



**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	8
Project 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	8
Project 2B: Community-Based Care Coordination.....	10
Project 2C: Transitional Care	12
Project 2D: Diversion Interventions.....	14
Project 3A: Addressing The Opioid Use Public Health Crisis	15
Project 3B: Reproductive and Maternal/Child Health.....	17
Project 3C: Access to Oral Health Services	19
Project 3D: Chronic Disease Prevention and Control	21
REQUIRED PORTFOLIO NARRATIVE	23
Partnering Provider Project Roles.....	23
Partnering Provider Engagement	34
Partnering Provider Management	48
Alignment with Other Programs.....	53
Regional Readiness for Transition to Value-based Care.....	59
Technical Assistance Resources and Support.....	67

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SUBMISSION INSTRUCTIONS

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

- *Project work plans.* Work plans are a key component of the Implementation Plan. ACHs must detail key milestones, work steps to achieve those milestones, deliverables, accountable ACH staff and partnering provider organizations, and timelines from DY2, Q3 to DY5.
- *Portfolio narrative.* ACHs must respond to a set of questions, included in these instructions, which detail implementation approach and activities with partnering providers and coordination with health systems and community capacity building and other initiatives across their portfolio of projects between DY2, Q3 through DY3, Q4. The intent of describing roles and activities for a narrow timeframe is to capture concrete examples of implementation steps as they get underway, while not overly burdening ACHs to report on the full timeframe of Medicaid Transformation, or the full scope of work by partnering providers.

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

Work Plan Template. The Implementation Plan Work Plan Template (Excel workbook) provided by HCA is for use by ACHs in completing the Work Plan component of the Implementation Plan. ACHs may submit an alternative work plan format; however, ACHs

must meet the minimum requirements outlined below, and provide complete responses to all questions in the Portfolio Narrative section.

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

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

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

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

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

PROJECT WORK PLAN REQUIREMENTS

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**¹ accountable for completion of the work step, and whether it is the ACH staff or the partnering provider organization that is leading the work step, or whether responsibilities are shared.
- **Timeline** for completing action steps and milestones.

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

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

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

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

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

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

the Medicaid Transformation Project Toolkit and updated or omitted some milestones for the sake of clarity and applicability.

- 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.)

Project 2B: Community-Based Care Coordination

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

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

Stage 3: Scale & Sustain Milestones

- Expand the use of care coordination technology tools to additional providers and/or patient populations. (Completion no later than DY 4, Q4.)
- Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)

- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)
- Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)
- Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)

Project 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.)

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.)

Project 3A: Addressing The Opioid Use Public Health Crisis

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

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

Stage 3: Scale & Sustain Milestones

- Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g. to cover additional high needs geographic areas), as well as defining a path forward to deploy the partnership's expertise, structures, and

capabilities to address other yet-to-emerge public health challenges. (Completion no later than DY 4, Q4.)

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

Project 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.)

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.)

Project 3D: Chronic Disease Prevention and Control

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

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

Stage 3: Scale & Sustain Milestones

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

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

REQUIRED PORTFOLIO NARRATIVE

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

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

ACHs should read each prompt carefully before responding.

Partnering Provider Project Roles

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

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

In total, examples must reflect:

- A mix of providers traditionally reimbursed and not traditionally reimbursed by Medicaid.²
- All projects in the ACH's portfolio.

ACH Response

Responses must cover the following:

- What is the name of the partnering provider organization?
- What type of entity is the partnering provider organization?
- In which project/project(s) is the partnering provider organization involved?

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

- What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?
- 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?

ACH Response:

Throughout the Implementation Plan, HealthierHere will use the terms “Innovation Partner” and “Practice Partner” to refer to the organizations HealthierHere is partnering with to transform health care in King County, and the term “Innovation and Practice Partners” to refer to the two sets of organizations collectively.

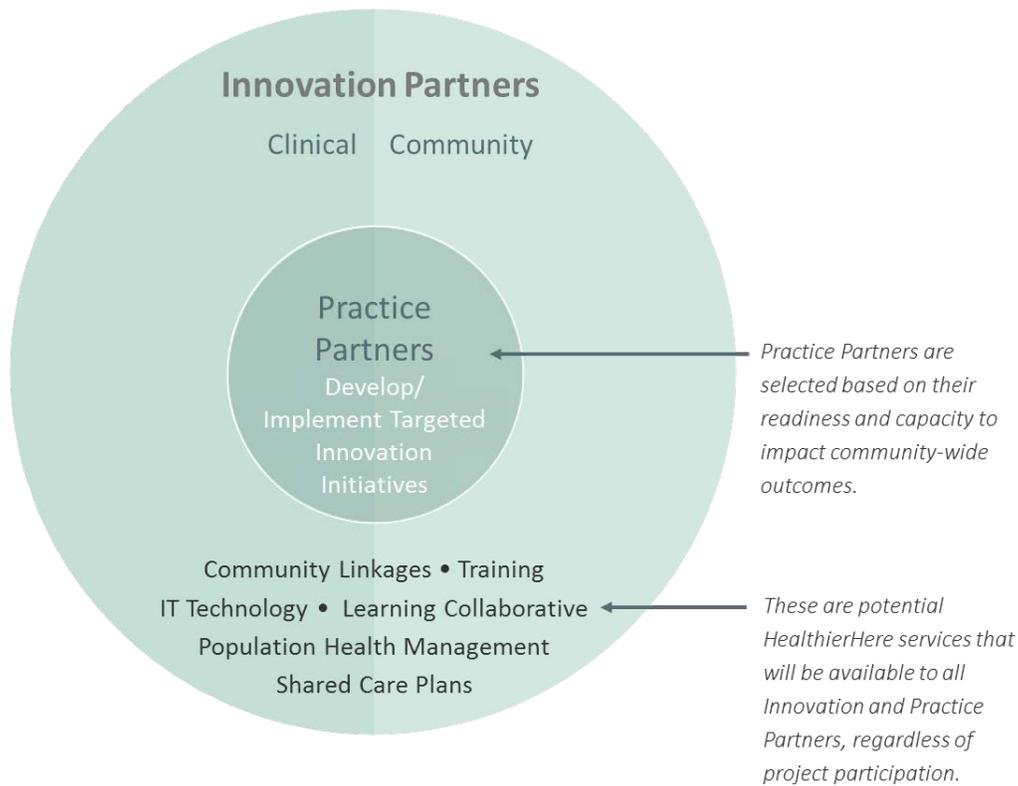
Innovation Partners are all clinical and community organizations in King County that are interested in partnering with HealthierHere on Medicaid transformation and have demonstrated their intent to partner with HealthierHere through completion of a Current State Assessment (CSA) and/or Health Information Exchange and Technology (HIE/HIT) Assessment, and/or by registering in the Financial Executor (FE) portal. Many Innovation Partners were engaged in critical and innovative health care activities prior to the Medicaid Transformation Project (MTP), and their knowledge and experiences have and will continue to inform HealthierHere’s portfolio and project approaches and strategies. As described later in the Implementation Plan, HealthierHere is in the process of developing various learning forums in which all Innovation Partners will be invited to continue their relationship with HealthierHere, learn from leaders in King County and beyond about their experiences with health care transformation, and share their stories and questions. Innovation Partners may become Practice Partners (described below) as they demonstrate readiness and capacity to impact community-wide outcomes through HealthierHere’s projects. Today, HealthierHere has over 40 Innovation Partners.

Practice Partners are a subset of Innovation Partners that HealthierHere will contract with to develop and implement targeted innovation initiatives, including the transformation projects described in the Implementation Plan. The contracts will outline the relationship between HealthierHere and each Practice Partner, including the expectations and deliverables for Practice Partner project implementation that will lead to payment disbursement. HealthierHere will work with both *Clinical Practice Partners* – hospitals, Federally Qualified Health Centers (FQHCs), and behavioral health agencies (BHAs) – and *Community Practice Partners* – including, but not limited to, community-based organizations (CBOs), county agencies, nongovernmental organizations, and others embedded within and serving their local communities. Today, HealthierHere has

26 Clinical Practice Partners; HealthierHere will identify Community Practice Partners in Q4 2018.

The relationship between Innovation and Practice Partners is depicted below. HealthierHere is in the process of developing services and tools that will benefit Innovation and Practice Partners, such as community-clinic linkages, Quality Improvement Learning Collaboratives, trainings, and population health management tools.

Figure 1. **Innovation and Practice Partners**



HealthierHere is excited to share information about our Practice Partners and their project implementation activities with the Health Care Authority (HCA). We highlight four Practice Partners below. These partners cover all Practice Partner types and projects.

Figure 2. **Featured Practice Partners' Projects**

Organization Name	Practice Partner Type	Featured Project	Other Projects
Seattle Indian Health Board	FQHC/Tribal	3D. Chronic Disease Prevention and Control	N/A
Harborview Medical Center	Hospital/Health System	2C. Transitional Care	2A. Bi-Directional Integration of Physical and Behavioral Health through Care Transformation; 3A. Addressing the Opioid Use Public Health Crisis; 3D. Chronic Disease Prevention and Control
Navos	BHA	2A. Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	2C. Transitional Care; 3D. Chronic Disease Prevention and Control
Recovery Café	Community Partner	3A. Addressing the Opioid Use Public Health Crisis	N/A

Each Practice Partner and its plan for transformation is described below.

Seattle Indian Health Board

The Seattle Indian Health Board (SIHB), a nonprofit organization, is a leader in providing community health care and services for the American Indian and Alaska Native population in the greater Seattle/King County area. Its mission is to:

“...advocate for, provide, and ensure culturally appropriate, high quality, and accessible health and human services to American Indians and Alaska Natives.”

As a Practice Partner in the Chronic Disease Prevention and Control project, SIHB will be expanding the comprehensive care team model that it currently uses to care for patients with an opioid use disorder (OUD) to its care for patients with asthma and chronic obstructive

pulmonary disorder (COPD). The comprehensive care team is comprised of an advanced practitioner, a traditional health practitioner, a behavioral health specialist, a dentist, a medical assistant, and a patient navigator who performs outreach and scheduling for clients. SIHB has had tremendous success with this model in increasing access to low-barrier medication assisted treatment (MAT) and managing patients with OUD. The program grew from 34 patients to 218 patients in one year, with 1,179 medical visits for OUD patients. The program has recently begun tracking outcome metrics such as overdoses, overdose deaths, follow-up rates, outpatient/inpatient treatment, days of sobriety, ED visits, preventive health screening accomplished, and much more. SIHB will adapt this team-based approach to address chronic disease management; its initial focus will be on patients with asthma and COPD.

SIHB is infusing other elements of innovation in its work, including:

- The Southcentral Foundation trained the SIHB leadership team in the Nuka System of Care, a relationship-based, customer-owned approach to transforming health care. SIHB is implementing a model of care inspired by this training.
- SIHB has plans to develop a pediatric asthma program with a community health worker (CHW) who conducts home visits and performs home remediation efforts.
- SIHB recently hired two clinical pharmacists who function as hybrid case managers. These clinical pharmacists can adjust medication doses and will work in conjunction and in parallel with the comprehensive care team and pediatric community health worker. Since clinical pharmacists are able to adjust dosages via the phone, they can assist with asthma and/or COPD management in an efficient manner.

Starting in Demonstration Year 3 (DY 3), SIHB will undertake the following key steps as it implements the transformation project:

- Implement a tailored model of care inspired by the Nuka System of Care
- Use a modified Screening, Brief Intervention, and Referral to Treatment (SBIRT) screen to assess patients for social determinants of health (SDOH) and Culturally and Linguistically Appropriate Services (CLAS)
- Build out a complete data and reporting team, including recruitment of a chief information officer (CIO) and data and reporting manager
- Build a data warehouse to collect, assess, and report data
- Enhance capabilities to create patient registries for all chronic diseases managed by primary care, including asthma and COPD, and integrate patient registries into its population health management workflow
- Empanel patients to integrated care teams
- Integrate clinical pharmacists as hybrid case managers with the ability to adjust medication doses as needed
- Enhance case management services through recruitment of two licensed independent clinical social workers

- Develop a pediatric asthma program that will involve CHWs conducting assessments during home visits and leveraging tablet-based templates to document information that will be seamlessly pushed into SIHB's electronic health record (EHR); CHWs will implement home remediation efforts based on identified needs

In addition to the key steps described above, SIHB will participate in the Quality Improvement Learning Collaboratives for the Chronic Disease Prevention and Control project and regularly report data on project metrics to HealthierHere. SIHB plans to expand the chronic care team model to other disease conditions in the later years of the MTP.

Harborview Medical Center

Harborview Medical Center (HMC) is a 400 plus bed public hospital owned by King County and managed by the University of Washington. Founded in 1877 as a small welfare hospital in south Seattle, HMC continues to serve a vital role in managing and improving the health of some of King County's most vulnerable residents. In addition to offering integrated primary and behavioral health care, HMC has providers in most specialties and is the only Level I Trauma and Burn Center in Washington.

HMC, which has extensive experience caring for Medicaid beneficiaries, has expressed interest in participating in all four HealthierHere projects. As part of Medicaid transformation, HMC will enhance its existing work in a number of ways. One major priority is HMC's intent to deepen and expand its work with community partners to impact the SDOH. HMC has many existing strong relationships with FQHCs, behavioral health providers, substance use disorder (SUD) and OUD providers, CBOs, and local government. Starting in DY 3, HMC will also deploy new tools within its EHR to improve care management.

On a system level, HMC is eager to work with HealthierHere on advancing HIE and HIT strategies and tools to enhance communication among clinical and nonclinical providers. HMC's work with HealthierHere will be coordinated by the HMC Care Management Committee, which is co-chaired by an associate medical director and assistant administrator with participation from many staff. HMC plans to assign each project a lead, many of whom are involved in other projects pertaining to similar populations, and providers and other frontline staff will support the project's implementation.

As a Practice Partner in the Transitional Care project, HMC has expressed interest in participating in all three sub-projects: (1) Hospital Discharges for High-Risk Medicaid Individuals, (2) Psychiatric Care Transitions from Hospital Settings, and (3) Transitions of Care from Jail. HMC plans to undertake the following key steps to implement its projects.

1) Hospital Discharges for High-Risk Medicaid Individuals

- Use EHR and population health management tools to identify high risk Medicaid patients, document their care, and track progress
- Assess patients for social complexity, identify barriers to discharge and successful transitioning to a community setting, and determine necessary community and social supports
- Provide care through an integrated, person-centered, and multidisciplinary team, including physicians, nurse practitioners, nurses, social worker, physical therapy, pharmacy, and peer support
- Create an HMC Multidisciplinary Transition Team to provide care management support through an interdisciplinary team and facilitate a warm handoff to a community support specialist (CSSs) and/or a community provider upon discharge; the CSS will be able to rely on the clinical expertise of the HMC team while the HMC team relies on the community expertise of the CSS
- Improve self-management through motivational interviewing and one-on-one support from caseworkers
- Encourage completion of physician orders for life-sustaining treatment (POLST) forms
- Collaborate and integrate with other innovations for individuals transitioning from inpatient hospital stays; for example, HMC is partnering with the Downtown Emergency Service Center to provide HMC patients experiencing, or at risk of, homelessness with appropriate wraparound services post-discharge

2) *Psychiatric Care Transitions from Hospital Settings*

- Use HMC and external systems (e.g., Epic Care Everywhere, Pre-Manage/EDie) to provide integrated health records for HMC patients
- Implement the Actualizing Social and Personal Identity Resources (ASPIRe) model, an evidence-based tool to evaluate clinical service performance and improve the quality of allied health services
- Implement the LACE Plus Tool, a risk stratification tool to identify patients at risk for readmission or death within 30 days of discharge
- Track, through the Peer Bridger program, specific indicators, such as the rate of rehospitalization, outpatient mental health and SUD enrollment, Medicaid enrollment, and emergency department (ED) visits
- Encourage completion of POLST forms
- Provide team-based care
- Expand the CSS workforce
- Continue to provide patient self-management support services
- Assign an outpatient mental health peer or peer specialist to engage with patients prior to discharge and facilitate a warm handoff to a CSS and/or community provider upon discharge; the CSS will be able to rely on the clinical expertise of the HMC team while the HMC team relies on the community expertise of the CSS

3) *Transitions of Care from Jail*

- Continue to provide jail medical staff access to HMC population management tools through Epic EHR
- In coordination with the jail, explore the use of tools such as PreManage to create a panel
- Expand care planning as King County system-wide tools develop
- Provide team-based and integrated care through the Familiar Faces Integrated Care Management Team – “Vital Team” – and scale program to serve focus population
- Enhance Vital Team programs and services related to intensive case management, community support services, and self-management skills
- Expand partnership with Evergreen Treatment Services REACH program to offer integrated physical and behavioral health services
- Connect individuals to community resources, including housing and peer support as well as medical/behavioral care services
- Enhance coordination with jail release planners
- Partner with the grant recipient of the request for information (RFI) for the Reentry Case Management Service
- Provide telepsychiatry services at the jail to ensure continuity of care planning

In addition to the key steps described above, HMC will participate in the Quality Improvement Learning Collaboratives for the Transitional Care project and regularly report data on project metrics to HealthierHere.

Recovery Café

Recovery Café is a nonprofit organization that provides long-term recovery support to a community of approximately 1,000 low-income individuals who have experienced homelessness, addiction, and other mental health challenges. The Café’s current membership is a diverse mosaic of women and men of different ethnicities, expressions of gender, and sexual orientations, and a wide range of ages. Almost 40% identify as dual diagnosis, 13% are veterans, and 12% have some form of physical disability or chronic illness. The Café’s membership largely reflects the racial/ethnic makeup of the homeless population in King County, with a disproportionate number of people of color utilizing services. Many members have been incarcerated at some time, and their criminal records are obstacles to housing and employment.

The stigmas of addiction and mental illness are often a constant and unwelcome dynamic Café members encounter. Overall, one of the greatest challenges members face is a deep sense of

isolation, despair and loneliness. When they first come to Recovery Café, many members feel unknown and uncared for, with little sense of belonging or being wanted anywhere. The Café practices “radical hospitality” and provides a warm and welcoming place of support and stability for all individuals seeking to break the cycle of destruction and despair. Prospective members need to attest to at least 24 hours of sobriety to join, and those who experience a relapse are welcomed back once they are 24 hours sober. Other membership requirements include participating in weekly Recovery Circles and performing regular community service by volunteering at the Café. Members can receive a range of services at the Café, including two nutritious meals a day (lunch and dinner), wellness classes (yoga and walking clubs), recovery-oriented classes (including 12-step programs), volunteer and skill-building opportunities, and referrals to services such as opioid treatment. The Café also hosts regular health activities including monthly on-site clinics with volunteer nurses from the King County Public Health Reserve Corps and regular hepatitis and HIV screenings from the Hepatitis Education Project.

As a Community Practice Partner in HealthierHere’s Addressing the Opioid Use Public Health Crisis project, Recovery Café will be a champion of long-term recovery and play a crucial role in reaching the “hidden” focus population for this project, individuals with OUD who are disengaged from primary care and community behavioral health. Recovery Café will connect individuals to treatment services at HealthierHere’s clinical Practice Partners via warm handoffs. Recovery Café will continue its referral work and will track and report referrals to MAT providers, referrals to psychosocial care, referrals to the two King County hub and spoke networks (HMC and Valley Cities), and referrals to providers of testing and treatment for hepatitis C and HIV. HealthierHere will support Recovery Café in its developing pilot work with two clinical Practice Partners – Community Psychiatric Clinic (CPC) and Evergreen Treatment Services (ETS) – to advance opioid treatment and overdose prevention by extending the Café’s intensive support services to individuals seeking services through CPC and ETS.

Recovery Café Executive Director David Coffey will oversee the Café’s MTP work and has designated a Special Projects Team to implement the project. Recovery Café will participate in the Quality Improvement Learning Collaborative for the Opioid project as well as other HealthierHere sponsored learning activities.

Navos

Navos, a nonprofit organization, is one of the largest behavioral health providers in Washington state and offers a full spectrum of behavioral health services to more than 12,000 low-income children, youth, and adults annually. Navos and the Navos Consortium of subcontracting behavioral health and social service providers give clients individualized support and education through evidence-based programs and services, including psychiatric inpatient programs for adolescents and adults, specialized services for clients ranging from 5 weeks to over 100 years

old, residential treatment, supported community housing, supported employment, and through colocation and key partnerships, including primary care within the behavioral health campus.

As a Practice Partner in the Integrated Whole Person Care in Community Behavioral Health Centers project, Navos will expand existing practices and programs designed to serve well-identified subpopulations, beginning in DY 3. Through its Integrated Health Care Program, Navos and its on-site primary care partners from Public Health – Seattle & King County offer multiple services within mental health clinics, including behavioral health, primary care, laboratory, substance use disorder treatment, and other services.

By building on this experience, Navos will be able to offer integrated care to more of the people the organization already serves. For example, routine screenings – currently conducted for those seeking certain medications – will be expanded to a larger population. Similarly, Navos will expand its Integrated Health Care Program to include more than the 1,000 individuals currently served per year.

Within the Integrated Health Care Program, an interdisciplinary care team – Team Wellness Integration at Navos (WIN) – provides a higher level of service to adults with both serious and persistent mental illnesses and chronic medical illnesses who are also high utilizers of emergency services. WIN will be expanded, with the goal of doubling WIN’s capacity from 45 to 90 individuals. This expansion will enable Navos to broaden qualifying criteria and serve not only individuals with uncontrolled diabetes and hypertension, but also those who are at varying levels of disease management.

As part of its commitment to workforce development and effective bi-directional care delivery, Navos is developing an Integrated Health Academy to provide nonmedical staff with training and education on chronic medical conditions. The Academy will inventory best practices with the goal of adapting, expanding, and improving protocols and health outcome metrics. Navos also will expand its existing referral and collaborative care relationships with primary care partners, including International Community Health Services, SeaMar Community Health Centers, Country Doctor Community Clinic, Swedish Ballard, and Public Health – Seattle & King County.

In addition to the work described above, Navos plans to:

- Conduct holistic screenings more effectively with primary care partners on-site at mental health clinics
- Train community support workers to collect and assess body mass index and blood pressure data for all clients
- Revise its tobacco screening policies to include the stages of change

- Update its diabetes screening policies to address participants using antipsychotic medications
- Develop a clinical pathway for metabolic syndrome
- Add more patient navigators/peer support specialists to its staff, assisting in care transitions from area hospitals and enabling increased referrals to community and other behavioral health programs and services to ensure continuity of care
- Add two full-time nurse care managers and three data-abstracting staff to bolster its WIN program
- Increase their EHR's patient identification, stratification, and health information sharing capabilities
- Develop training for community support workers on chronic disease management, motivational interviewing, and tailoring of integrated care plans

Navos will also participate in the Quality Improvement Learning Collaborative for the Integrated Whole Person Care project and regularly report data on project metrics to HealthierHere.

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?

ACH Response:

- **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?**

HealthierHere will establish Quality Improvement Learning Collaboratives (Learning Collaboratives) for each of its four projects. These Learning Collaboratives will be the foundation of HealthierHere's strategy to support Practice Partners in their transformation projects and serve as the primary forum for Innovation and Practice Partners to learn from each other and share their progress. It will also be an important opportunity for HealthierHere to identify how it can better support Practice Partners as well as prepare Innovation Partners for transformation.

In addition to the Learning Collaboratives, HealthierHere will sponsor and host trainings to enhance Innovation and Practice Partner capacity and spread best practices. HealthierHere will also hold regular Partner Learning Webinars through which HealthierHere will draw on local subject matter experts to share best practices and lessons learned on specific topics relevant to transformation as broad training opportunities for Innovation and Practice Partners.

Each of these is described in more detail below.

Figure 3. HealthierHere Training and Technical Assistance Resources

	Learning Collaborative		Trainings	Partner Learning Sessions
Audience	All Practice Partners (at launch) Innovation Partners (DY3 Q3 and beyond)	<i>Learning Collaboratives will inform HealthierHere's training offerings as well as the topics of Partner Learning Sessions</i>	Subset of Innovation and Practice Partners	All interested parties
Scope	Support project-specific information sharing and learning; contribute to project- and system-level deliverables (e.g., quality improvement plan)		Enhance Innovation and Practice Partner capabilities and close gaps to support project implementation	Spread best practices and provide training ACH-wide
Format	In-person and webinar		In-person	Webinar

Quality Improvement Learning Collaboratives. The Learning Collaboratives will be the foundation of HealthierHere’s strategy to support Practice Partners in their transformation projects and serve as the primary forum for Innovation and Practice Partners to learn from each other and share their progress. All Practice Partners will be expected to participate in the Learning Collaboratives. Starting in DY 3, Q3, Innovation Partners will be invited to participate. HealthierHere believes that making the Learning Collaboratives available beyond Practice Partners will facilitate organizations’ transitions from Innovation Partner to Practice Partner and assist with scale and sustainability of transformation efforts long term.

The objectives of the Learning Collaboratives are to:

1. Disperse knowledge across Innovation and Practice Partners
2. Develop shared tools and quality improvement methods
3. Address common challenges
4. Improve performance on project metrics

The Learning Collaboratives will kick off in November 2018 and meet regularly throughout 2019 and later DYs. All Practice Partners will be required to participate through their contracts with HealthierHere. Participation in the Learning Collaboratives will be a payment deliverable for DY 3; HealthierHere anticipates making incentive payments to Practice Partners based on their Learning Collaborative participation. HealthierHere believes that tying payment to Learning

Collaborative participation will ensure consistent participation among Practice Partners' leadership, which will be critical to the success and impact of the Learning Collaboratives. While Innovation Partners will not be compensated, their participation will enhance their readiness to become a Practice Partner in future DYs.

HealthierHere staff will work closely with Practice Partners to define the curriculum for the Learning Collaboratives. The initial focus of the Learning Collaboratives will be on finalizing the project workflows and developing the ACH-wide quality improvement approach, including the identification and validation of local performance and process metrics. The Learning Collaboratives will also provide a venue for regular ACH-wide check-ins on project progress and performance; during these sessions, HealthierHere and Practice Partners will review accomplishments, challenges, and performance on metrics. The planned Learning Collaborative curriculum through DY 3, Q2 is detailed below.

Figure 4. Learning Collaborative Curriculum, DY 2, Q4 through DY 3, Q2

Month	Topic
November 2018	Kickoff and Information Gathering
January 2019	System Solutions – Workflow Development
February 2019	System Solutions – Workflow Development and Quality Improvement Planning
March 2019	Quality Improvement Planning Policies and Procedures for Workflows Local Performance and Process Metric Validation
April 2019	Policies and Procedures for Workflows Local Performance and Process Metric Validation
May 2019	Local Performance and Process Metric Validation
June 2019	Review Final Quality Improvement Plan/Final Opportunity for Stakeholder Input
July – December 2019	Future topics will be determined by Learning Collaborative participants

HealthierHere developed an initial list of project-specific learning collaborative topics based on Practice Partners' feedback in their Change Plans. This list is under development and will be refined with Innovation and Practice Partners on an ongoing basis to support continued learning. The Learning Collaborative curriculum will also be informed by how HealthierHere Practice Partners are performing and the ACH's overall performance on metrics.

Figure 5. Draft Curriculum for DY 3, Q3 through DY 5

Bi-Directional Learning Collaborative	Transitional Care Learning Collaborative	Opioids Learning Collaborative	Chronic Disease Learning Collaborative
<ul style="list-style-type: none"> • Demystifying primary care and medical terminology • Understanding behavioral health as a specialty referral • OUD screening • Strategies for ensuring patients understand the working relationship among team members (with the Chronic Disease Learning Collaborative) 	<ul style="list-style-type: none"> • Shared care planning • Working in hospitals as an outside agency 	<ul style="list-style-type: none"> • Expanding access to naloxone • Fast-track MAT pathways from EDs • Managing co-occurring disorders with OUD • Alternative pain management approaches 	<ul style="list-style-type: none"> • Co-occurring behavioral health disorders with diabetes • Co-occurring behavioral health disorders with cardiovascular disease • Strategies for ensuring patients understand the working relationship among team members (with the Bi-Directional Learning Collaborative)

Trainings. The objectives of the formal trainings are to enhance Innovation and Practice Partners’ capacity and close gaps in capabilities. Formal trainings will generally be in-person with opportunities for practice and application exercises. Some trainings may be web-only; this will depend on the vendor and its methods. HealthierHere will contract with training vendors to deliver training to subsets of Innovation and Practice Partners, as appropriate by project. There will be an early focus on Practice Partners with identified needs critical to project success. HealthierHere developed an Investment Prioritization Tool (IPT) to select and prioritize the funding and scheduling of training topics, as well as other Domain 1 and 2 investments. As trainings are prioritized, HealthierHere will proceed with contracting with the respective training partner(s).

Recognizing that bi-directional whole person integration is essential to achieve health care transformation, HealthierHere is planning significant targeted investments to support integration. One of those investments is training that will be delivered by the University of Washington Advancing Integrated Mental Health Solutions (UW AIMS) Center. UW AIMS will deliver training to 10 behavioral health practice teams to support their transition to integrated care. The training will take place over approximately one year and consist of three phases. The phases and their goals and activities are summarized below.

Figure 6. UW AIMS Integrated Care Training Plan

	Phase 1	Phase 2	Phase 3
	Planning for Whole Person Care	In-Person Training for Bi-Directional Integration	In-Person and Virtual Coaching and Additional Training
Goal	Evaluate staffing options and choose evidence-based strategies for whole person care	Learn how to operationalize the principles of measurement-based, treat-to-target, whole person care, working together as a team	Ensure practice teams understand key aspects of care and maintain fidelity to the clinical model so that desired outcomes can be achieved
Duration	Three to six months	Two days	Six months
Activities	<ul style="list-style-type: none"> • Develop program goals • Develop organizational and clinic-level staffing plans • Evaluate current state workflows and plan/test future state workflows • Orient providers to whole person care skills • Conduct financial modeling • Select and plan for registry tool 	<ul style="list-style-type: none"> • Apply and practice skills gained in Phase 1 • Operationalize principles of measurement-based, treat-to-target, whole person care • Practice role-specific tasks and skills 	<ul style="list-style-type: none"> • Support integrated care teams as they launch their practices to ensure fidelity to the clinical model • Hold monthly 60-minute facilitated coaching calls • Review registry reports to identify/address implementation challenges • Conduct training in additional necessary clinical skills • Make case presentations

Additional potential topics for training in DY 3 include change management, population health management, quality improvement, and team-based care. The curriculum will evolve based on feedback from the Learning Collaboratives about what Innovation and Practice Partners need to be successful in the MTP.

HealthierHere will continue to offer trainings in DY 4 and DY 5, based on Innovation and Practice Partners’ needs; as HealthierHere scales its projects, it plans to use a train-the-trainer model through which experienced Innovation and Practice Partners or “champions” will train their peers. HealthierHere will also continue to contract with relevant training vendors as needed, to the extent their programs are successful.

Partner Learning Webinars. These regularly scheduled ACH-wide Partner Learning Webinars will be a forum for sharing best practices identified through the Learning Collaboratives, spreading innovation, hosting ACH-wide trainings, and capitalizing on the diverse, rich, and deep knowledge of Innovation and Practice Partners engaged in health system transformation. The greater King County community will be invited and encouraged to participate in Partner Learning Webinars, even if they are not current Innovation or Practice Partners. Partner Learning Webinars will feature subject matter experts from HealthierHere, Innovation and Practice Partners, and the King County community, who will share their experiences and learnings on topics of broad interest across the ACH and relevant to the MTP and system transformation. Each Learning Webinar will also be a venue for sharing updates on ACH progress and milestones.

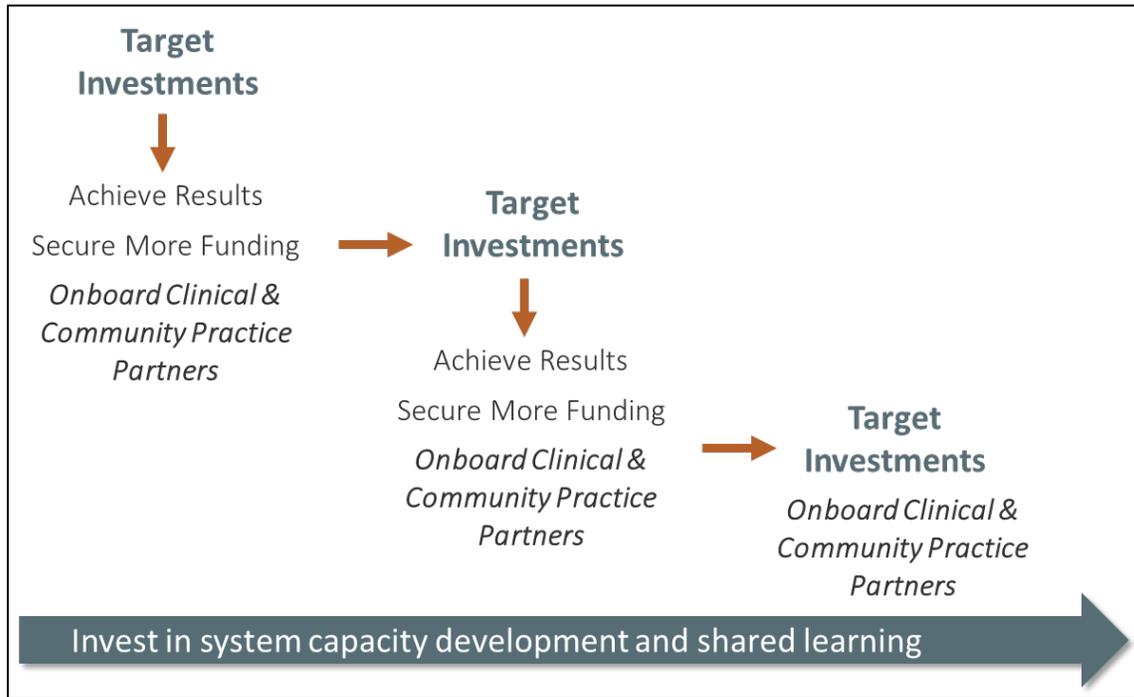
Figure 7. **Draft DY 2, Q4 – DY 3, Q4 Partner Learning Webinar Topics**

Month	Partner Learning Webinar Topics
October 2018	PreManage: Local Perspectives on Best Practices
December 2018	Empanelment and Registries – A Population Health Perspective
February 2019	Achieving Equity and Addressing Health Disparities
April 2019	Value-Based Payment
June 2019	Opioid Prescribing Best Practices
August 2019	Equity/CLAS
October 2019	Motivational Interviewing
December 2019	Health Literacy

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

HealthierHere is actively engaging Clinical and Community Innovation and Practice Partners of all sizes, including those with limited capacity that deliver critical services within King County. At the heart of HealthierHere’s strategy is an organizational- and Governing Board-level commitment to equity and investing in historically underfunded providers, such as BHAs and CBOs. HealthierHere is carrying out this commitment in several ways (described below), and a central tenet of its approach is the staged onboarding of Clinical and Community Practice Partners (see Figure 8). As HealthierHere achieves process and performance measures and secures incentive funding through its work with the initial cohort of Practice Partners, HealthierHere will have the capacity and resources to bring on additional Practice Partners as well as to continue its investments in system capacity development (e.g., training, Domain 1).

Figure 8. Staged Approach to Onboarding Providers



Through the CSA, HIE/HIT Assessment, and Change Plans, HealthierHere identified its first cohort of Clinical Practice Partners. While these Practice Partners have demonstrated capacity and readiness to advance the MTP, there are many other clinical and community providers that play critical roles in health care delivery in King County. HealthierHere intends to bring additional Practice Partners on board in DY 3, but in the immediate future, HealthierHere is focused on demonstrating success and advancing critical metrics to ensure it is able to draw down incentive funding. As HealthierHere draws down incentive funding, it will in turn be able to onboard and support additional Clinical and Community Practice Partners, as illustrated above. While the first cohort of Clinical Practice Partners is being onboarded and throughout the MTP, HealthierHere will make learning opportunities and trainings available to all Innovation Partners, and make infrastructure investments that allow Innovation Partners to take steps toward building their capacity and readiness so they can transition to the role of Practice Partners.

Examples of how HealthierHere is engaging community partners and smaller Practice Partners with limited capacity are described below.

1. **Definition of Community Partner:** Under the guidance of HealthierHere’s Director of Equity and Community Partnerships, the Community and Consumer Voice (CCV) Committee refined the definition of CBO for HealthierHere’s purposes, adopting the

term *Community Partner* in an effort to be inclusive of many types of organizations working in their communities. The definition and its key terms are below; in the remainder of the Implementation Plan, this term will be used in lieu of CBO.

Figure 9. **Community Partner Definition**

Definition
<p><i>Community Partners are those formally organized groups, organizations and/or institutions with an established and trusted presence and history working within a community in a nonclinical setting that provide and/or promote the community support and innovation necessary to help HealthierHere meet its goals for improving health and health equity in King County. Community partners may or may not provide direct health services, but are “trusted advisors” within the community that reach HealthierHere’s focus populations.</i></p>
Key Terms
<p><u>Provide</u> – CBOs that directly provide health services.</p> <p><u>Promote</u> – CBOs that may not directly provide health services, but are “trusted advisors” within the community that reach HealthierHere’s focus populations.</p> <p><u>Groups</u> – Refers to formally organized grassroots, trusted advisors, or consumer groups (requires having either nonprofit status or a fiscal sponsor).</p> <p><u>Organizations and Institutions</u> – Refers to formally organized nonprofit, governmental, and/or private “entities” representing community interests and delivering services to community members.</p> <p><u>Established and Trusted Presence and History</u> – Refers to those Community Partners who are highly regarded, respected and trusted within and by community members directly. These Community Partners have an established relationship with community members that is built on trust, accountability, shared goals, and priorities.</p>

- Small Grants Program:** Under the guidance of HealthierHere’s CCV Committee, HealthierHere developed a small grants program for Community Partners to conduct education within the community about Medicaid transformation work. The program is targeted to nonprofit, community-based social and human services organizations and grassroots community groups that serve people of color and low-income, immigrant, and refugee community members in King County. In addition to raising community awareness, this project will enhance Community Partners’ awareness of HealthierHere’s work and prime them for participation in projects relevant to their populations and services.

3. **Community Partner Strategy:** HealthierHere is seeking out potential Community Practice Partners, including small organizations with limited capacity. HealthierHere's strategies include:
- a. Hosting learning sessions in fall 2018 that will educate Community Partners about what HealthierHere is doing and begin identifying areas where Community Partner participation will be critical; this work will continue in early 2019.
 - b. Asking Practice Partners to identify Community Partners with which they have existing referral relationships and partnerships through the Change Plan and CSA. *(Completed in August 2018)*
 - c. Facilitating an informal RFI process in late fall 2018 that will ask Community Partners to identify their interest in and ability to participate in Medicaid transformation at three levels:
 - i. Engagement – Community Partner is ready and able to contribute to the success of HealthierHere's project portfolio now.
 - ii. Technical Assistance – Community Partner may not be ready or have capacity to be a Practice Partner at this time, but would like to be included in technical assistance and training opportunities sponsored by HealthierHere and receive information about the MTP moving forward. These Community Partners may become Community Practice Partners in the future, and HealthierHere will explore matching them with a “mentor” Community Practice Partner.
 - iii. Information – Community Partner may provide services at the intersection of the MTP and would like to continue to receive information, but will not formally engage with HealthierHere at this time.
 - d. Inviting Community Partner to complete a Community Partner Assessment to help determine their readiness for an active partnership with HealthierHere and participation in projects. This Community Partner Assessment will include questions about the community members that the Community Partner serves, the scope of their services, relationships to traditional health care providers, and the resources required to expand or enhance services for the MTP.
 - e. Developing selection criteria for inviting Community Partners to complete a Change Plan or other instrument detailing how they will participate in HealthierHere projects and the resources needed to be successful. While HealthierHere aims to be inclusive, it has limited resources and, as with its approach to onboarding Clinical Practice Partners, it plans to take a staged approach to onboarding Community Practice Partners. HealthierHere anticipates the first cohort of Community Practice Partners will be those that are serving larger numbers of Medicaid beneficiaries, are offering services that are aligned

with HealthierHere's projects, and have some capacity to participate in transformation.

- 4. Investments in Partners with Limited Capacity:** HealthierHere is using an IPT to prioritize potential investment opportunities, including investments in Community and Clinical Practice Partners with limited capacity. The IPT applies screens to all potential investments to evaluate their alignment with HealthierHere's investment criteria, potential impact on pay-for-performance measures, and cost. Among the investment principles emphasized in the IPT is *equity*, defined as "addressing the areas of greatest need, health disparities, and under investment as determined by authentic community engagement." HealthierHere is working with its stakeholders and through the governance process to apply equity as a guiding principle and lens within the IPT to ensure the ACH intentionally examines funding opportunities for those with limited capacity and examines the unintended consequences associated with prioritizing certain investments over others.

Potential investments have been identified through the CSA, HIE/HIT Assessment, and Change Plans. For example, the CSA and HIE/HIT Assessment revealed BHAs lag behind hospitals and FQHCs with respect to population health management capabilities. Because of this, HealthierHere will likely prioritize investment in a shared care plan platform for those BHAs without an equivalent software platform and without access to alternative sources of funding. This investment will enable BHAs to enhance their care management capabilities and integrate physical and behavioral health care treatment plans, a core component of Medicaid transformation and the implementation of Project 2A.

In addition to investing in Practice Partners, HealthierHere will make training and technical assistance available to all Innovation Partners through the Learning Collaboratives and targeted training opportunities. Organizations that may not have the capacity to participate as Innovation Partners can still benefit from the Partner Learning Webinars and from HealthierHere's health systems and community capacity building (Domain 1) investments. HealthierHere's plan for training and technical assistance is detailed in our response to the prior question.

- 5. Partner Learning Webinars:** HealthierHere will continue to engage and share its learnings with all interested stakeholders through regular Partner Learning Webinars, with the goal of continuously supporting all Innovation Partners as they plan for practice transformation. The Learning Webinars are an evolution of HealthierHere's Partner Summits, which were an outreach vehicle to bring new partners into the fold, communicate important updates relevant to DY 1 partner deliverables, and gather input into proposed focus populations and evidence-based approaches as HealthierHere

began implementation planning. All Innovation and Practice Partners – regardless of size – will be invited to participate in these Partner Learning Webinars to hear from local subject matter experts as they share best practices and lessons learned related to practice- and system-level transformation. As discussed above, HealthierHere has identified a list of topics for Partner Learning Webinars beginning in October 2018 (see Figure 7). HealthierHere will invite external subject matter experts as well as provider and community champions from within the ACH to present during the Partner Learning Webinars.

6. **Partnership with King County Integrated Care Network (KCICN):** HealthierHere is actively engaged with the KCICN to advance integrated managed care (IMC) implementation in King County, including the support of smaller BHAs with limited capacity. HealthierHere surveyed BHAs with respect to investments needed for the transition to IMC and is working closely with King County to distribute integration incentives to BHAs to support infrastructure investments as well as training and technical assistance. These investments will be critical to bolstering BHA capacity to ensure their successful transition to IMC as well as successful participation in transformation projects. More information about HealthierHere’s partnership with the KCICN and the transition to IMC is on page 53 in the *Alignment with Other Programs Section* under Project 2A.
- **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)?**

HealthierHere is making every effort to minimize the administrative burden on its Practice Partners. Examples of streamlined activities related to HealthierHere’s request for Practice Partners to complete Change Plans, Practice Partner contracts, and HealthierHere’s investment strategy are described below. HealthierHere views its ability to streamline processes and minimize burden as part of its value proposition to Practice Partners and therefore will continue to seek out opportunities to serve in this role.

- **Change Plan Process:** With the goal of being respectful of partners’ resources, HealthierHere did not invite all Innovation Partners to complete Change Plans. Rather, HealthierHere identified those partners that will be critical to immediate project implementation success because they represent the majority of Medicaid beneficiaries in King County, and that satisfied readiness criteria, and invited them to complete Change Plans. Similarly, HealthierHere will identify potential community partners that are interested and ready to participate in transformation projects with clear guidance and criteria, and invite them to complete Change Plans.

HealthierHere believes this invitation process removes the uncertainty of a competitive application process. As HealthierHere scales its projects beyond the initial cohort of Clinical and Community Practice Partners (see Figure 8), it will ask additional partners meeting basic readiness requirements to complete Change Plans to continue the process of transformation across King County.

- **Partner Contracting:** HealthierHere is in the process of developing its second contract, which will detail the expectations and payment deliverables for Practice Partners in DY 3. HealthierHere is actively looking for opportunities to collaborate across ACHs to align on requirements for Practice Partners and streamline their reporting.
 - **Learning Collaborative:** HealthierHere Learning Collaboratives will bring Practice Partners together to collaborate on clinical protocols and quality improvement plans. Rather than each organization tackling these on their own, HealthierHere will facilitate a process to develop standard protocols and a quality improvement plan for the ACH which may be modeled by Practice Partners.
 - **Domain 1 Investments:** As HealthierHere identifies critical investments for health systems and community capacity building, it plans to enter into ACH-wide contracts on behalf of its Practice Partners. For example, HealthierHere will engage training vendors to carry out formal trainings on behalf of the ACH; HealthierHere will not require individual Practice Partners to contract with vendors and obtain reimbursement for trainings. Similarly, HealthierHere plans to make HIT/HIE investments that will be coordinated and made available across all Practice Partners and, potentially, all Innovation Partners as efforts are scaled.
- **How is the ACH coordinating with other ACHs in engaging partnering providers that are participating in project activities in more than one ACH?**

HealthierHere continues to coordinate with other ACHs, including its neighboring ACHs with which it shares Practice Partners. HealthierHere achieves this coordination through several mechanisms:

- **ACH Executive Director Meetings:** All ACH executive directors come together monthly for a cross-ACH meeting. These meetings are opportunities to share learnings and address common challenges, as well as to coordinate with HCA and statewide associations, such as the Washington State Hospital Association (WSHA) to align strategies and standardize activities, protocols and processes wherever possible. During these meetings, the executive directors identify opportunities for

coordination among ACHs that share providers as well as statewide opportunities for coordination.

The ACH executive directors are currently working on an approach to streamlining training and technical assistance across the ACHs. For example, if all ACHs are interested in training on change management, it could be centrally hosted and offered statewide. And if one ACH has a vendor contract in place, that may expedite other ACHs' access to that vendor through a common training. Topics that have strong interest across the ACHs, and that align with HealthierHere's needs, include:

- Quality improvement
 - Team-based care
 - Value-based payment (VBP) contracting
 - Trauma-informed care
 - PreManage for BHAs
 - Workforce development
- *ACH Leadership Coordination:* HealthierHere's management team is in regular communication with their counterparts at other ACHs. For example, HealthierHere's Chief Operating Officer (COO) initiated a program leads work group that meets bimonthly to discuss partner engagement strategies and share implementation approaches, and that seeks to better coordinate and align programmatic activities across ACHs. The program leads work group is in the process of identifying overlapping partners to develop a "common partner list"; the program leads are discussing how practice and reporting requirements can be streamlined or standardized for those organizations participating in more than one ACH. The ACHs hope this effort will minimize the burden on organizations crossing ACH borders.
 - *ACH Data Leads Coordination:* The ACH data leads meet regularly to discuss pay-for-performance and related topics. This group will endeavor to limit the administrative burden of reporting by coordinating reporting requirements across ACHs. While ACHs will not all capture reporting in the same tool, there is the potential for alignment on the measures and the frequency of their collection. This effort will also be coordinated with the program leads work group (described above).
 - *HealthierHere – ACH Direct Coordination:* HealthierHere is actively coordinating with other ACHs by request of overlapping Practice Partners. For example, HealthierHere collaborated with Pierce County on the HIE/HIT Assessment, CSA, and Change Plan, resulting in coordinated and streamlined requests to potential overlapping Practice Partners. HealthierHere is also coordinating with ACHs around potential Domain 1 strategies and investments. Specifically, HealthierHere is in discussions with Greater

Columbia ACH and Olympic Community of Health regarding EDie and PreManage implementation and uptake. HealthierHere is also working with other ACHs on mechanisms to jointly contract on behalf of common partners as well as put standard contract requirements in place where partners and projects overlap.

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?

ACH Response:

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

HealthierHere is approaching Medicaid transformation through the implementation of 11 sub-projects, listed below.

Figure 10. HealthierHere Project Portfolio Sub-Projects

Parent Project	Sub-Projects
Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	1. Behavioral Health Settings 2. Primary Care Settings
Transitional Care	3. Hospital Transitions 4. Jail Transitions 5. Psychiatric Transitions
Addressing the Opioid Use Public Health Crisis	6. Opioid Treatment 7. Opioid Prescribing 8. Prevention of Opioid-related Overdoses
Chronic Disease Prevention and Control	9. Diabetes 10. Asthma/COPD 11. Cardiovascular Disease

HealthierHere has worked with its partnering providers to develop [Clinical Summaries](#) detailing implementation expectations for Practice Partners for each sub-project. Across projects, HealthierHere expects Practice Partners to:

- Provide individually tailored, whole person, integrated care
- Ensure community-rooted, culturally responsive, and linguistically appropriate care
- Address important population health needs in the region, including prevention, management, and recovery
- Build a stronger bridge among medical, behavioral health, and community providers
- Elevate and integrate social determinants of health as critical components of an effective and efficient care delivery system
- Promote equity and reduce health disparities
- Support the transition to VBP for long-term sustainability

HealthierHere is in the process of developing its second partner agreement, which will detail the specific payment deliverables for Practice Partners in DY 3. These payment deliverables will be tied directly to HealthierHere's expectations for Practice Partner project implementation. The Incentive Funds Flow Work Group and Finance Committee are working with the Chief Financial Officer (CFO), Director of Clinical Practice Transformation, and their teams to develop these payment deliverables. HealthierHere anticipates the payment deliverables will include, but not be limited to:

- Adoption of policies, procedures, and protocols
- Development of a Practice Partner work plan
- Demonstrated progress against the work plan, including the key tenets of HealthierHere's project approach:
 - Utilize population health management tools
 - Assess whole person care needs
 - Implement team-based care
 - Develop integrated care planning
 - Provide self-management support
 - Link to community resources
- Participation in project-specific Learning Collaboratives
- Development of an organization-level quality improvement approach
- Timely reporting of project performance measures (see response to next question for more details)
- Participation in cultural competency and health equity trainings
- Implementation of strategies to move toward value-based care
- Participation in activities to advance community-clinical linkages

Practice Partners may also have unique payment deliverables based on their roles in project implementation.

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

HealthierHere will use three categories of key indicators to measure implementation progress among Practice Partners. Data related to these indicators will be used to produce regular implementation and performance progress updates, likely in the form of an interactive dashboard.

1. *Pay-for-Performance Measures* – HealthierHere is accountable for pay-for-performance measures beginning in 2019. Public Health – Seattle & King County, HealthierHere’s contractor for data management and analysis, will obtain data to regularly assess the region’s progress against project-relevant pay-for-performance measures. When not available from existing resources, HealthierHere will obtain data from Practice Partners related to local performance and process metrics. These interim checkpoints will give HealthierHere the opportunity to course correct if needed and modify approaches to change the impact on specific measures. HealthierHere plans to share these interim progress reports with Practice Partners to encourage their continued focus on interventions impacting pay-for-performance measures.
2. *“Local” Measures* – Through the development of the Clinical Summaries and in collaboration with Practice Partners, HealthierHere has identified metrics that will be meaningful to the achievement of Medicaid transformation in King County and that will enable HealthierHere to take a more comprehensive view of its projects and focus populations. These measures will be in addition to the required pay-for-performance measures and may represent metrics that are well established among Practice Partners, or metrics HealthierHere believes are critical to achieving its mission. HealthierHere will work with Practice Partners to develop and report these metrics as well as assess the availability of such metrics through other data sources (i.e., Public Health – Seattle & King County, the Homeless Information Management System, local jail data, etc.). Examples of potential “local clinical measures” are included below.

Figure 11. **Example Local Clinical Measures**

Metric	Definition
Diabetes screening for people with behavioral health conditions who are using antipsychotic medication	People aged 18 to 64 years with mental health or substance use disorders who were using an antipsychotic medication and took a glucose test or HbA1c test during the measurement year.

Metric	Definition
Blood pressure control	Percentage of patients aged 18 through 85 years who had a diagnosis of HTN and whose blood pressure was adequately controlled (<140/90) during the measurement year.
Smoking cessation	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention <ul style="list-style-type: none"> a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as tobacco users, who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user
BMI screening and follow-up	Percentage of patients aged 18 years and older with a documented BMI and follow-up plan when appropriate.

In addition to local clinical measures, HealthierHere will work with community partners and subject matter experts to develop equity and SDOH measures. These will be important to assessing the impact of Community Practice Partner activities and identifying opportunities for further investment and improvement.

3. *Pay-for-Reporting/Process Measures* – HealthierHere will ask Practice Partners to regularly report on project implementation through attestations and/or other qualitative reporting. HealthierHere will aim to minimize the reporting burden on Practice Partners while also collecting sufficient information to ascertain project implementation progress. Process measures will, in some cases, be payment deliverables for Practice Partners. For example, Practice Partners will likely be asked to attest to the adoption of the clinical workflows specific to their sub-projects as a payment deliverable in 2019.
 - **What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?**

HealthierHere will use a combination of qualitative and quantitative data to assess Practice Partners against implementation progress indicators. HealthierHere will work with Public Health – Seattle & King County and the Department of Community and Human Services to pull in data available through county systems, rather than creating duplicative reporting requirements or data systems. Any implementation progress indicators that cannot be gathered through available data sources will be collected directly from Practice Partners.

HealthierHere is in the process of assessing tools to streamline Practice Partner reporting and data collection, and it plans to implement a software system that will make reporting seamless and standardized across providers. HealthierHere is also actively initiating discussions across ACHs with respect to alignment of progress indicators.

HealthierHere plans to develop a dashboard to report information on implementation progress back to Practice Partners. HealthierHere believes the two-way sharing of information and transparency of the ACH's performance will be critical to achieving transformation, especially with respect to supporting quality improvement activities and performance management at the Practice Partner and ACH level. The Performance Measurement and Data (PMD) Committee will work closely with the Data Analytics Manager to develop this dashboard, identifying the metrics critical for Practice Partner and overall ACH success, as well as the most effective format and publishing schedule to inform implementation efforts.

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

HealthierHere will regularly assess Practice Partners' needs at the portfolio and sub-project levels to inform its investments in training, technical assistance, and other opportunities to support Practice Partners. Should HealthierHere identify that a Practice Partner is not meeting project milestones, it will:

- Set up a meeting with the Practice Partner's leadership to review project implementation progress and discuss challenges and mitigation strategies
- Work with the Practice Partner to develop an improvement plan that addresses project milestones
- Support the Practice Partner's improvement plan
- Pair the Practice Partner with a "mentor" Practice Partner to serve as a guide and peer support system throughout implementation; mentors may be compensated for their time
- Meet regularly with the Practice Partner to monitor progress and modify the improvement plan as necessary

When issues with Practice Partner performance arise, HealthierHere will also assess whether there are project- or system-level barriers impeding the Practice Partner's performance. It will review dashboard data as well as seek input from the Learning Collaboratives to inform its understanding of the issue. Should a project- or system-level barrier be identified, HealthierHere will work with the affected Practice Partners to mitigate the barrier or identify alternative strategies.

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?**

ACH Response:

The most significant need for alignment is with King County's transition to IMC, which will begin in 2019. HealthierHere's management team is closely involved in the county's transition efforts, participating in the King County IMC planning committees (leadership, clinical operations, finance, joint operations, early warning systems, and communications). HealthierHere is leading efforts to understand what BHAs will need to successfully make the transition to IMC and provide necessary technical assistance and resources. In October 2018, BHAs will receive incentive funding to support this transition through a contract with HealthierHere; HealthierHere will retain a portion of the incentive funding to support training for BHAs, and a portion will go to King County to support the transition process. This training will largely be focused on technical assistance needed to support providers in moving to a multi-payer managed care environment, working and negotiating with MCOs, and implementation of the care models HealthierHere is supporting through Project 2A.

The emerging KCICN will provide the infrastructure to ensure BHAs are able to participate in integrated care. HealthierHere is working with the ICN and its BHAs to identify training and technical assistance needs as well as to ensure all BHAs have access to PreManage and complete training on the platform. In addition, HealthierHere is meeting regularly with MCOs to understand their vision for integrated care and how they plan to support implementation of Project 2A while also supporting the larger statewide transition to IMC. Lastly, HealthierHere is working to ensure alignment on quality measures across the MTP and the transition to IMC.

During the project planning process, HealthierHere developed an inventory of initiatives that may intersect with Project 2A. Through its engagement with many of these local initiatives, HealthierHere believes its approach to project implementation will foster the expansion of existing initiatives and avoid duplication. HealthierHere's Practice Partners are also very engaged in other bi-directional integration efforts. HealthierHere is encouraging them to use

the transformation project as a means to complement existing efforts and fill gaps that other resources are not able to cover to achieve more robust integration.

Other initiatives that are well aligned with HealthierHere's implementation of Project 2A include the Mental Health Integration Program (MHIP) and Health Homes initiative. HealthierHere will expand what the MHIP has accomplished to populations and settings the program has not been able to address due to funding limits, as well as additional primary care and behavioral health settings. In addition, Practice Partners will facilitate referral of individuals to Health Homes when the screening process reveals they meet the qualifying criteria to be enrolled in a Health Home.

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?**

ACH Response:

The state and King County have invested significantly in the development of programs and services to combat the opioid crisis, with a focus on prevention, treatment expansion, overdose prevention, and recovery supports. Washington state's [Opioid Response Plan](#) details the state's strategy, and the [King County Heroin and Prescription Opiate Addiction Task Force Report](#) articulates the local King County approach to addressing the opioid crisis. Both of those reports identify specific programs and projects that are underway to help Washington state and King County reach their goals. Building on this work, and work that WSHA is sponsoring across hospital systems, HealthierHere has identified programs and projects that are being shepherded by the state and county that we will align with during the MTP. These include:

- **Mental Illness and Drug Dependency (MIDD) Multi-pronged Opioid Strategy** – Through the MIDD .1% sales tax, King County has awarded over \$550,000 in buprenorphine treatment and coordination funding to six organizations that are also HealthierHere Practice Partners. This sales tax funds low-barrier buprenorphine expansion projects in King County as well as centralized care coordination. Because HealthierHere Practice Partners in the opioid project have received funding through the MIDD strategy, HealthierHere will work to braid its incentive funding with this existing funding source to support the continued impact and sustainability of Practice Partners' projects.
- **Hub and Spoke Networks** – King County is home to two of the six hub and spoke networks in Washington state. This statewide project was created as part of the federal 21st Century Cures Act and is funded by the Substance Abuse and Mental

Health Services Administration (SAMHSA) through State Targeted Response (STR) grants administered by HCA. The hub and spoke model connects networks of community providers around a central hub that provides MAT. This allows hubs to identify, collaborate, and subcontract with spoke sites to provide integrated MAT to individuals. HMC and Valley Cities, both of which are HealthierHere Practice Partners, are King County's hubs. HealthierHere will work with HMC and Valley Cities to expand access to MAT in King County through the hub and spoke model.

- [Washington Recovery Help Line](#) – The Washington Recovery Help Line is a public resource for information on MAT with buprenorphine and other support services. The Help Line details where services are available along with what types of insurance are accepted and the hours of service. HealthierHere will promote the Recovery Help Line through its Community and Clinical Innovation Partners, with the goal of increasing the number of providers offering MAT as well as the number of individuals who contact the Help Line to find treatment and resources.
- **Mobile MAT** – Practice Partner ETS was awarded federal funding to purchase a mobile van for MAT. A second, locally funded van will provide supportive services for individuals receiving treatment. ETS will use the mobile vans to expand access to MAT and supportive services as part of HealthierHere's Opioid project.
- **Washington State Agency Medical Directors Group Interagency Guideline on Prescribing Opioids for Pain** – HealthierHere will encourage adoption of this guideline to continue the reduction in new prescriptions and promote alternatives to opioids for chronic pain.
- **Washington State Medical Association/Washington State Hospital Association/HCA Opioid-Prescribing Variance Reports** – HealthierHere will distribute opioid-prescribing variance reports to Practice Partners to enable them to see how their prescribing practices compare to those of other clinicians. Comparative reports will be used to track progress across King County as well as HealthierHere's Practice Partners and identify areas for improvement.
- **King County Secure Medicine Return Program** – King County has placed drop boxes for the secure return of medications in over 110 locations throughout the county. Locations such as pharmacies, FQHCs (HealthierHere Practice Partners), and law enforcement offices are participating in the Secure Medicine Return Program. HealthierHere will promote these drop boxes through its network of Community and Clinical Innovation and Practice Partners to help meet its opioid prescribing goals.
- **Naloxone Kit Distribution** – King County's Behavioral Health and Recovery Division (BHRD) provides funding for naloxone kits to all BHAs and their pharmacies. The first prescription for a naloxone kit is available without preauthorization for Medicaid beneficiaries. Behavioral health providers also have access to biannual naloxone training through BHRD and the Seattle/King County Coalition on Homelessness. HealthierHere will reach out to all BHA Practice Partners to ensure they are aware of this benefit and encourage them to use it.

In addition, HealthierHere aims to work in partnership with WSHA to increase support for the state Opioid Plan's recommendation regarding the use of the Prescription Monitoring Program (PMP) among Practice Partners, and promote integration of their EHRs with the PMP to enable seamless access to PMP information at the point of care. HealthierHere also aims to increase the number of prescribers with a Drug Enforcement Administration (DEA) waiver as well as increase the number of pharmacists registered with the state's PMP and partner with King County and WSHA on low-barrier induction within EDs and transition to community providers.

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?**

ACH Response:

HealthierHere's approach to Project 2C will scale related initiatives that have been tested and proven and add to their capacity to ensure the focus populations are supported in their transitions from jails, inpatient care, and hospitals. This includes but is not limited to:

- The Department of Social and Health Services and HCA's **Health Home program**, that offers comprehensive transitional care and follow-up, individual and family support, care coordination, and referrals to community and social services for high-cost, high-risk enrollees. HealthierHere and its Practice Partners are learning from the Health Home program and applying its practices to new focus populations. Health Home participants will not receive duplicative services from HealthierHere's Transitional Care initiative; Health Home participants will be screened out by Practice Partners participating in both initiatives.

- **King County's Familiar Faces Initiative**, which works with individuals who have been booked into jail four or more times in a 12-month period and have a mental health or substance use condition. Familiar Faces aims to create a system of integrated care for this population by putting the individual at the center of a care team. HealthierHere is coordinating with the Familiar Faces Initiative to support individuals enrolled in their program and transitioning to the community. Today, Practice Partners are working with the Familiar Faces Initiative and the King County jail through the REACH and Vital Team programs.
- HealthierHere is working closely with King County and the KCICN to support the transition to IMC and ensure BHAs have the resources needed to participate in IMC. *(Please see previous response for Project 2A)*
- HealthierHere is partnering with the **Area Agency on Aging** as they contributed to the Transitions of Care clinical summary, participated in Implementation Work Groups and subject matter expert interviews and reviews. Their pilot program with Practice Partner Valley Medical Center is especially promising. This pilot program uses a discharge navigator to assist high risk patients with navigating medical, behavioral health, and social services with a goal of reducing avoidable ED visits and future hospitalizations.
- The **King County Peer Bridger Program** works collaboratively with patients on discharge planning and connecting them with community-based services and supports. This program provides services to individuals to support their recovery as they transition from inpatient psychiatric settings back into the community and to reduce future readmissions in collaboration with partners across the continuum of care. All services are provided under the direction of a mental health professional (MHP), and care teams include recovery navigators and peer recovery coaches. Current Peer Bridger sites include Western State Hospital and Practice Partners Navos and HMC. HealthierHere is building on the learnings of this program and, in some cases, will be expanding the capacity of Peer Bridgers or similar staff at Practice Partner hospitals.
- The **Transition Support Program (TSP)** is Practice Partner Sound Health Solution's (previously Sound Mental Health) program and focuses on patients who are on involuntary mental health holds in local EDs and are not engaged in mental health or substance abuse treatment. The TSP supports patients during and after discharge by providing direct one-to-one support and using robust care teams to help people successfully transition back into their community, connect to long-term care, and reduce/prevent more acute illnesses that result in costly hospital readmissions. TSP focuses on single bed certifications and can be used to divert patients from costlier psychiatric hospital stays by connecting patients to community behavioral health and social supports before they leave the ED. Care teams include mental health

professionals/licensed social workers, peer support specialists (peers), and registered nurses (RNs). Patients also receive access to a prescriber.

- **Medicaid MCOs** are legally obligated to coordinate care for their members upon release from a correctional facility and are therefore natural HealthierHere partners. Their responsibilities include taking an evidence-based approach to care coordination as members transfer to the community and providing assistance with access to medical services and medications as well as assistance with other supports such as transportation, housing, and employment. Currently, a United HealthCare pilot is underway at SCORE Jail. HealthierHere will be collaborating to understand lessons learned from this pilot and continue to work with local MCOs to ensure successful transitions from jail settings.

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?**

ACH Response:

During the project planning phase, HealthierHere scanned the community to identify programs and services addressing chronic disease. The most prevalent program is the King County Asthma Program. HealthierHere is actively learning and building on the King County Asthma Program and its use of CHWs for chronic disease treatment and prevention.

HealthierHere will deploy CHWs to reach the project’s focus population and offer enhanced services. The focus population will also be screened for behavioral health and social needs, consistent with HealthierHere’s focus on whole person care.

HealthierHere is also building on the lessons learned from the Many Minds Collaborative, which created two pilots with HealthierHere Practice Partners to manage chronic conditions for people with serious mental illness (SMI). The HMC pilot has focused on diabetes management and the CPC pilot has focused on managing blood pressure. The pilots will end in October 2018, and the collaborative is developing a toolkit with lessons learned. HealthierHere’s Learning Collaborative will review the toolkit and consider how to incorporate the lessons learned into the project’s workflow and implementation.

Several programs use CHWs in King County, including the CHW Program of Public Health – Seattle & King County. HealthierHere will draw on the experience of this program and others to inform project implementation.

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?

ACH Response:

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

Practice Partners are actively working to advance along the VBP continuum, increasingly linking payment to quality and value, and testing alternative payment models. Below are four examples of actionable steps Practice Partners are taking and HealthierHere is supporting:

1. Practice Partners participated in HCA’s annual VBP survey. Practice Partners recognize the importance of state support for the transition to VBP and the state’s potential role in removing barriers that otherwise impede providers from progressing along the VBP continuum. HealthierHere sent multiple communications using multiple channels (e.g., online, newsletters, emails, and public announcements) to provider organizations

encouraging them to complete the survey. HealthierHere is considering making completion of the survey a payment deliverable for Practice Partners in DY 3.

2. Practice Partners will participate in an ACH-wide Learning Collaborative on VBP. The Learning Collaborative will spread best practices and lessons learned from Innovation and Practice Partners that have made progress in the transition to VBP. It will also be an opportunity for ACH-wide trainings on VBP. *(Please see the response to the next question on provider champions for additional detail.)*
3. Practice Partners are building the technical infrastructure and quality improvement processes needed to support their participation in VBP. Today, some Practice Partners lack internal data warehouses and reporting capabilities to effectively measure and track their performance over time. Recognizing that these capabilities are fundamental to successful participation in VBP, Practice Partners are making critical investments in their EHRs and data systems to ensure they are prepared to enter into value-based contracts where they will assume accountability for clinical and quality outcomes as well as the cost of their patient population. Practice Partners whose infrastructure is less mature are in the process of defining requirements and procuring systems that will support their transition. HealthierHere is connecting these Practice Partners with others in the ACH that have made progress toward VBP, to ensure Practice Partners who are at the beginning of their transitions can learn from the experiences of their peers.

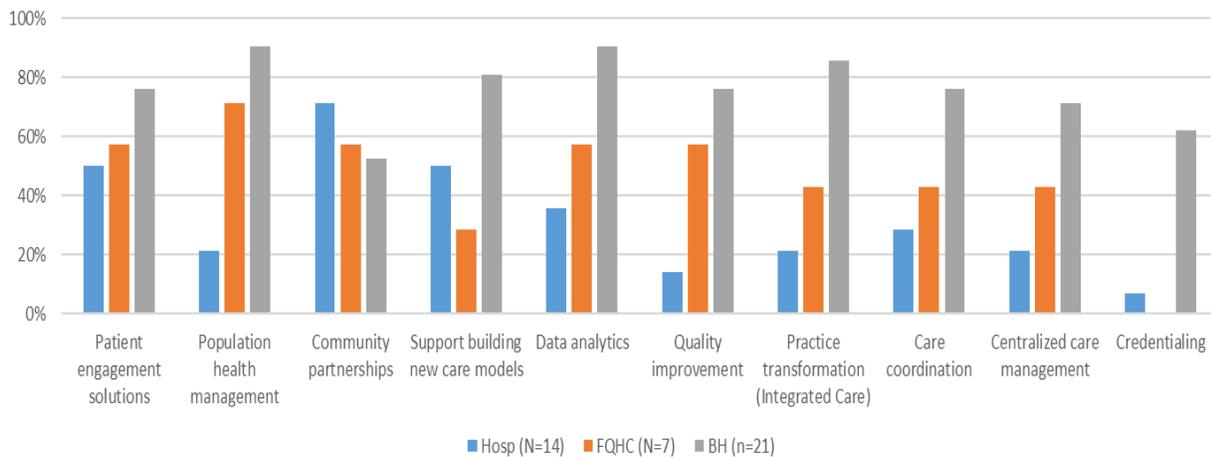
Practice Partners that have experience with value-based contracts are also enhancing their capabilities by integrating into their systems external data sources such as claims and eligibility data, allowing them to better track performance and identify areas for improvement.

4. Practice Partners are building on their experience with contracts in the Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model (APM) Framework Category 2 (Fee-for-Service – Link to Quality and Value) to advance to Categories 3 and 4. For example, Practice Partners with experience in shared savings/upside-only arrangements are moving to shared risk arrangements with both upside and downside risk. And Practice Partners that have piloted payment models with a subset of providers or for a subset of their population are scaling to encompass greater numbers of providers and patients.
- **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?**

HealthierHere is working with its Governing Board, Finance Committee, and Incentive Funds Flow Work Group to identify VBP “champions” in King County. Champions are providers and organizations that are proactively moving along the VBP continuum toward alternative payment models and population-based payments. HealthierHere will convene a VBP champion-led Learning Collaborative to support Practice Partners in their pursuit of value-based care goals.

HealthierHere asked CSA respondents to identify VBP topics on which they require training. The responses are summarized in Figure 12 below and show the most significant need for training exists among behavioral health agencies (BHAs). HealthierHere will use this information to design a curriculum that will bring critical information to Innovation and Practice Partners and enable their transition to VBP.

Figure 12. CSA Respondents’ VBP Training Needs



HealthierHere will seek VBP subject matter experts outside of the ACH to share their experiences and learnings through the Learning Collaborative. For example, HealthierHere is in close contact with several New York Performing Provider Systems (PPSs) and plans to identify topics where they bring unique experience, such as working with MCOs and community partners.

HealthierHere also plans to engage its champions in ongoing dialogue with the state around the transition to VBP and the VBP roadmap. For example, HealthierHere’s participants on the MVP Action Team are two champions who will serve as liaisons between Innovation and Practice Partners, the state, and MCOs, and advocate for the needs of HealthierHere Innovation and Practice Partners at the state level. The MVP Action Team participants, who also sit on HealthierHere’s Finance Committee, will help identify tools and best practices that can be disseminated through the Learning Collaborative. They will seek feedback on important topics

from HealthierHere Innovation and Practice Partners and represent their views in larger discussions with the MVP Action Team.

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?

ACH Response:

- **What actionable steps is the ACH taking to facilitate information exchange between providers at points of care? Provide three examples.**

Among its three components for long-term success, HealthierHere prioritizes investments in HIT and HIE. Specifically, HealthierHere aims to achieve:

Collaboration between the health care system and social services, evidenced by an interconnected HIE/HIT system connecting providers from both systems and including payment models that incorporate social service providers.

As a first step toward advancing interconnection and secure, effective, and efficient data exchange, HealthierHere conducted an HIE/HIT Assessment to understand Innovation Partners' current and planned capabilities relative to EHRs, HIE, telehealth, mobile applications, population health management, registries, and other technologies. Among its findings, which are detailed in HealthierHere's first Semi-Annual Report (SAR), the Assessment found three critical gaps:

- BHAs generally do not have access to clinical data from services delivered in the primary care setting.
- Most BHAs are not notified when their clients present in the ED and do not have access to information about the services sought and provided.
- Referral and coordination systems to support clinical-community linkages are fragmented.

HealthierHere also asked potential Practice Partners about their capabilities and needs through their Change Plans. The information gathered through the Change Plans both confirmed the critical gaps above and illuminated the opportunity to identify, assess, and deploy potential solutions. HealthierHere is using an IPT to define, evaluate, and prioritize potential investments,

with the goal of identifying those investments that will have the most cost-effective impact on the management, coordination, and delivery of care as well as HealthierHere's ability to meet pay-for-performance metrics.

Below are three investments that HealthierHere is currently evaluating to address the critical gaps described above.

1. **Community Need:** BHAs' lack of access to clinical data from services delivered in the primary care setting.

Potential Investments to Address the Gap: Today, BHAs do not have access to patient information collected and stored in the primary care or hospital setting. For example, BHAs frequently lack access to a patient's medication history, lab results, or recent inpatient or outpatient medical procedures. This information, however, is critical to understanding the whole person and to delivering integrated, whole person care. To address this gap, HealthierHere is evaluating the expansion of existing tools such as Collective Medical Technologies' (CMT) PreManage and the OneHealthPort (OHP) Clinical Data Repository (CDR) to provide information to BHAs at the point of care. HealthierHere has spoken with both vendors regarding the opportunity and costs to expand the use of their tools in the behavioral health setting and to ensure their use is optimized through ongoing training and support, as well as product enhancements.

2. **Community Need:** Most BHAs are not notified when their clients present in the ED and do not have access to information about the services sought and provided.

Potential Investments to Address the Gap: CMT's HIE tool EDie collects admission, discharge, and transfer (ADT) data from the EDs a patient has visited and delivers that information in the form of actionable insights to ED clinicians and the patients' designated care team. This information is not currently available to most BHAs or providers outside of the ED setting, but the information can be particularly powerful for BHAs that are treating patients with complex medical issues; for these patients, ED utilization is an indicator of the patients' well-being and can prompt important changes to patient care. Today, all hospital EDs in King County are using EDie, and HealthierHere has discussed strategies to leverage this system to support BHAs' access to customized alerts and notifications. As with all potential technology solution investments, HealthierHere continues to work with its Practice Partners to ensure they understand the technology and are supported and able to optimize its use.

3. **Community Need:** Referral and coordination systems to support clinical-community linkages are fragmented.

Potential Investments to Address the Gap: HealthierHere understands the importance of supporting community-clinical linkages and is actively participating in local and statewide conversations about community-clinical linkages to assess Innovation and Practice Partners’ needs and identify available solutions. HealthierHere believes the foundation of community-clinical linkages is a comprehensive directory of community services from which Innovation and Practice Partners can identify community resources, ascertain the availability of resources, and make referrals. Accordingly, HealthierHere will prioritize the availability of a robust and up-to-date community resource directory for King County. To that end, HealthierHere is participating in the Shared Community Inventory (SCI) Redesign Team’s efforts to develop a statewide SCI of resources for community members and professionals. As part of efforts to identify community resources in an accurate and timely fashion, HealthierHere is also assessing the value and viability of tools that offer electronic, closed-loop referrals between community and clinical providers. As it is currently conceptualized, a community-clinical linkage solution (CCLS) will enable a network of multidisciplinary providers (including traditional health care and community providers) to participate on an integrated care team.

- **How is the ACH leveraging Transformation incentives, resources, and activities to support statewide information exchange systems?**

After concluding its in-depth needs assessment, HealthierHere is finalizing its HIE/HIT strategy and is actively evaluating the potential for statewide information exchange systems to support the ACH and its Practice Partners, including but not limited to OHP and the SCI. Among HealthierHere’s HIE/HIT guiding principles are “Leverage existing data infrastructure and roles where possible” and “Align with other ACH HIE/HIT investments.” These principles are part of the IPT that HealthierHere is using to evaluate and prioritize potential HIE/HIT investments. The IPT also considers whether a potential technical solution is being funded elsewhere, such as by the state. As HealthierHere considers how it will leverage Transformation incentives and resources to address the current gaps hindering the delivery of integrated whole person care, it will evaluate OHP, SCI, and other statewide systems for potential partnerships and services.

HealthierHere has met with Rick Rubin, CEO of OHP, and is continuing to dialogue with OHP about how it can support HealthierHere’s goals. Specifically, HealthierHere believes there are opportunities for OHP to support BHA access to clinical information through OHP’s CDR as well as access to drug history information through the PMP. HealthierHere staff recently participated in an OHP demonstration to the KCICN; four King County BHAs are participating in a pilot with OHP, and HealthierHere will learn from their experiences to inform how the ACH partners with OHP. Practice Partners could also benefit from access to Health Action Plan (HAP) data through OHP; however, HAP data cannot be shared under current OHP and state policy.

HealthierHere reviewed and appreciated the *Medicaid Transformation Program Guidance to ACHs on IT and Health IT Investments* from Laura Kate Zaichkin on August 24, 2018. The state's commitment to investing in and enhancing the CDR confirms HealthierHere's approach to working with OHP to advance information sharing in King County. HealthierHere will comply with the state's direction to only consider investments that enhance and embrace statewide services and national standards as well as work with other ACHs to consider where cost savings or efficiencies may be gained.

As mentioned above in example 3, HealthierHere is participating on the SCI Redesign Team. The goal is to develop a statewide SCI of resources for community members and professionals who seek services and supports. HealthierHere believes this is an important effort with the potential to deliver significant value to patients and providers alike, and will continue to participate on the Redesign Team to ensure the ACH perspective is represented, and will consider how the SCI can support HealthierHere's goal of supporting community-clinical linkages.

Technical Assistance Resources and Support

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

ACH Response

Response should cover the following:

- What technical assistance or resources have the ACH identified to be helpful? How has the ACH secured technical assistance or resources?
- What technical assistance or resources does the ACH require from HCA and other state agencies?
- What project(s)/area(s) of implementation would the ACH be interested in lessons learned or implementation experience from other ACHs?

ACH Response:

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

HealthierHere has secured technical assistance in the form of consulting services, legal services, training contracts, and ongoing contracts with Public Health – Seattle and King County and The Seattle Foundation. These resources have been valuable as HealthierHere simultaneously builds its organizational infrastructure and capacity and fulfills requirements of the MTP and its contract with HCA. A brief summary of these resources appears below.

- *Consulting Services:* HealthierHere has contracted with two firms and multiple individuals to provide targeted consulting assistance with:
 - Development of the HIE/HIT Assessment and subsequent analysis and recommendations
 - Project management
 - Governance
 - Governing Board planning and facilitation
 - Development of HealthierHere deliverables to HCA
 - Development of an Investment Prioritization Tool
 - Medical Officer support
- *Legal Services:* HealthierHere does not have in-house counsel. As such, HealthierHere works with a local law firm to advise HealthierHere on legal matters including bylaws, conflict-of-interest policies, and partner contracts.
- *Training Contracts:* HealthierHere is in the process of securing contracts with training partners to administer timely programs to HealthierHere Practice Partners. These trainings will be essential to ensuring Practice Partners are prepared for project implementation.

- *Public Health – Seattle and King County*: HealthierHere continues its relationship with Public Health – Seattle and King County to provide the ACH with support for data and analytics. HealthierHere recently hired a Data Analytics Manager to lead the organization’s data analytics strategy and work; she is working closely with Public Health – Seattle and King County and will increasingly oversee this work for the organization.
- *The Seattle Foundation* – The Seattle Foundation continues to serve as HealthierHere’s fiscal sponsor, disbursing funding as well as providing back office services for HealthierHere.

In addition, HealthierHere has sought technical assistance and advice from several New York PPSs that have led Medicaid transformation initiatives since 2015. These PPSs include Bronx Partners for Healthy Communities, The Center for Regional Healthcare Innovation, the Finger Lakes PPS, and Community Care of Brooklyn. HealthierHere is in an ongoing dialogue with these PPSs about Community Partner engagement, Practice Partner engagement and management, quality measures and reporting, program management, sustainability, supporting the transition to VBP, and other topics. HealthierHere is planning daylong site visits with three of the PPSs in early November.

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

HealthierHere appreciates the ongoing dialogue with HCA about the assistance or resources HCA and other state agencies may provide. HealthierHere identified the following opportunities and would be happy to discuss these with HCA and/or the appropriate state agency at any time.

1. HealthierHere would benefit from additional information and guidance from HCA regarding statewide investments in HIE/HIT that the ACHs may leverage to support Medicaid transformation. For example, HCA could help by streamlining the process for BHA participation in OHP’s CDR. Examples of potential support and assistance may include: (1) providing guidance on behavioral health data sharing within OHP, in particular the segregation of SUD data and consent management and (2) increasing the functionality of OHP exports for population health management purposes, including the ability to extract data by provider/entity (as opposed to just by patient).
2. Additional information from HCA about potential efforts to integrate Community Partner and/or SDOH data into current HIE systems will help inform HealthierHere’s investment decisions and HIE/HIT strategy. HealthierHere is concerned that HIPAA restrictions and lack of a streamlined and/or consistent consent process may limit the utility of some statewide systems.

3. Continued guidance and resources from the state will be helpful in furthering HealthierHere's ability to support providers as they enroll in and effectively use existing registry resources, such as the PMP. Common barriers identified by providers include difficulties with the licensing and registration process, lack of (or difficulty with) integration with EHRs, and lack of guidance/training on how to integrate registry usage into existing clinical work streams.
 4. HealthierHere would appreciate additional assistance in transitioning BHAs to VBP. HealthierHere would be willing to participate in a statewide working group with other ACHs, MCOs, and BHAs, as well as HCA, to develop payment models aligned with the integrated care models BHAs are being asked to support.
 5. HealthierHere, and the ACH community as a whole, would benefit from increased collaboration and sharing of relevant code and technical resources used to produce estimates of pay-for-performance metrics and other clinical quality and outcome measures. The sharing of code and technical resources would ensure consistency and transparency in the analyses and local performance monitoring of these key transformation and implementation metrics.
 6. HealthierHere appreciates the HCA's efforts to facilitate ongoing learning among ACHs and would ask the HCA to continue to do this and share information across electronic, phone, and in-person forums.
 7. HealthierHere is participating in the Health System Capacity Building Partnership (HSCBP); the Partnership is composed of ACHs, the Association of Washington Public Hospital Districts (AWPHD), the University of Washington, the Department of Health, and HCA. HealthierHere believes this effort should be continued statewide and with participation across the ACHs. The recent work plan reviewed by the HSCBP identified important opportunities for statewide coordination and alignment around intergovernmental transfer (IGT) investments in workforce, team-based care, training, scope of practice and licensing, telehealth, and overall system-wide capacity building.
 8. HCA should continue to develop guidance and templates regarding 42CFR. These will help break down barriers to HealthierHere Practice Partner participation in information exchange in support of team-based care, shared care planning, and clinical-community linkages.
- **What project(s)/area(s) of implementation would the ACH be interested in lessons learned or implementation experience from other ACHs?**

HealthierHere is helping facilitate cross-ACH conversation and collaboration on a variety of topics related to project implementation. Recent conversations have included:

- Approaches to partner Change Plan development
- Collaborating on partner training
- Developing common intermediary measures
- Win211/SCI
- Sharing of technology tools and applications

HealthierHere would be interested in other ACHs' lessons learned or implementation experience regarding:

- Development of payment models to support BHAs and Community Partners
- Funding models for coordination/navigation staff
- Continuous monitoring and quality improvement
- Supporting VBP adoption among Practice Partners
- Embedding equity principles into funding and programmatic decisions
- Strategic Community Partner engagement in Medicaid transformation and the SDOH
- Facilitating stronger community-clinical linkages

List of Acronyms

ACH	Accountable Community of Health
ADT	Admission, discharge, and transfer
APM	Alternative payment model
ASPIRe	Actualizing Social and Personal Identity Resources
AWPHD	Association of Washington Public Hospital Districts
BHAs	Behavioral health agencies
BHRD	Behavioral Health and Recovery Division
BMI	Body mass index
CBOs	Community-based organizations
CCLS	Community-clinical linkage solution
CCV	Community and Consumer Voice Committee
CDR	Clinical data repository
CFO	Chief Financial Officer
CHW	Community health worker
CIO	Chief Information Officer
CLAS	Culturally and linguistically appropriate services
CMT	Collective Medical Technologies
COO	Chief Operating Officer
COPD	Chronic obstructive pulmonary disorder
CSA	Current State Assessment
CSS	Community support specialists
DESC	Downtown Emergency Service Center
DY	DSRIP Year
ED	Emergency department
EHR	Electronic health record
ETS	Evergreen Treatment Services
FD	Fire department
FE	Financial Executor
FQHCS	Federally Qualified Health Centers
HAP	Health Action Plan
HCA	Health Care Authority
HCP-LAN	Health Care Payment Learning and Action Network
HIE/HIT	Health information exchange and technology
HMC	Harborview Medical Center
HSCBP	Health System Capacity Building Partnership
ICHS	International Community Health Services
IGT	Intergovernmental transfer
IMC	Integrated managed care
IPT	Investment Prioritization Tool

KCICN	King County Integrated Care Network
MAT	Medication assisted treatment
MCOs	Managed care organizations
MHP	Mental health professional
MTP	Medicaid Transformation Project
OHP	OneHealthPort
ODD	Opioid use disorder
PMD	Performance, measurement and data
PMP	Prescription Monitoring Program
POLST	Physician orders for life-sustaining treatment
PPS	Performing Provider System
RFI	Request for information
RN	Registered nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SAR	Semi-Annual Report
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCI	Shared Community Inventory
SDOH	Social determinants of health
SIHB	Seattle Indian Health Board
SMI	Serious mental illness
STR	State targeted response
SUD	Substance use disorder
TSP	Transition support program
UW AIMS	University of Washington Advancing Integrated Mental Health Solutions
VBP	Value-based payment
WIN	Wellness Integration at Navos
WSHA	Washington State Hospital Association