self-management support – specifically through diabetic education provided at TCCH. There is an opportunity to consistently distribute surveys for patients to receive feedback.

## Opportunities:

**Organized Evidence Based Care** - *Use planned care according to patient need. Identify high risk patients and ensure they are receiving appropriate care and case management services. Use point-of-care reminders based on clinical guidelines. Enable planned interactions with patients by making up-to-date information available to providers and the care team prior to the visit.*

- During a patient visit, even if an acute visit, chronic problems are addressed if time permits. Comprehensive guideline-based information is available. Care managers are utilized regularly to communicate with patients and the care team. There are opportunities the tracking and measurement of behavioral health outcomes and the development of care plans.
- Within the behavioral health department there is an opportunity to adopt workflows that allow for consistent screenings for physical health measures and the universal use of best practice evidence by behavioral health providers.

**Continuous & Team Based Healing Relationships** – *Establish and provide organizational support for care delivery teams that are accountable for the patient population/panel. Link patients to a provider and care team so both patients and provider/care teams recognize each other as partners in care. Assure that patients are able to see their provider or care team whenever possible. Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.*

- Patients at TCCH are encouraged to see their PCP but it is not a priority in appointment scheduling. The continuity of care between primary care and behavioral health could be strengthened. A strength within this concept is that non-physician team members do provide clinical support.

**Engaged Leadership** - *Provide visible and sustained leadership to lead overall cultural change as well as specific strategies to improve quality and spread and sustain change. Ensure that the PCMH transformation effort has the time and resources needed to be successful. Ensure that providers and other care team members have protected time to conduct activities beyond direct patient care that are consistent with the medical home model. Build the practice’s values on creating a medical home for patients into staff hiring and training processes.*

- Despite the lower quantitative score, leadership at TCCH is engaged in practice transformation. Executive leaders do provide visible support, however there is an opportunity for executive leaders to dedicate resources to quality improvement. Clinical leaders are engaged in QI and practice transformation, but are needing a pathway/process for implementation. There are opportunities to improve TCCH's onboarding and training process to combat turnover.

**Empanelment** - Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis. Assess practice supply and demand, and balance patient load accordingly. Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need.

- Currently, patients are not assigned to a specific practice panel. Registry data is not being used and reporting on care outcomes and/or gaps are not available to the care team. In order to enhance empanelment, there is a need to increase the understanding/configuration of NextGen. This will allow the QI team to ensure that reporting capabilities have been established so reports and registries can be generated.

### Goal: Standardize workflows across sites

#### Domain: QI

Action steps:	Person responsible	Due date
Develop Standard Operating Procedures for each department	Jenna, Martin, Sam, Veronica	12/1/18

### Goal: Ensure functionality of operating systems

#### Domain:

Action steps:	Person responsible	Due date
Review NextGen PM to ensure that all fields are set up correctly	Jenna, Martin, Sam, Veronica	12/1/18

Practice Transformation Involvement	
Name of PTN:	Name of Contact:
Description of services received by PTN: N/A	
Plan for alignment with Hub activities:	

Qualis Health Supportive Activities:
N/A

Action Steps for the Next (insert timeframe)	Responsible Team Member

## Monthly Updates/Achievements:

### July

- *Completed Billing and IT Self-Assessment Survey*

### August

- *Practice Transformation Kick Off Meeting – 8/10/18*
- *Reviewed Standard Operating Procedures (SOPs) for pharmacy – 8/20/18*
- *Reviewed SOPs for Behavioral Health – 8/22/18*
- *Reviewed Next Gen optimization and determined initial focus areas: provider list, payer list, real time eligibility, and autoflow. – 8/31/18*

### September

- *Reviewed SOPs for medical reception – 9/6/18*
- *Reviewed NextGen optimizations on created workflows with screenshots for staff. – 9/7/18*

# 2019 Transformation Incentive Allocation Definitions: Milestone Deliverables for Practice Transformation PCMH Contracting

## Assessments (HIT/EHR)

HIT and EHR Assessments will be part of Practice Transformation early phase with the Initial Cohort of Partnering Providers (ICPP) engagement.

See: *GCACH Program Year 2018 Implementation and Milestone Reporting Summary Guide 1.c. An Approach to Milestone 1* You will work with your Transformation Navigator to complete a Transformation Implementation Plan will include but not limited to Infrastructure, training, workflows, etc. in order to transform your practice successfully.

These are contained in EDIE/PM and PHM tools.

## Bi-Directional Integration of Behavioral Health and/or Primary Care

1. This will be completed once professionals are in place and services are being provided and billed to MCOs. This will be integrated into the contract between the MCO and provider organization.
2. The practice will identify an evidenced-based tool for screening
3. The practice will identify an evidenced-based tool for treatment

Milestone will be based on completion of all three categories above.

See: **2.i. Key Questions for Behavioral Health Integration 4. You can incorporate a variety of tools and instruments into your practice to support care (page 10)**

## Empanelment of Patient

1. Provider will have a process for receiving the MCO panel reports on a monthly basis. They will proactively manage this list and cross-reference to EHR for empanelment. your practice will proactively work toward maintaining at least 95% empanelment to provider(s) or care teams in PY 2019
2. The provider practice's staff, with corresponding qualifications, will proficiently manage their empaneled patient population, under the guidance of the GCACH Practice Transformation staff.

See: *GCACH Program Year 2018 Implementation and Milestone Reporting Summary Guide 2.b. New Primary Care Strategies – Access and Continuity*

See: **2.c. Reporting for Milestone 2**

Milestone will be based on completion of the category above.

## Access and Continuity

1. Your practice will identify two of the primary care strategies indicated in Access and Continuity as a starting place ([see list](#)). You might choose to start with a strategy that you have already been testing in your practice or you might choose a new strategy to address an unmet need. Other strategies will be implemented as success as gained from primary strategies.
2. Practice will provide after-hours access to the care team:
  - Attest that patients continue to have 24-hour/7-day-a-week access to a care team practitioner who has real-time access to the electronic medical record. Provider on-call will be either a licensed practitioner or RN
  - Implement at least one type of opportunity for care provided outside of office visits: patient portal, email, text messaging, structured phone visit
  - Communicate a commitment to timely responses to asynchronous forms of communication: portal messages, email, text messages and voice mail
3. Providers will be allowed to 24/7 remote access to the organization's EHR

Milestone will be based on completion of all three categories above.

See: 2.b. New Primary Care Strategies

See: **3.f. Terms and Conditions for Milestone 3 (page 18)**

## Quality Improvement (QI) Team

The provider practice will choose and use a formal model for quality improvement that is designed and included in the Practice Transformation Implementation Workplan (PTIW). This will lead to the formation of a QI team, with membership linked to the formal model.

See: <http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-QI-Strategy-1.pdf>

## Risk Stratification

Practice will risk stratify patients, achieving risk stratification of at least 75% of empaneled patients by end of FY 2019.

See: **2.d. Terms and Conditions for Milestone 2 (page 8)**

## Care Management

1. Provide care management to at least 80% of highest risk patients (those that are clinically unstable, in transition, and/or otherwise need active, ongoing, intensive care management).
2. Implement Behavioral Health Integration and one of the following two specific care management strategies for patients in higher risk cohorts:
  - Self-management support for at least three high risk conditions
  - Medication management and review the strategy

See: **2.d. Terms and Conditions for Milestone 2**

Milestone will be based on completion of both of the category above by end of FY 2019.

## Training

1. **Medication-Assisted Treatment (MAT):** All PCPs to increase their awareness of treatment therapies available for treating opioid substance-abuse. Training will lead to certification by end of FY 2019, verified by the GCACH but facilitated by either the GCACH or their own internal organization.
2. **Prescription Monitoring Program:** All PCPs to increase their awareness of the WA Dept. of Health Prescription Monitoring Database. Provider will attend certified training program by end of FY 2019, verified by the GCACH but facilitated by either the GCACH or their own internal organization.
3. **Oral Health Assessment and fluoride treatment:** Primary care providers will undergo certification to perform oral screening and assessment to identify caries and tooth decay, and to provide early adolescent fluoride varnish application.

## Patient and Families Engagement

Practice will have the opportunity to engage in one or more of the following options:

1. Option A: Conducting practice-based patient surveys on a monthly basis
2. Option B: Quarterly Patient and Family Advisory Council (PFAC) meetings
3. Option C: Engaging a PFAC plus conducting office-based surveys

See: 4.b. Considerations for Milestone 4 Options

## Reporting

Reporting on the remainder of the PY 2018 Milestones will be quarterly. Metrics will be entered into the online portal presented by the GCACH. Reporting metrics will be tied to the following categories:

1. Clinical Quality Metrics
2. Pay-for-reporting metrics
3. Practice Transformation Process Measures

## Quality Improvement

Practice will report on MEDICAID TRANSFORMATION PROJECT Clinical Quality Measures (CQMs):

- a. Report the EHR clinical quality measures required by MEDICAID TRANSFORMATION PROJECT for your region
- b. Provide panel (provider or care team) reports on at least three measures at least quarterly to support improvement in care

2019 will be the benchmark year for value-based reimbursement.

See: 5.c. Reviewing and Learning from Your CQM Data

## ED and Hospital Follow-Up

Provider practice will carry out the following activities:

1. Implement EDIE/PreManage software
2. Proactively go into EDIE/PreManage on a daily basis to pull ED and hospital utilization data for their patient population
3. Select two of the three options below, building on your Program Year 2019 activities:
  - Track percent of patients with ED visits who received a follow-up phone call within one week
  - Contact at least 75% of patients who were hospitalized in target hospital(s), within 72 hours
  - Enact care compacts/collaborative agreements with at least two groups of high-volume specialists in different specialties to improve transitions of care including primary care to cardiology, gastroenterology, orthopedics and sub-acute services (for example, a skilled nursing facility)

**See: 6.e. Resources for Care Coordination**

## Shared Decision-Making

Provider practice will carry out the following activities:

1. Identify and implement shared decision-making tools or aids in two health conditions, decisions or tests Make the decision aid available to appropriate patients and generate a metric for the proportion of patients who received the decision aid
2. Provide quarterly counts of patients receiving the decision aids and show growth in use of the aids using run charts
3. Guidance or coaching in deliberation, designed to improve the patient's involvement in the decision process ([http://www.dartmouthatlas.org/downloads/reports/preference\\_sensitivepdf](http://www.dartmouthatlas.org/downloads/reports/preference_sensitivepdf))

**See: 7.b. Terms and Conditions for Milestone 7**

## Practice Transformation Learning Collaborative

1. In Q4 2019, your practice will attest to participating in the Practice Transformation Learning Collaborative, participating in at least one learning webinar per month, engaging with the GCACH staff and/or Leadership Council.
2. Exemplar Clinics: Additional incentive dollars will be available to clinics that are PCMH recognized (nationally), conducting bi-directional integration, and successfully exhibiting all the components of the PCMH. These Exemplar Clinics will be available for collaboration, academic detailing and mentoring for other organizations implementing the PCMH.

**See: 8.b. Reporting for Milestone 8**

## Health Information Technology

1. By the end of Q2 2019, your practice will indicate that you are using an ONC-certified EHR.
2. In subsequent quarters, your practice will have the ability to exchange health information and attest that all Eligible Professionals have successfully identified the settings in which you are

able to exchange electronic patient information securely to other entities (i.e., direct secure messaging, patient portal, etc.)

See: **9.b. Reporting for Milestone 9**

## **Cost Analysis & 2019 Budget**

In 2018, your program will report final funding and costs associated with the Practice Transformation Implementation Workplan as well complete a budget projection for 2019.

## **Practice Transformation Implementation Workplan (PTIW)**

Within each of the eight change concepts of the Safety Net Medical Home model, each practice will successfully implement the workflows outlined in the GCACH Program Year 2018 Implementation and Milestone Reporting Summary Guide, based upon review by the GCACH. Each practice will be re-evaluated within a year to determine progress and achievement of their benchmark scores for each change concept.

## **Hospital Utilization**

1. **ED Visits (See P4P definition):** Subsequent to PM implementation, provider will collect ED visit data through PreManage software using EDIE on a daily basis. This will be tasked to case manager/care coordinator, nurse, or MA. Some MCOs (e.g. Molina) require the organization to collect this information.
2. **Inpatient admissions (See P4P definition):** Subsequent to PM implementation, provider will collect Inpatient data visit data through PreManage software using EDIE on a daily basis. This will be tasked to case manager/care coordinator, nurse, or MA. Some MCOs (e.g. Molina) require the organization to collect this information.