



Healthier Washington Medicaid Transformation
Accountable Communities of Health
Semi-Annual Report Template
Reporting Period: January 1, 2018 – June 30, 2018

July 2018

Table of Contents

Table of Contents	2
Semi-Annual Report Information and Submission Instructions	3
ACH Contact Information.....	7
Section 1: Required Milestones for Demonstration Year (DY) 2, Quarter 2	8
A. Milestone 1: Assessment of Current State Capacity	8
B. Milestone 2: Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment).....	27
C. Milestone 3: Define Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations.....	33
D. Milestone 4: Identification of Partnering Providers.....	84
Section 2: Standard Reporting Requirements.....	85
ACH-Level Reporting Requirements	85
A. ACH Organizational Updates	85
B. Tribal Engagement and Collaboration	86
Tribal Engagement and Collaboration Activities for the Reporting Period	87
Project Reporting Requirements	88
C. Project Status Update	88
Portfolio-Level Reporting Requirements.....	92
D. Partnering Provider Engagement	92
E. Community Engagement	96
F. Health Equity Activities.....	102
G. Budget and Funds Flow	105

APPENDICES:

Appendix A. Current State Assessment Survey Tool: Hospitals and Health Systems

Appendix B. Current State Assessment Findings Slide Deck

Appendix C. HIE/HIT Assessment Findings Slide Deck

Appendix D. Clinical Summaries

Appendix E. Medicaid Provider Project-Specific Agreement

Appendix F. Audited Financial Statements

ATTACHMENTS: Semi-Annual Report Workbook

Semi-Annual Report Information and Submission Instructions

Purpose and Objectives of ACH Semi-Annual Reporting

As required by the Healthier Washington Medicaid Transformation’s Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit Semi-Annual Reports for project achievement. ACHs will complete a standardized Semi-Annual Report template developed by HCA. The template will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each Demonstration Year (DY):

- **July 31** for the reporting period January 1 through June 30
- **January 31** for the reporting period July 1 through December 31

Semi-annual reporting is one element of ACH Pay-for-Reporting (P4R) requirements. The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones and metrics based on approved Project Plans. As needed, ACHs may be requested to provide back-up documentation in support of progress. HCA and the Independent Assessor will review Semi-Annual Report submissions.

Reporting Requirements

The Semi-Annual Report template for the reporting period January 1, 2018 to June 30, 2018 includes two sections as outlined in the table below. Section 1 instructs ACHs to report on and attest to the completion of required milestones scheduled to occur by DY 2, Quarter 2 per the Medicaid Transformation Toolkit. Section 2 requests information to satisfy ongoing reporting requirements to inform the Independent Assessor and HCA of organizational updates and project implementation progress.

Each section in the semi-annual report contains questions regarding the regional transformation work completed during the reporting period. ACHs are required to provide responses that reflect the regional transformation work completed by either:

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

Please read each prompt carefully for instructions as to how the ACH should respond.

ACH Semi-Annual Report 1 – Reporting Period: January 1 through June 30, 2018	
Section	Sub-Section Description
	Milestone 1: Assessment of Current State Capacity

ACH Semi-Annual Report 1 – Reporting Period: January 1 through June 30, 2018	
Section	Sub-Section Description
Section 1. Required Toolkit Milestones (DY 2, Q2)	Milestone 2: Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment)
	Milestone 3: Define Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations
	Milestone 4: Identification of Partnering Providers
Section 2. Standard Reporting Requirements	ACH Organizational Updates
	Tribal Engagement and Collaboration
	Project Status Update
	Partnering Provider Engagement
	Community Engagement
	Health Equity Activities
	Budget and Funds Flow

Key Terms

The terms below are used in the Semi-Annual Report and should be referenced by the ACH when developing responses.

1. **Community Engagement:** Outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.
2. **Health Equity:** Reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.¹
3. **Key Staff Position:** Position within the overall organizational structure established by the ACH to reflect capability to make decisions and be accountable for the following five areas: Financial, Clinical, Community, Data, Program Management and Strategy Development
4. **Partnering Provider:** Traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.
5. **Project Areas:** The eight Medicaid Transformation projects that ACHs can implement.
6. **Project Portfolio:** The full set of project areas an ACH is implementing.

¹ Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017. Accessible at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393.

Semi-Annual Report Submission Instructions

ACHs must submit their completed Semi-Annual Reports to the Independent Assessor **no later than July 31, 2018 at 3:00p.m. PST.**

File Format

ACHs must respond to all items in the Microsoft Word Semi-Annual Report template and the attached Microsoft Excel workbook in narrative or table format, based on the individual question instruction. ACHs are strongly encouraged to be concise in their responses.

ACHs must include all required attachments, and label and make reference to the attachments in their responses where applicable. Additional attachments may only substantiate, not substitute for, a response to a specific question. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

Files should be submitted in Microsoft Word and Microsoft Excel or a searchable PDF format. Below are examples of the file naming conventions that ACHs should use:

- *Main Report or Full PDF:* ACH Name.SAR1 Report. 7.31.18
- *Excel Workbook:* ACH Name. SAR1 Workbook. 7.31.18
- *Attachments:* ACH Name.SAR1 Attachment X. 7.31.18

Note that all submitted materials will be posted publicly; therefore, ACHs must submit versions that can be public facing.

Washington Collaboration, Performance, and Analytics System (WA CPAS)

ACHs must submit their Semi-Annual Reports through the WA CPAS which can be accessed at <https://cpaswa.mslc.com/>. **ACHs must upload the Semi-Annual Report, workbook, and any attachments to the sub-folder titled “Semi-Annual Report 1 – July 31, 2018.”** The folder path in the ACH’s directory is:

Semi-Annual Reports → Semi-Annual Report 1 – July 31, 2018.

Please see the WA CPAS User Guide provided in fall 2017, and available on the CPAS website, for further detail on document submission.

Semi-Annual Report Submission and Assessment Timeline

Below is a high-level timeline for assessment of the Semi-Annual Reports for reporting period January 1, 2018 – June 30, 2018.

ACH Semi-Annual Report 1 – Submission and Assessment Timeline			
No.	Activity	Responsible Party	Timeframe
1.	Distribution of Semi-Annual Report Template and Workbook to ACHs	HCA	March 30, 2018
2.	Overview of Semi-Annual Report Template	HCA/IA	Apr 9, 2018
3.	Publish pre-recorded webinar with additional information about the Semi-Annual Report assessment	IA	Apr 2018
4.	Submit Semi-Annual Reports	ACHs	July 31, 2018
5.	Conduct assessment of reports	IA	Aug 1-25, 2018
6.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Aug 25-30, 2018
7.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Aug 26-Sept 14, 2018
8.	If needed, review additional information within 15 calendar days of receipt	IA	Sept 10-29, 2018
9.	Issue findings to HCA for approval	IA	TBD

Contact Information

Questions about the Semi-Annual Report template, submission, and assessment process should be directed to WADSRIP@mslc.com.

ACH Contact Information

Provide contact information for the primary ACH representative. The primary contact will be used for all correspondence relating to the ACH's Semi-Annual Report. If secondary contacts should be included in communications, please also include their information.

ACH Name:	HealthierHere
Primary Contact Name	Gena Morgan, Chief Operating Officer
Phone Number	(206) 849-6262
E-mail Address	gmorgan@healthierhere.org
Secondary Contact Name	Susan McLaughlin, Executive Director
Phone Number	(206) 790 – 3709
E-mail Address	smclaughlin@healthierhere.org

Section 1: Required Milestones for Demonstration Year (DY) 2, Quarter 2

This section outlines questions specific to the milestones required in the Medicaid Transformation Project Toolkit by DY 2, Q2. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone 1: Assessment of Current State Capacity

1. **Attestation:** The ACH worked with partnering providers to complete a current state assessment that contributes to implementation design decisions in support of each project area in the ACH’s project portfolio and Domain 1 focus areas. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item A.1, provide the ACH’s rationale for not completing a current state assessment, and the ACH’s next steps and estimated completion date. If the ACH checked “Yes” in item A.1, respond “Not Applicable.”

ACH Response: Not Applicable

3. Describe assessment activities and processes that have occurred, including discussion(s) with partnering providers and other parties from which the ACH requested input. Highlight key findings, as well as critical gaps and mitigation strategies, by topic area for the project portfolio and/or by project.

ACH Response:

During the first half of DY2, HealthierHere reviewed and conducted assessments to enhance its understanding of the current state of needs and capacity in the region as well as partner readiness for transformation. Notably, HealthierHere reviewed assessments recently conducted by Public Health – Seattle and King County and the Health Care Authority (HCA). Figure 1 below depicts the assessments that are informing HealthierHere’s planning and implementation approach to health system transformation.

Figure 1. **King County Assessments**

Assessment Name	Assessment Lead	Completed	Description
<u>Hospital/ Health System Current State Assessment</u>	HealthierHere	May 2018	Survey results enhanced HealthierHere's understanding of hospitals'/health systems' current state of readiness for system transformation
<u>BHA Current State Assessment</u>	HealthierHere	May 2018	Survey results enhanced HealthierHere's understanding of King County behavioral health agencies (BHAs) current state of readiness for system transformation
<u>FQHC Current State Assessment</u>	HealthierHere	May 2018	Survey results enhanced HealthierHere's understanding of Federally Qualified Health Centers' (FQHCs) current state of readiness for system transformation
<u>HIE/HIT Assessment</u>	HealthierHere	March-April 2017	Survey results enhanced HealthierHere's understanding of partnering providers' Health Information Exchange/Health Information Technology (HIE/HIT) capabilities and gaps
<u>Survey of Medicaid Clients</u>	HealthierHere (see pp. 11-15 of link)	2017	Survey results enhanced HealthierHere's understanding of Medicaid clients' needs and informed project selection and development
<u>Regional Health Needs Inventory</u>	King County for HealthierHere	2017	The inventory of locally available health data resources helped HealthierHere develop transformation projects
<u>Familiar Faces Current State and Future State Map</u>	King County	2013-current	The Familiar Faces vision for the future puts the individual at the center of a care team; this vision is informing HealthierHere's approach to team-based care
<u>King County Community Health Needs Assessment</u>	King County	2017	The Health Needs Assessment informed HealthierHere's understanding of community demographics, life

Assessment Name	Assessment Lead	Completed	Description
			expectancy, leading causes of death, and chronic illness in the region
<u>HCA's Value-based Roadmap and Value-based Purchasing Survey Results</u>	HCA	2017	The survey results provide a progress report on state Paying for Value Goals and will inform HealthierHere's VBP roadmap

The cornerstone assessments that are informing HealthierHere's understanding of partners and implementation decisions are: (1) the Current State Assessment (CSA), and (2) the HIE/HIT Assessment. These assessments are detailed below. HealthierHere has shared the results of these assessments with its stakeholders to help them better understand the information collected and inform HealthierHere's approach to health system transformation.

Current State Assessment. HealthierHere developed and administered the CSA to enhance its understanding of the current state of readiness for system transformation at the partner and regional levels. Fifty hospitals/health systems, FQHCs, and BHAs in King County were invited to complete the CSA, and approximately 90% responded. (See *Appendix A. Current State Assessment Survey Tool: Hospitals and Health Systems* for an example of the CSA survey tool)

The CSA gathered information about partner organizations (e.g., size, locations, services offered) and their experience and capabilities relative to:

- Workforce
- VBP
- The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)
- Quality Improvement
- Care Coordination

The CSA also gathered information about partners' interest in participating, and intent to participate, in HealthierHere's four projects and their foundational capabilities critical to project participation.

HealthierHere reviewed and analyzed the information collected through the CSA and shared its findings with stakeholders. The findings are being used to inform HealthierHere's investment plan, project implementation plans, provider contracting,

and overall approach to system-wide health transformation. HealthierHere is engaging partners in one-on-one conversations to confirm and deepen its understanding of findings, and discuss implications for partner participation in the Medicaid Transformation Project (MTP). A summary of key findings at the portfolio (across projects) and project levels appears below in Figure 2; critical gaps and emerging strategies to address those gaps are described in Figure 4. (See *Appendix B. Current State Assessment Findings Slide Deck* for a more detailed summary of the CSA findings)

Figure 2. **Summary of CSA Key Findings**

CSA Key Findings	
Portfolio-level Key Findings	
Workforce	<ul style="list-style-type: none"> • Partners are experiencing staff shortages among: <ul style="list-style-type: none"> ○ Community health workers (CHWs) and peers ○ Medical staff, including primary care providers (PCPs), nurses, and medical assistants ○ Care coordinators/managers/navigators ○ Behavioral health professionals, especially those specializing in substance use disorders (SUDs) • Partners lack access to external training, including training on team-based care, CHW roles, and various evidence-based approaches specific to HealthierHere’s projects
VBP	<ul style="list-style-type: none"> • Hospital/health system and FQHC partners report including VBP provisions in contracts • Partners have yet to incorporate links to social determinants of health into their approaches to VBP • BHAs lag behind hospitals/health systems and FQHCs in their readiness for VBP • While all partners would benefit from some level of VBP training, BHAs have the greatest need for training
National CLAS Standards	<ul style="list-style-type: none"> • Most partners use the National CLAS Standards • Partners do not consistently interpret important patient-facing materials (e.g., consent, medication instructions, education materials)

CSA Key Findings

Quality Improvement and Performance Measurement

- Most partners have quality improvement (QI) processes in place
- Over 80% of hospital/health system and FQHC respondents are using their quality improvement processes to provide feedback to providers, whereas fewer than 20% of BHAs are providing feedback to providers
- Quality improvement and performance measurement strategies are not used continuously by approximately half the BHA respondents; more than two-thirds of FQHCs and over 80% of hospital/health system respondents use strategies continuously

Care Coordination

- Partners' electronic health records (EHRs) do not sufficiently support care coordination (i.e., HIE, shared care plans)
 - EHR use is less mature among BHAs than among health systems/hospitals and FQHCs
- Partners' facilities are generally not designed to facilitate team-based care and interdisciplinary patient consults (e.g., physical and behavioral health)
- The current culture of care is largely siloed

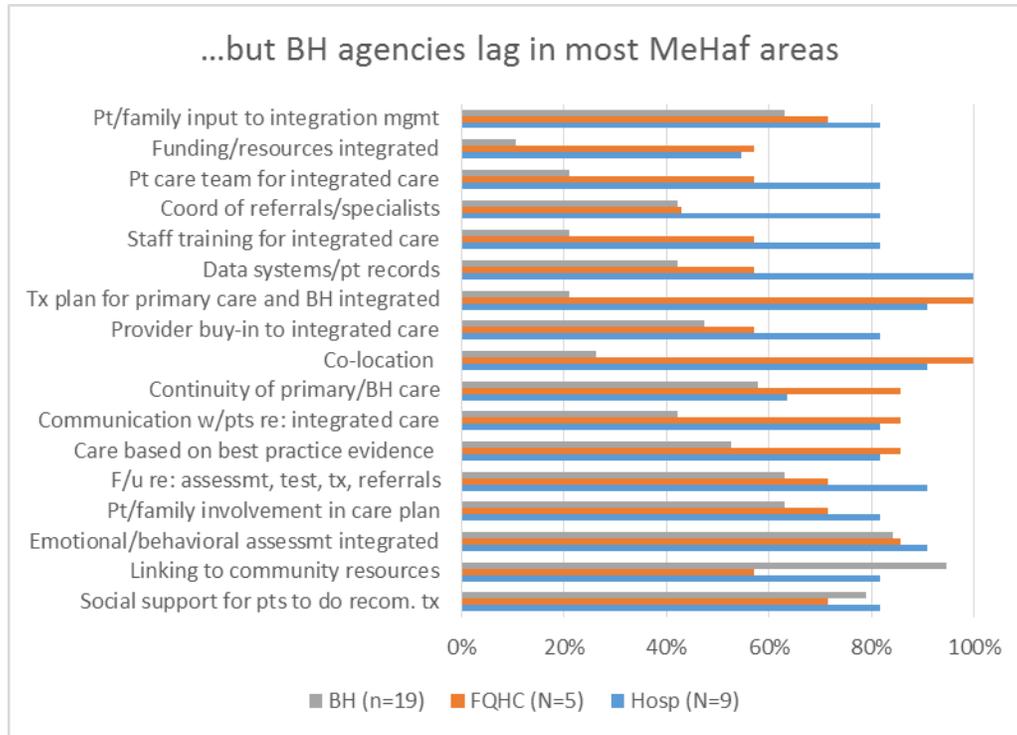
Project-level Key Findings

2A: Bidirectional Integration of Physical and Behavioral Health through Care Transformation

- The majority of respondents plan to implement the Collaborative Care model
- Partners face common barriers to implementing integrated care, including health IT, financial systems, and contracting
- Partners need training on integrated care and population health management; BHAs are especially in need of training
- Respondents completed components of the Maine Health Access Foundation (MeHAF) self-assessment, which found some common strengths among all partners, but also showed BHAs lag behind FQHCs and hospitals/health systems in all categories. See Figure 3 below.

CSA Key Findings

Figure 3. Summary of MeHaF Responses by Respondent Type



2C: Transitional Care

- Hospitals/health systems are the most mature with respect to offering patient services pre- and post-discharge (e.g., medication reconciliation, patient/caregiver education, follow-up visits)
- Respondents are using tools to facilitate care transitions that address elements of the evidence-based tools in the toolkit; however, they are not using the tools exactly as prescribed
- Respondents identified the following barriers to transitional care:
 - Lack of housing
 - Lack of communication/collaboration among participants (e.g., discharge information sharing)
 - Delayed access to mental health/SUD treatment, specialty care, and clinics
 - Lack of funding for outreach, CHWs, and to support longer PCP appointments

CSA Key Findings

- Staffing challenges/shortages
- Lack of skilled nursing facility and adult family home funding models, beds, and willingness to accept patients

3A: Addressing the Opioid Use Public Health Crisis

- Respondents use opioid best practices inconsistently
- Hospitals/health systems use opioid prescribing guidelines more than other settings; both hospitals/health systems and FQHCs have taken steps to implement prescribing guidelines, including training providers and monitoring opioid prescribing practices
- Providers are not consistently registering with or using the Prescription Monitoring Program (PMP), and few have integrated the PMP with their EHRs outside the hospital/health system setting

3D: Chronic Disease Prevention and Control

- Respondents have common high interest in diabetes and cardiovascular disease; FQHCs had the most interest in pediatric and adult asthma among respondents
- BHAs generally do not use or have access to chronic disease registries; 60% or more of hospitals/health systems and FQHCs have an asthma registry and 80% or more have a diabetes registry
- Respondents have inconsistent approaches to care plans, and care plans generally do not include a description of how services will be coordinated
- The composition of chronic disease care teams varies, with FQHCs employing the most diverse teams, including CHWs, pharmacists, and registered dietitians
- Hospitals/health systems are more likely to provide illness self-management, but use of specific models is low
- Barriers to partner use of CHWs include financing/funding, integration of CHWs into workflow, space constraints, and training

HealthierHere is in the process of developing strategies to address partnering providers' common needs critical to projects' success and regional health care transformation. An initial list of gaps appears below with corresponding emerging mitigation strategies; these strategies are under development and will be augmented and refined through HealthierHere's ongoing work with stakeholders.

Figure 4. **Partnering Providers’ Critical Gaps and Emerging Mitigation Strategies**

Partnering Providers’ Critical Gaps (Portfolio-level)	Emerging Mitigation Strategies
<p>Staffing – Partnering providers need support recruiting and retaining: medical staff; behavioral health providers, especially substance use providers; CHWs; and peer support specialists (peers).</p>	<p>As part of its Domain 1 activities focused on workforce, HealthierHere will build statewide health system capacity through its participation in the Health System Capacity Building Work Group in partnership with all 9 ACHs, the University of Washington, the Association of Washington Public Hospital Districts, and the HCA. HealthierHere is also developing strategies to support local partnering providers’ staffing needs and is evaluating potential strategies, including training and technical assistance (TA); subsidizing select types of providers (e.g., CHWs, care coordinators) to advance team-based care; and collaborating with training organizations to cultivate the appropriate health care workforce pipeline to meet King County’s needs.</p>
<p>Care Models – Partnering providers reported low and inconsistent use of toolkit care models.</p>	<p>HealthierHere is working with partnering providers to articulate the specific evidence-based care model and practice guidelines providers will need to follow for each project, including supporting team-based staffing models (e.g., adding CHWs and care coordinators to the care team). HealthierHere will offer partnering providers training and TA on the models, practice coaching, and identify champions among partnering providers to share best practices.</p> <p>HealthierHere is considering funding MTP key staff roles, such as program managers, at some partner organizations, especially partners that are large and complex.</p>

Partnering Providers' Critical Gaps (Portfolio-level)	Emerging Mitigation Strategies
	<p>Program managers would coordinate and monitor the progress of clinical projects at major partner organizations and serve as the liaison between the partner and HealthierHere.</p>
<p>EHRs – The majority of partnering providers have implemented EHRs, but the lack of interoperability and use of shared care plans limits effective team communication and population management, especially outside the inpatient and ambulatory care environments.</p>	<p>HealthierHere developed principles to guide its HIE and HIT investments, and is developing a framework to evaluate the feasibility of specific investment opportunities. HealthierHere will invest in HIE and HIT infrastructure to drive system transformation across projects and partners.</p>
<p>Funding Models for Care Coordination – Partnering providers reported needing VBP models that support care coordination and staff to implement care coordination activities (e.g., CHWs and peers).</p>	<p>HealthierHere is actively engaged with managed care organizations (MCOs) and the state around VBP models. HealthierHere plans to work with stakeholders to develop VBP models that support CHWs, peers, and other positions not traditionally reimbursed under Medicaid beyond the MTP.</p>
<p>Clinical-Community Linkages – Partnering providers need stronger relationships with community-based organizations (CBOs), especially housing providers, to support the social determinants of health (SDOH) and shared care plans.</p>	<p>HealthierHere is in the process of developing a community engagement plan focused on meaningful and thoughtful CBO engagement. CBOs will be chosen based on their alignment with HealthierHere goals and objectives and ability to assist with the success of specific projects and overall transformation.</p> <p>HealthierHere is also actively learning about other communities' 211 efforts to link community based social services to clinical settings (i.e., San Diego 211 Community Information Exchange (CIE)).</p> <p>HealthierHere is developing a plan to link</p>

Partnering Providers' Critical Gaps (Portfolio-level)	Emerging Mitigation Strategies
	community based social services, augmenting the existing 211 program to connect King County residents to critical health care and social services, including CBOs and the healthcare delivery system, through some type of CIE.
<p>BHA Support – BHAs' capabilities lag behind those of their hospital and FQHC counterparts, and BHAs will require additional support to participate in HealthierHere projects.</p>	<p>HealthierHere will support BHAs through project 2A (bidirectional care) as well as Domain 1 activities focused on quality improvement, HIE and HIT, and VBP. As project implementation begins, HealthierHere will identify opportunities to provide additional support (e.g., QI training, financial, or other) to BHAs in efforts to mitigate disparities in transformation readiness. Additionally, HealthierHere is providing strategic advice and meeting regularly with the King County Behavioral Health Organization (BHO) regarding how funding for fully integrated managed care (FIMC) can best support BHAs during the transition.</p>

HIE/HIT Assessment. HealthierHere developed and administered an assessment to understand partners' capabilities related to HIE and HIT. The HIE/HIT assessment evaluated Medicaid health partners' and behavioral health partners' capabilities relative to:

- EHRs
- HIE
- Telehealth and mobile applications
- Other technologies
- Population health management and registries

Fifty partners, including hospitals/health systems, FQHCs, and BHAs, were invited to complete the HIE/HIT assessment, and approximately 90% responded.

The major themes from the HIE/HIT assessment are:

- There is large variability in HIE/HIT capacity and use within and across sectors
- Partners have limited data partnerships and information systems that support clinical-community linkages
- Across sectors, there are fragmented referral and coordination systems to address social determinant needs (e.g., housing, employment, food insecurity, childcare)

Key findings are summarized by theme below. (See *Appendix C. HIE/HIT Assessment Findings Slide Deck* for a more detailed summary of the HIE/HIT assessment findings.)

Figure 5. **HIE/HIT Assessment Findings**

Theme	Key Findings
<p>Across and within sectors, there is large variability in HIE/HIT capacity and use</p>	<ul style="list-style-type: none"> • Partners use at least 18 different EHR systems • BHAs have the greatest gap in capabilities: <ul style="list-style-type: none"> ○ 75% report using an EHR ○ 16% have population health management systems or tools ○ 24% have disease registries ○ Over half have no PMP access or plans for its use • There is great variability among partners relative to EHR infrastructure and use, especially with respect to data collection and sharing • While most hospitals reported population health capabilities, most FQHCs and BHAs do not have such capabilities <ul style="list-style-type: none"> ○ Those that have population health management systems generally use them to identify gaps in care; only half are using them to monitor and track patients ○ Most hospitals and FQHCs have and use patient registries to improve the quality of patient care; many of these registries are managed manually or through Excel spreadsheets; fewer than a quarter of BHA respondents have registries
<p>Partners have limited data partnerships and information systems that</p>	<ul style="list-style-type: none"> • The majority of respondents do not share data through their EHRs with CBOs or social service agencies

Theme	Key Findings
support clinical-community linkages (e.g., sharing data through EHRs for shared care planning and coordination of care)	<ul style="list-style-type: none"> • Over half of hospitals/health systems and BHAs reported exchanging some health information via paper or fax with CBOs or social service agencies • Shared care planning and coordination are needed among and across all provider types (e.g., hospital/health system to BHA, FQHC to BHA)
Across sectors, there are fragmented referral and coordination systems to address social determinant needs	<ul style="list-style-type: none"> • There are several referral systems that exist for various focus populations in the region, but the majority are not linked to EHRs • There is no technology platform in place that supports data sharing and coordination activities across CBOs and social service agencies

Based on these findings, and in collaboration with stakeholders, HealthierHere developed principles to guide its HIE and HIT investments as well as a framework for assessing the feasibility of investment options.

Figure 6. **Guiding Principles for HIE and HIT Investments**



4. Describe how the ACH has used the assessment(s) to inform continued project planning and implementation. Specifically provide information as to whether the ACH has adjusted projects originally proposed in project Plans, based on assessment findings.

ACH Response:

The CSA and HIE/HIT Assessment helped identify key areas in which partnering providers will require support to be successful in project implementation and contribute to regional health care transformation. While HealthierHere has not adjusted the projects proposed in its project plans, the CSA and HIE/HIT Assessment assisted the ACH in refining where and how to make investments for maximum impact. For example, HealthierHere will:

- Prioritize investments in BHAs to help close the gap in BHAs' core capabilities relative to hospitals/health systems and FQHCs.
- Prioritize training for partnering providers around the evidence-based care models.
- Support workforce development and increase health system capacity throughout the region to help drive transformation.
- Establish forums where providers can learn from others' experiences (e.g., project work groups, learning collaboratives).
- Develop both a catalytic investment framework that will define investment opportunities to bring about transformation, and criteria for evaluating such opportunities and estimating their impact relative to HealthierHere's overarching vision for health system transformation.
- Identify areas where the ACH can serve as a critical stakeholder table, convening diverse stakeholders and trusted leadership around common needs and complex issues requiring broad consensus (e.g., HIE, data governance).

As HealthierHere continues with planning and implementation efforts, the CSA results, in addition to input from stakeholders, will continue to guide activities within and across projects.

5. Provide examples of community assets identified by the ACH and partnering providers that directly support the health equity goals of the region.

ACH Response:

Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people." In pursuit of this goal, HealthierHere's work is closely aligned with and informed by the work of other transformational initiatives in King County. HealthierHere identified community assets within King County to help address health disparities and advance health outcomes throughout our region. Each of these initiatives

focuses on identifying community assets and providing additional support to amplify community voice in service delivery, planning, policy, and decision-making processes. Notably, these initiatives (described below) aim to eliminate disparities and create more equitable systems while addressing the acute needs of individuals who experience or are at risk of disparate health and social outcomes. These community assets include, but are not limited to:

- **[Best Starts for Kids](#)**: King County voters approved the Best Starts for Kids (BSK) Levy (Ordinance 18088) in late 2015, creating a vital source of funding to build healthier communities. BSK is the most comprehensive approach to early childhood development in the nation. BSK invests in programs to promote healthier, more resilient families and communities, starting with prenatal support and continuing through the teenage years. The levy generates \$65 million annually for investments in prevention and early intervention for children, youth, families, and communities. While many BSK strategies are addressing access to services, some investments are focused on making systemic changes that drive health outcomes. These include investments in addressing the inequitable overrepresentation of youth of color in the juvenile justice system.
- **[Veterans, Seniors and Human Services Levy](#)**: In November 2017, King County voters approved the Veterans, Seniors and Human Services Levy (VSHSL) (Ordinance 18555), which will generate \$52 million annually for investments in programs and services aimed at improving the health and well-being of veterans, seniors, and other vulnerable populations. Funds are allocated to four major categories: 1) regional health and human services to veterans and military service members and their respective families, and other persons in King County; 2) housing stability investments that include new capital facilities and regional health and human services for veterans, seniors, and vulnerable populations; 3) senior center investments that will be used to help senior centers expand capacity, extend hours, reach new groups of seniors, and offer new services for seniors and their caregivers; and 4) capacity-building support for small organizations, partnerships, and groups that provide VSHSL-funded services for veterans, seniors, and vulnerable populations.
- **[King County Mental Illness and Drug Dependency Sales Tax](#)**: King County's Mental Illness and Drug Dependency (MIDD) is a countywide 0.1% sales tax generating about \$67 million annually specifically for programs and services for people living with mental illness and chemical dependency. King County's MIDD goal is that people living with, or at risk of, behavioral health conditions are healthy, have satisfying social relationships, and avoid becoming part of the criminal justice system. MIDD priorities include: 1) funding services and programs to keep people out of, or from returning to, jail and the criminal justice system, including upstream prevention and diversion activities; 2) investing in a treatment-on-demand system that delivers treatment to people who need it when they need it, so crises can be avoided or shortened; and 3) creating services that are responsive to the unique needs of King County's

geographic and cultural/ethnic communities.

- **Familiar Faces:** The Familiar Faces initiative is centered on creating a system of integrated care for complex health populations. Familiar Faces refers to a population defined as individuals who are frequent utilizers of a King County jail (defined as having been booked into jail four or more times in a 12-month period) and who also have a mental health and/or substance use condition.
- **Communities of Opportunity:** Communities of Opportunity is a community-led initiative designed to identify locally driven strategies to strengthen community connections, economic opportunity, health outcomes, and housing for low-income residents and communities of color in King County. The initiative currently supports 27 place-based and cultural community organizations in building on existing community assets, preserving community and cultural anchors, and including the community's voice in the development of strategies to address equity, disparities, and the impact of institutional and structural racism.
- **Social Justice Initiatives:** The [King County Equity and Social Justice Initiative](#) and [Seattle Race and Social Justice Initiative](#) have been engaging in race and social justice work to address equity for residents in King County. The King County Office of Equity and Social Justice developed a county-wide equity and social justice strategic plan after conducting an assessment to identify disparities experienced by communities of color, immigrant and refugee community members, and low-income community members in King County. That assessment included the identification of community strengths and assets.
- **Healthy King County Coalition:** The coalition brings together more than 40 King County organizations around the common vision of health equity and justice for everyone, regardless of where they live. The coalition supports access to healthy eating, smoke- and drug-free environments, and safe places to be active, and strives to reduce disparities, including health and wellness differences affected by factors such as race, ethnicity, and income.
- **Crisis Clinic:** The Crisis Clinic offers telephone-based crisis intervention, information, and referrals to community services for youth and adults in King County. Its services include:
 - Emotional support to those in crisis through a 24-hour crisis line.
 - Referrals to community services based on a database of more than 5,000 services through King County 211.
 - A peer-answered help line for people living with mental health challenges.
- **Within Reach:** Within Reach helps families and individuals across Washington connect with the resources and services needed to be healthy and safe. It acts as the single point of entry to the many resources a family needs to be healthy, including connecting families to food, health coverage, child development

support, immunizations, and much more.

- **You Belong Here (YBH):** As part of our participation in ReThink Health, HealthierHere has had the opportunity to partner in the incubation of a movement called You Belong Here. You Belong Here is a small group of funders and regional leaders who have been talking about what it would take to put our region on a path where:
 - We work with intention across sectors, institutions, and communities to apply our region’s assets and untapped capacities to create a more inclusive future;
 - We co-create lasting solutions to our toughest regional challenges by tackling their underlying causes rather than just focusing on the symptoms;
 - Our region progresses in a way that reflects our values: We uphold and champion our shared values and seek to become a place where everyone has a sense of belonging and can contribute their best.

You Below Here calls the set of conditions that would lead to these outcomes “civic muscle,” and believes they need strengthening.

With support from the Gates Foundation and Seattle Foundation, You Belong Here has convened a diverse set of leaders who have made a two-year (2018 and 2019) commitment to this effort. In its earliest phase, You Belong Here is beginning by talking and listening deeply to others in the region. By meeting with employers, grassroots community leaders, social sector leaders, millennials, longtime residents, and new arrivals, it will gain a diverse set of perspectives and ensure that its approach is building civic muscle and a sense of belonging and inclusion.

Many of the community groups, social service agencies, and CBOs involved with these initiatives also engage in efforts to either address the social determinants of health or to reach community members who comprise the focus populations included within HealthierHere’s project portfolio, and are actively engaged with the HealthierHere Board and committees.

Additionally, HealthierHere continues to engage with ethnic health boards around the health disparities affecting the populations they represent. The Somali Health Board is an active participant on the Community and Consumer Voice (CCV) Committee and acts as an advocate for Somali immigrants and refugees and their health outcomes. The Somali Health Board is actively coordinating with eight other ethnic health boards in King County to establish the Community Health Board Coalition to ensure the perspectives of underserved populations have a shared and powerful voice for health by creating a joint policy agenda.

6. Provide a brief description of the steps the ACH has taken to address health equity knowledge/skill gaps identified by partnering providers, and how those steps connect to

ACH transformation objectives.

ACH Response:

HealthierHere and its governance bodies lead with health equity, work to eliminate disparities in health and well-being, and address the current power dynamic and institutional and structural racism in the health care system that perpetuates inequities.

The HealthierHere Governing Board leads with health equity by:

- Ensuring all meetings are open to the public, accepting public comment during meetings, and integrating members of the public in work groups during Governing Board meetings
- Requiring health equity to be addressed in all Governing Board decision-making memos, describing how the recommendation(s) considered health equity and other core values
- Incorporating health equity into its charters and the charters of its committees

HealthierHere is actively pursuing health equity through its CCV Committee, CBO engagement, CSA, and funding methodology which are described briefly below.

Community and Consumer Voice Committee. During MTP planning in DY2, HealthierHere continued convening its CCV Committee comprised of community leaders, CBOs, Medicaid consumers, and others committed to advancing health equity in King County. In June 2018, HealthierHere chartered the committee as a formal committee of the Governing Board, formalizing the Committee's role in the HealthierHere governance structure and relationship to the Governing Board. The CCV Committee is an important asset and was established during planning efforts in 2016. Its members represent critical stakeholders working with diverse populations, including racially and ethnically diverse populations, immigrants, refugees, and those who statistically experience health inequities such as individuals with behavioral health conditions or who are experiencing homelessness. The CCV Committee meets monthly and provides guidance, advice, and input into HealthierHere's planning and decision-making processes to ensure that community supports to advance health equity are in place, while also working to ensure that the health care system becomes more culturally responsive.

The CCV Committee is advising HealthierHere on health equity-focused activities, including:

- *Non-native English/Low Health Literacy.* In DY1, the CCV Committee conducted a survey of individuals who are non-native English speaking or who have lower health literacy, focusing on their knowledge and use of and access to Medicaid services. The results of this survey were used by HealthierHere to inform project planning efforts in DY2.
- *Key CBO Partners.* HealthierHere is working with the CCV Committee to gather

information about how CBOs engage with Medicaid beneficiaries, which will be important to transformation efforts. The Committee is also reviewing the CSA findings related to partnering providers' CBO relationships to inform HealthierHere's overall CBO strategy.

Direct CBO Engagement. HealthierHere is also taking steps to engage CBOs; CBOs will be critical to achieving widespread health system transformation. The two primary ways HealthierHere is engaging CBOs are through the following:

- *CBO Assessment* – HealthierHere plans to administer a CBO assessment in summer 2018 to gather information about how CBOs are addressing the social determinants of health (e.g., food security, employment/training, housing) in King County, specifically: their projects of interest; regions and populations served; scope of services; Medicaid volume; and organizational infrastructure, including HIE/HIT. This assessment will help HealthierHere better understand the large and diverse CBO landscape and identify priority partners ready to participate in HealthierHere projects as well as priority partners who may require investment or capacity-building support to strengthen bi-directional partnerships with the healthcare delivery system.
- *Small Grants Program* – HealthierHere is developing a small grants program to further increase community members', Medicaid consumers', and CBOs' voices in driving transformation in the region. The program is intended to increase participation in HealthierHere community engagement, planning, and implementation activities, including reaching out to CBOs' respective focus populations, especially non-English-speaking populations. CCV Steering Committee members Roi-Martin Brown, of the Washington Community Action Network; Jihan Rashid, of the Somali Health Board; Hallie Pritchett, of Lake Washington Institute of Technology; Sybill Hyppolite, of SEIU 1199NW; Elizabeth Bennett, of Seattle Children's Hospital; and Hani Mohamed, of Community Health Plan of Washington, are working with HealthierHere to develop the criteria for the grant program.

Current State Assessment. To inform its health equity strategy, HealthierHere gathered information about clinical providers' health equity capabilities in the CSA, including the extent to which providers:

- Have a mission statement that reflects a commitment to providing culturally competent care
- Have adopted the National CLAS Standards or other guidance to incorporate cultural competence into organizational planning
- Have policies and/or procedures addressing cultural sensitivity and effective communication in the provision of care
- Offer ongoing training on cultural and language diversity

- Make information available to clients in languages other than English
- Make interpreter services available across different communication media (e.g., phone, face to face, video)
- Involve community representatives in the planning, design, and evaluation of client services for culturally diverse populations
- Tailor patient communications about integrated care to the individual patient's needs, culture, language, or learning style

HealthierHere is using the information gathered from the CSA regarding health equity knowledge/skills gaps to identify the depth of partnerships that providers have with CBOs to address the SDOH, barriers to effectively addressing the SDOH, barriers to partnerships, and the innovation that is necessary to work together. Once that information is analyzed, it will be shared with the CCV Committee and CBO partners to “ground truth” the results and begin to develop creative and sustainable strategies to address the identified gaps.

Creating a culturally competent and responsive health care delivery system and implementing the National CLAS Standards are only pieces of the solution. Establishing trusted relationships with physical and behavioral health care providers, creating support systems and safety networks for community members accessing health care, addressing the SDOH, and including client voices in health care delivery systems as well as health policy and planning decisions are central to shifting the institutional and structural barriers that lead to health inequities. Creating partnerships to address health inequity; developing partnerships between health care providers and CBOs addressing the SDOH; and ensuring that workforce development strategies and curricula meaningfully incorporate cultural competence, relevance, and community voice are a few examples of the interim strategies that will be implemented to address health equity knowledge and skills gaps.

Funding Methodology. Additionally in DY2, HealthierHere developed its allocation methodology for 2018 partner engagement and planning dollars. The methodology allocates 40% of funds earned by HealthierHere to nontraditional Medicaid providers. These funds will help providers address the disparities identified in the Regional Health Needs Inventory (RHNI) and CSA.

B. Milestone 2: Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment)

1. **Attestation:** During the reporting period, the ACH has identified common gaps, opportunities, and strategies for statewide health system capacity building, including HIT/HIE, workforce/practice transformation, and VBP. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item B.1, provide the ACH’s rationale for not identifying common gaps, opportunities, and strategies for statewide health system capacity building. Describe the steps the ACH will take to complete this milestone. If the ACH checked “Yes,” respond “Not Applicable.”

ACH Response: Not Applicable

3. Describe progress the ACH has made during the reporting period to identify potential strategies for each Domain 1 focus area that will support the ACH’s project portfolio and specific projects, where applicable.

ACH Response:

The CSA and HIE/HIT Assessment gathered information about partnering providers’ capabilities and needs relative to the three Domain 1 focus areas: population health management systems, workforce, and VBP.

HealthierHere reviewed and analyzed the information collected through the CSA and HIE/HIT Assessment and shared the results through its stakeholder process, including at a Partner Summit meeting and with project work groups. HealthierHere is using the results to inform the development of Domain 1 strategies that support the ACH’s portfolio of projects as well as individual projects. These strategies will be refined through the stakeholder process, and a first round of strategies will be approved by the Governing Board this summer. HealthierHere will continue to refine its Domain 1 strategies throughout the MTP.

The figure below depicts the development of Domain 1 strategies in the first half of DY2.

Figure 7. Domain 1 Progress January 1-June 30, 2018



As HealthierHere approaches project implementation, it is focused on ensuring that health care partners have the necessary foundational capabilities to be successful and improve health outcomes with their respective focus populations. These capabilities are depicted below at both the system and patient care levels. HealthierHere’s emerging Domain 1 strategies are focused on supporting these foundational capabilities.

Figure 8. Foundational Capabilities of Partnering Providers



4. Provide information as to whether the ACH has adjusted Domain 1 strategies as originally proposed in its Project Plan based on ongoing assessment.

ACH Response:

HealthierHere continues to work toward implementing the Domain 1 strategies

described in its project plan. The CSA, HIE/HIT Assessment, and targeted conversations with stakeholders have helped HealthierHere understand partnering providers' capabilities and needs. In response, HealthierHere is working to refine Domain 1 strategies to better address partnering providers' needs. These strategies are described below.

Figure 9. **Refined Domain 1 Strategies**

Domain 1 Strategies	
Workforce	
Portfolio Strategies	<ul style="list-style-type: none"> • Provide training and TA on population health management and care models that are foundational to the implementation of HealthierHere's projects • Build capacity and support for CHWs, peer support specialists, care coordinators, and team-based care through direct funding and development of VBP models to sustain these positions beyond the MTP • Develop standards of practice for screening and care coordination • Create career pathways in partnership with local community colleges • Support workforce development and training in partnership with King County • Disseminate resources available through the state's Practice Transformation Support Hub
Project-specific Strategies	<ul style="list-style-type: none"> • Support positions not funded by Medicaid (e.g., CHWs, peer support specialists) that are critical to effectively implementing the selected evidence-based approaches • Identify and make available opioid prescribing resources from partners with established evidence-based programs
Value-based Payment	
Portfolio Strategies	<ul style="list-style-type: none"> • Convene Incentive Funds Flow Work Group monthly to develop funding model for future incentive funds for partnering providers; the work group will make recommendations to the Finance Committee for review before the model is advanced to the Governing Board

Domain 1 Strategies	
	<ul style="list-style-type: none"> • Work with MCOs and other ACHs on a common approach to sustainability and value-based care • Participate on the MVP Action Team to inform HealthierHere’s VBP strategies (HealthierHere’s CFO and two Finance Committee members participate on the MVP Action Team) • Hold individual and group meetings with MCOs to discuss VBPs
Project-specific Strategies	<ul style="list-style-type: none"> • The King County BHO is contracting with Health Management Associates (HMA) to help with the behavioral health network’s transition to VBP, and HealthierHere staff are actively engaged in this process to ensure alignment.
Population Health Management Systems	
Portfolio Strategies	<ul style="list-style-type: none"> • Develop guiding principles for HIE and HIT investments and a framework within which to evaluate potential investments • Evaluate potential investments that will advance population health management in King County; investments under consideration reflect those priorities identified through the HIE/HIT Assessment (e.g., shared care plans, HIE, registries, eConsult, telehealth, technical assistance, sharing of best practices) • Collaborate with other ACH leadership and statewide partners (e.g., Washington State Hospital Association, or WSHA) to identify common needs, opportunities for joint investments, and assets that may be leveraged across ACHs • Develop materials with messaging specific to their audiences regarding the importance of HIE and HIT (e.g., providers, CBOs) • Work with community stakeholders to explore ways to align with and leverage existing HIE and HIT infrastructure and assets in King County; for example: <ul style="list-style-type: none"> ○ Identifying opportunities to build upon OneHealthPort ○ Working with traditional and non-traditional providers such as fire and emergency medical responders to expand PreManage as a tool for shared care planning ○ Expanding access to and effective utilization of the

Domain 1 Strategies	
	<p style="text-align: center;">Emergency Department Information Exchange (EDIE)</p> <ul style="list-style-type: none"> ○ Working with the King County integrated health data hub • Support BHAs in HIE and HIT adoption, including training and TA • Explore opportunities to establish a communication system linking clinical and community based providers (i.e., EHRs via the Crisis Clinic and King County’s 2-1-1 referral system).
Project-specific Strategies	<ul style="list-style-type: none"> • Standardize project-specific notifications to participating providers • Develop shared care plans tailored to focus populations and projects • Facilitate real-time information sharing on emergency department (ED) and inpatient admissions through PreManage • Work with OneHealthPort to support clinical data repositories and HIE

5. Describe the ACH’s need for additional support or resources, if any, from state agencies and/or state entities to be successful regarding health system capacity building in the Transformation.

ACH Response:

HealthierHere would like additional clarification and support from the state on VBP, specifically more specific definitions of what the state means by VBP and understanding how HealthierHere can advance project implementation and sustainability of health system transformation through future VBP approaches. This support can be facilitated through the MVP Action Team or other technical assistance from the state.

HealthierHere is collaborating with the other ACHs to identify common needs, and welcomes the opportunity to continue this dialogue with HCA. Potential needs are identified below, and HealthierHere will follow up with HCA as these are refined.

Figure 10. Potential Areas of State Support

Systems for Population Health Management	Workforce	Value-based Payment
<ul style="list-style-type: none"> • Data governance • Interoperability 	<ul style="list-style-type: none"> • Training and TA for key workforce positions 	<ul style="list-style-type: none"> • Continuing support for MVP Action Team

Systems for Population Health Management	Workforce	Value-based Payment
<ul style="list-style-type: none"> • HIE • Disease registries • Telehealth • PreManage/EDIE • Centralized registries 	<p>within required projects (e.g., CHWs, peer support specialists, care coordinators)</p> <ul style="list-style-type: none"> • Development of career pathways • Collaborative solutions for provider shortages (e.g., recruitment, expanding scope of practice and reimbursement) 	<ul style="list-style-type: none"> • MCO VBP and quality improvement requirements • VBP models to support CHWs, peers, and other positions not reimbursed by Medicaid • Guidance on ACH's role in VBP • VBP guidance for providers, especially behavioral health providers

C. Milestone 3: Define Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

For this milestone, the ACH should either:

A. Respond to items C.1-C.3 in the table following the questions, providing responses by project. (For projects the ACH is not implementing, respond “Not Applicable.”)

Or,

B. Provide an alternative table that clearly identifies responses to the required items, C.1-C.3. The ACH may use this flexible approach as long as required items below are addressed.

1. Medicaid Transformation Approaches and Strategies

Through the Project Planning process, ACHs have committed to a set of projects and associated strategies/approaches. For each project, please identify the approach and targeted strategies the ACH is implementing. The state recognizes that ACHs may be approaching project implementation in a variety of ways.

For each project area the ACH is implementing, the ACH should provide:

- a. A description of the ACH’s evidence-based approaches or promising practices and strategies for meeting Medicaid Transformation Toolkit objectives, goals, and requirements.
- b. A list of transformation activities ACH partnering providers will implement in support of project objectives. Transformation activities may include entire evidence-based approaches or promising practices, sub-components of evidence-based approaches or promising practices, or other activities and/or approaches derived from the goals and requirements of a project area.
- c. If the ACH did not select at least one Project Toolkit approach/strategy for a project area, and instead chose to propose an alternative approach, the ACH is required to submit a formal request for review by the state using the Project Plan Modification form. The state and independent assessor will determine whether the ACH has sufficiently satisfied the equivalency requirement.

2. Target Populations

Provide a detailed description of population(s) that transformation strategies and approaches are intended to impact. Identify all target populations by project area, including the following:

- a. Define the relevant criteria used to identify the target population(s). These criteria may include, but are not limited to: age, gender, race, geographic/regional distribution, setting(s) of care, provider groups, diagnosis, or other characteristics. Provide sufficient detail to clarify the scope of the target

population.

Note: ACHs may identify multiple target populations for a given project area or targeted strategy. Indicate which transformation strategies/approaches identified under the project are expected to reach which identified target populations.

3. Expansion or Scaling of Transformation Strategies and Approaches

- a. Successful transformation strategies and approaches may be expanded in later years of Medicaid Transformation. Describe the ACH's current thinking about how expanding transformation strategies and approaches may expand the scope of target population and/or activities later in DSRIP years.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Project 2A: Bi-directional Integration of Physical and Behavioral Health

1. Transformation Strategies and Approaches

a. Evidence-based Approaches

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

HealthierHere and its partnering providers will implement the following evidence-based approaches to integrate whole person care in:

1. Community Behavioral Health Centers
2. Primary Care Setting

1. Integrated Whole Person Care in Community Behavioral Health Centers

Based upon the [Bree Collaborative Behavioral Health Integration](#) model and the [AIMS Center Collaborative Care Model](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Conduct holistic screenings in the behavioral health setting, or confirm that they have been completed by primary care partner organization, with a focus on asthma, COPD, diabetes, and CVD. Screenings could include:
 - BMI screening for all or an identified subset of individuals served by the organization
 - Blood pressure screening, for all or an identified subset of individuals served by the organization
 - Tobacco use screening, for all or an identified subset of individuals served by the organization
 - Diabetes screening for all individuals using antipsychotic medication

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a PCP, social worker, or other appropriate provider.
- Provide best practice, culturally appropriate interventions to help individuals manage chronic conditions within community behavioral health centers and/or integrated care settings.
- Provide individuals with greater need with ongoing support and treatment via a co-located, integrated, or partner primary care organization.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- The care team will refer individuals to community resources, including chronic disease self-management programs, as appropriate.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- A community support specialist or a member of the integrated health care team will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can “teach back” expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual's needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

2. Integrated Whole Person Care in Primary Care Settings

Based upon the [Bree Collaborative Behavioral Health Integration](#) model and the [AIMS Center Collaborative Care Model](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.

- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Conduct standardized screenings in the primary care setting, with a focus on depression and SUD, including OUD.
- Stratify individuals by risk and severity of disease.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a behavioral health provider, social worker, or other appropriate provider.
- Provide Medication Assisted Treatment (MAT) when needed.
- Provide best practice, culturally appropriate mental health and/or substance use disorder treatment interventions within primary and/or integrated care settings.
- Provide individuals with greater need with ongoing support and treatment via a co-located, integrated, or partner primary care organization.
- Provide linkage to specialty behavioral health, including psychiatry, when needed.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Provide Self-Management Support:

- A community support specialist or a member of the integrated health care team will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual’s self-efficacy
 - c. Improve continuity of care with behavioral health care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for behavioral health care providers/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can “teach back” expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual’s needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual’s treatment and progress.

(See Appendix D. Clinical Summaries for more information on transformation strategies and approaches).

2. Target Populations

HealthierHere used a population health lens to understand target and “focus” populations across its portfolio and within individual projects. The analysis began by identifying 533,929 King County residents who had at least one day of Medicaid coverage between April 1, 2016, and March 31, 2017. To align with official inclusion criteria used by HCA in calculating pay-for-performance measures for each ACH region, HealthierHere removed individuals with a greater than 30-day gap in continuous coverage or any dual Medicare eligibility during the measurement period, reducing the cohort size to 304,406 individuals.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

The majority of members had no ED visits (74%), hospital stays for medicine/surgery reasons (98%), or behavioral health-related hospital stays (99%) during the measurement period. Of the members, 5.1% had three or more ED visits, and these members accounted for 49% of all ED visits in the cohort during the measurement period. Further, 6,085 members had one or more med/surg hospital stays, accounting for 100% of all med/surg hospital stays. Similarly, 4,139 members had one or more behavioral health-related hospital stays, accounting for 100% of all such hospital stays.

Members who had three or more ED visits or one or more of either a med/surg or behavioral health-related hospital stay comprise the “hot spot” cohort – this includes 20,357 members. While hot spot members represent only 6% of Medicaid members, they are accountable for 60% of ED visits. Compared to the larger cohort, the hot spot cohort includes a higher percentage of members ages 25-64 and a smaller percentage of members ages 5-17. Hot spot members were also more likely to be American Indian/Alaska Native, black, and white, and more likely to report English as a preferred written or spoken language.

HealthierHere then used the hot spot cohort to define the focus population aligned with each project. For purposes of this project, HealthierHere identified members with mental health, SUD, and behavioral health diagnoses, defined as:

- **Mental health:** Members with any mental health diagnosis (defined by DSHS-RDA) within the measurement period
- **SUD:** Members with any substance use disorder diagnosis (defined by DSHS-RDA) within the measurement period
- **Behavioral health-related hospitalization:** Members with one or more behavioral health-related hospital stays during the measurement period

Partnering providers will be asked to focus their efforts on individuals who fit the following profiles:

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

In Community Behavioral Health Centers: Medicaid members with mental health and substance use disorders (SUDs), including opioid use disorders (OUDs) who meet a minimum of 3 of the following criteria:

- Prescribed antipsychotic medication
- Prescribed four or more medications
- Diagnosed with one of the following chronic conditions: asthma, chronic obstructive pulmonary disease (COPD), diabetes, cardiovascular disease (CVD)
- Low health literacy
- Limited English proficiency
- Limited engagement with primary care (no primary care visit in the last six months)
- Homeless or housing instability
- Limited community supports (e.g. ineligible for other programs such as Health Homes)

In Primary Care Settings: Medicaid members within traditional and non-traditional primary care settings who are at risk for or have a diagnosis of depression and/or substance use disorder (SUD), including opioid use disorder (OUD).

HealthierHere’s analysis also confirmed that Medicaid hot spot members are likely to exist in multiple focus populations. Of note, 69% of hot spot members are included in two or more project focus populations and 40% are in three or more focus populations. HealthierHere anticipates that many of the members with one of the diagnoses above will also have or be at risk for chronic disease conditions (e.g., diabetes) that are the focus of other HealthierHere projects or will be transitioning from a care setting of interest (e.g., jail, inpatient). Therefore, HealthierHere will require its partners to approach all beneficiaries through an integrated whole person care approach, meaning there will essentially be “no wrong door” to entering treatment and all beneficiaries will undergo comprehensive screening. Under this approach, for example, a beneficiary with a SUD will benefit from providers’ efforts to integrate physical and behavioral health care as well as their efforts to enhance care for chronic conditions.

Finally, HealthierHere will make a concerted effort to identify members in what HealthierHere refers to as “hidden” populations. These members may seek services through non-Medicaid providers and therefore are not represented in the claims-level analysis, or they may not seek services at all due to lack of access or other reasons.

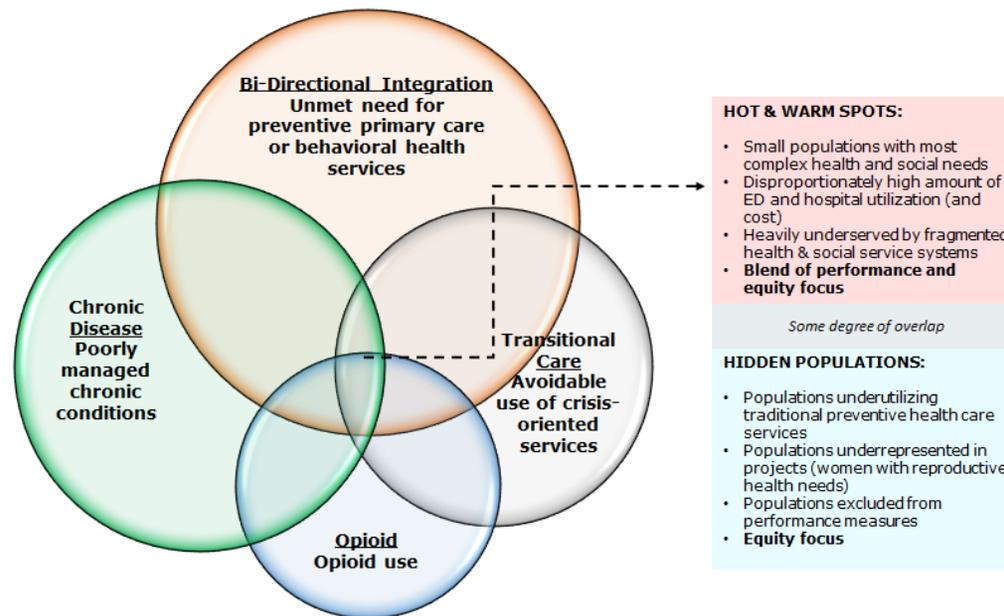
Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

HealthierHere believes this hidden population likely has high needs, similar to the needs of the hot spot and focus populations, and will work with its CBO partners to identify and reach out to members who may otherwise be hidden from the Medicaid health care ecosystem.

3. Expansion or Scaling of Transformation Strategies and Approaches

Inherent to the “hot spotting” approach described above is a target population expansion strategy. Initially, HealthierHere will focus MTP activities on Medicaid beneficiaries in hot and hidden spots, and over the course of the MTP, transformation strategies and approaches will be expanded to members in “warm spots.” Warm spots include members with lower utilization of services than members in hot spots, such as members with one or two ED visits per year. Importantly, all members who present at a partner with critical needs and conditions will be treated using an increasingly team-based and integrated whole person care approach.

Figure 11. Hot Spotting Approach



Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- HealthierHere will achieve this expansion by:
- Engaging a broader provider community – HealthierHere will take a phased approach to provider engagement, informed by both its capacity to meaningfully support providers and providers’ capacity to implement projects. All providers interested in the MTP and who wish to participate will have access to training opportunities with HealthierHere, learning collaboratives focused on the evidence-based models and best practices, and potential access to some system-level investments (e.g., HIE) as they become available. As partners become ready to engage in HealthierHere projects they will have the opportunity to access partner-level infrastructure investments as well as project-specific investments (e.g., training) to ensure their success. HealthierHere is in the process of identifying these levels of partner engagement and support.
 - Deepening CBO engagement – As HealthierHere partners with increasing numbers of CBOs, it will be better positioned to serve populations who are currently underutilizing services and who represent hidden populations; today, these individuals likely receive social or other services from CBOs and consider them to be trusted entities in their communities.
 - Spreading best practices – HealthierHere will work with its partnering providers to identify and scale innovative approaches implemented through the MTP; partnering providers will share these practices through project-specific learning collaboratives and other stakeholder convenings.
 - Aligning strategies with commercial payers and Medicare – HealthierHere will work with the state, commercial payers, and Medicare to align transformation strategies and corresponding VBP models.

Project 2B: Care Coordination

1. Transformation Strategies and Approaches

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

2. Target Populations

3. Expansion or Scaling of Transformation Strategies and Approaches

Project 2C: Transitional Care

1. Transformation Strategies and Approaches

a. Evidence-based Approaches

HealthierHere and its partnering providers will implement the following evidence-based approaches to facilitate:

1. Transitions of care from jail
2. Psychiatric care transitions from hospital settings
3. Hospital discharges for high-risk Medicaid individuals

1. Transitions of Care from Jail

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County’s transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [APIC model](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and the services that are needed, share integrated care plans and other Continuity of Care Documents as appropriate and allowed by law with primary care providers, social service providers (such as supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Offer in reach services before reentry to identify and plan for necessary medical, behavioral health, justice system, social services, and community supports, including assistance with health coverage, ensuring Medicaid eligible individuals are enrolled since coverage is suspended while they are incarcerated.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a behavioral health specialist, social worker, or other appropriate provider.
- Develop a plan for the treatment and services required to address the individual's needs, the identification of community and correctional programs for post-release services, and coordination of the transition plan to ensure implementation and avoidance of gaps in care with community-based services.
- Establish relationships with community-based physical and behavioral health providers and community partners who address the social determinants of health.
- Accommodate in reach services and provide a "warm hand off" for those individuals requiring additional help.
 - The individual will be introduced to a community support specialist (e.g. a care coordinator, community health worker, or peer support specialist with lived experience in the correctional system and/or behavioral health recovery) before reentry to establish trust.
 - Assign individuals at high risk for complications to a care manager.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate transition/reentry plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Share individuals' transition/reentry plan with their community support specialist and primary care provider (PCP)/community behavioral health provider to facilitate implementation and avoid gaps in care with community-based services.
- Ensure first appointment with PCP and/or Community Behavioral Health with prescribing capability is scheduled prior to reentry. This appointment should take place as soon as possible, ideally within one week of release.

Provide Self-Management support:

- All focus population individuals should receive self-management support by a member of the integrated health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit. When applicable, provide individuals with a 7-day supply of needed medications and a prescription for a 30-day supply, along with a medication plan and instructions on medication management upon reentry. As appropriate and allowed, the medication plan should be shared with the individual's community support specialist so that they can provide continuity and make sure the medication plan is shared with the PCP and care team on the receiving end and followed.
- Upon reentry, the assigned community support specialist will meet an individual and accompany them to his/her first appointment to establish a relationship with a partnering medical or behavioral health provider.
- After reentry, the community support specialist conducts in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual's needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

2. Psychiatric Care Transitions from Hospital Settings

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [Peer Bridger Program](#) and [Transition Support Program \(TSP\)](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, substance use, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- Hospital staff will screen individuals before discharge to identify those at high risk for readmission based on the criteria above.
- Increase the completion of [POLST forms](#) and other advance care planning documents at partner organizations.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include PCP, behavioral health provider, and community support specialists.
- Assist individuals in obtaining a PCP and/or a behavioral health provider (if they don't have one) prior to discharge.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Notify individual, caregivers, and community partners of planned discharge at least 48 hours in advance.
- Refer individual to community support specialist (e.g. peer bridgers, peer support specialists), as appropriate.
 - Community support specialists serving this focus population should:
 - Receive training in trauma-informed care, crisis intervention, and motivational interviewing
 - Work collaboratively with clinical teams towards the goal of utilizing the same community support specialist to work with individuals both in the hospital and post-discharge.
 - Have access to a fund for basic services and essential needs such as bus passes, cell phones, clothing, food, engagement activities, etc.
 - Have a caseload of 8 – 14 patients.
 - Collaborate with hospital discharge planners during the discharge process.
 - Sit in on care team meetings while the individual is still in the hospital.
 - Sit in on intake sessions with case managers and psychiatrists, as able and if the individual is willing.
 - Aim for ongoing engagement/reengagement in behavioral health treatment by the individual.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- Meet the patient where they are and share their own successful recovery stories to offer hope

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate transition and treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- High-risk individuals, caregivers, and community support specialists must be notified of planned discharge no later than 48 hours in advance to avoid adverse events upon discharge.
- Transition and treatment plans should include the following information:
 - Assigned community behavioral health specialist and PCP that includes post-hospitalization discharge notes
 - An updated and reconciled medication list
 - Next steps, including follow up appointments with specialist, as needed
- Aftercare appointments must be scheduled in coordination with the community support specialist.
- Ensure that the plan is available to all team members serving the individual's needs.
- Community support specialists will meet with individuals and their family caregivers before hospital discharge to develop individually tailored transition plans that:
 - Are based upon an assessment of needed community services and supports.
 - Emphasize productive interactions between the care team and the individual.
 - Include a reconciled medication list, follow-up appointment, and patient self-education (written at an appropriate health literacy level and in the individual's language).
- The individual must have an adequate supply of their medications upon discharge.

Provide Self-Management Support:

- All focus population individuals should receive self-management support by a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- After discharge, the community support specialist will conduct in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- c. Improve continuity of care with primary care follow-up
- d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
- e. Practice advocacy by identifying key questions for PCPs/specialists
- f. Educate on health system navigation
- g. Ensure patient can “teach back” expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual’s needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual’s treatment and progress.

3. Hospital Discharges for High-Risk Medicaid Individuals

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County’s transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based on the [Coleman model](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and the services that are needed, share transition plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

care providers (PCPs), behavioral health providers, social service providers (such as supportive housing), individuals, and their caregivers.

- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Hospital staff will screen individuals before discharge to identify those at high-risk for readmission based on the criteria above.
- Increase the completion of [POLST forms](#) and other advanced care planning documents at your organization.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a PCP, behavioral health provider, care coordinator, social worker, community support specialist, or other appropriate provider.
- Individuals meeting the appropriate criteria will be assigned to a community support specialist (providing care coordination/transition coaching and capable of making home visits. Matching criteria for the assignment of a community support specialist will include language and cultural competency.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate transition plans that support patient engagement with the care team. Transition plans should be based upon an assessment of needed community services and supports and include referral and linkage to culturally appropriate services. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all providers serving the individual's needs.

Provide Self-Management support:

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- All focus population individuals should receive self-management support by a member of the integrated health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- A community support specialist or a member of the integrated health care team will conduct in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual’s self-efficacy
 - c. Improve continuity of care with PCP/specialist follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can “teach back” expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including community support specialists.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual’s needs (e.g. transportation, food, shelter).
- For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual’s treatment and progress.

(See Appendix D. Clinical Summaries for more information on transformation strategies and approaches).

2. Target Populations

HealthierHere used a population health lens to understand target and “focus” populations across its portfolio and within individual projects. The analysis began by identifying 533,929 King County residents who had at least one day of Medicaid coverage between April 1, 2016, and March 31, 2017. To align with official inclusion criteria used by HCA in calculating pay-for-performance measures for each ACH region, HealthierHere removed individuals

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

with a greater than 30-day gap in continuous coverage or any dual Medicare eligibility during the measurement period, reducing the cohort size to 304,406 individuals.

The majority of members had no ED visits (74%), hospital stays for med/surg reasons (98%), or behavioral health-related hospital stays (99%) during the measurement period. Of the members, 5.1% had three or more ED visits, and these members accounted for 49% of all ED visits in the cohort during the measurement period. Further, 6,085 members had one or more med/surg hospital stays, accounting for 100% of all med/surg hospital stays. Similarly, 4,139 members had one or more behavioral health-related hospital stays, accounting for 100% of all such hospital stays.

Members who had three or more ED visits or one or more of either a med/surg or behavioral health-related hospital stay comprise the “hot spot” cohort – this includes 20,357 members. Compared to the larger cohort, the hot spot cohort includes a higher percentage of members ages 25-64 and a smaller percentage of members ages 5-17. Hot spot members were also more likely to be American Indian/Alaska Native, black, and white, and more likely to report English as a preferred written or spoken language.

HealthierHere then used the hot spot cohort to define the focus population aligned with each project. For purposes of this project, HealthierHere identified members with hospitalizations, defined as:

- Behavioral health-related hospitalization: Members with one or more behavioral health-related hospital stays during the measurement period
- Hospitalized and vulnerable: Members with one or more all-cause hospital stays AND (age 65 and over OR persons with disabilities coverage) during the measurement period

The “hospitalized and vulnerable” cohort includes higher percentages of members who report Russian or Vietnamese as a preferred written/spoken language compared to the hot spot cohort.

HealthierHere also reviewed April 2018 data for inmates at the South Correctional Entity (SCORE) and found 29% of SCORE inmates had three or more ED visits in the past year, demonstrating that the hot spot approach will also be applicable to the population transitioning from jail.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Partnering providers will be asked to focus their efforts on individuals who fit the following profiles:

Transitions of care from jail: Medicaid members returning to the community from jail who have complex health and behavioral health conditions that necessitate care coordination and/or disease management.

Psychiatric care transitions from hospital settings: Medicaid members who live with serious mental illness and/or substance use disorder discharged from inpatient psychiatric settings or ED holds who meet a minimum of 3 of the following criteria:

- Two or more chronic conditions
- Active mental health issue and/or substance use disorder
- Four or more prescribed medications
- Two or more hospitalizations and/or four ED visits in the past 12 months
- Low health literacy
- Limited English proficiency
- Limited engagement with primary care (no primary care visit in the last six months)
- Limited engagement and/or disengaged from behavioral health care
- Homeless or housing instability
- Limited community supports, ineligible for other programs such as Health Homes

Alternatively, a clinical provider's determination of high risk for readmission is acceptable without regard to the above criteria.

Hospital discharges for high risk Medicaid individuals: Medicaid members transitioning from inpatient hospital stays for chronic or acute conditions, including older adults and people with disabilities who meet a minimum of 3 of the following criteria:

- Age 50 or older
- Two or more chronic conditions
- Four or more prescribed medications
- Two or more hospitalizations and/or four ED visits in the past 12 months

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- Active mental health issue and/or substance use disorder
- Low health literacy
- Limited English proficiency
- Limited engagement with primary care (no primary care visit in the last six months)
- Homeless or housing instability
- Limited community supports, ineligible for other programs such as Health Homes

Alternatively, a clinical provider's determination of high risk for readmission is acceptable without regard to the above criteria.

HealthierHere's analysis also confirmed that Medicaid hot spot members are likely to exist in multiple focus populations. Of note, 69% of hot spot members are included in two or more project focus populations and 40% are in three or more focus populations. HealthierHere anticipates that many of the members with one of the diagnoses above will also have or be at risk for chronic disease conditions (e.g., diabetes) that are the focus of other HealthierHere projects or will be transitioning from a care setting of interest (e.g., jail, inpatient). Therefore, HealthierHere will require its partners to approach all beneficiaries through an integrated whole person care approach, meaning there will essentially be "no wrong door" to entering treatment and all beneficiaries will undergo comprehensive screening. Under this approach, for example, a beneficiary with a SUD will benefit from providers' efforts to integrate physical and behavioral health as well as their efforts to enhance care for chronic conditions.

Finally, consistent with its health equity mission, HealthierHere will make a concerted effort to identify members in what HealthierHere refers to as "hidden" populations. These members may seek services through non-Medicaid providers and therefore are not represented in the claims-level analysis, or they may not seek services at all due to lack of access or other reasons. HealthierHere believes this hidden population likely has high needs, similar to the needs of the hot spot and focus populations, and will work with its CBO partners to identify and reach out to members who may otherwise be hidden from the Medicaid health care ecosystem.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

3. Expansion or Scaling of Transformation Strategies and Approaches

Inherent to the “hot spotting” approach described above is a target population expansion strategy. Initially, HealthierHere will focus MTP activities on Medicaid beneficiaries in hot and hidden spots, and over the course of the MTP, transformation strategies and approaches will be expanded to members in warm spots. Warm spots include members with lower utilization of services than members in hot spots, such as members with one or two ED visits per year. Importantly, all members who present at a partner with critical needs and conditions will be treated using an increasingly team-based and integrated whole person care approach. See Figure 11, Hot Spotting Approach.

HealthierHere will achieve this expansion by:

- Engaging a broader provider community – HealthierHere will take a phased approach to provider engagement, informed by both its capacity to meaningfully support providers and providers’ capacity to implement projects. All providers interested in the MTP and who wish to participate will have access to training opportunities with HealthierHere, learning collaboratives focused on the evidence-based models and best practices, and potential access to some system-level investments (e.g., HIE) as they become available. As partners become ready to engage in HealthierHere projects they will have the opportunity to access partner-level infrastructure investments as well as project-specific investments (e.g., training) to ensure their success. HealthierHere is in the process of identifying these levels of partner engagement and support.
- Deepening CBO engagement – As HealthierHere partners with increasing numbers of CBOs, it will be better positioned to serve populations who are currently underutilizing services; today, these individuals likely receive social or other services from CBOs and consider them to be trusted entities in their communities.
- Spreading best practices – HealthierHere will work with its partnering providers to identify and scale innovative approaches implemented through the MTP; partnering providers will share these practices through project-specific learning collaboratives and other stakeholder convenings.
- Aligning strategies with commercial payers and Medicare – HealthierHere will work with the state, commercial payers, and Medicare to align transformation strategies and corresponding VBP models.

HealthierHere envisions successful project strategy dissemination and uptake throughout the region.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- Improvements in outcomes and reductions in cost will encourage providers to adopt the strategies. For example:
- A reduction in readmission rates and an improvement in health for the populations targeted by each project will demonstrate the value of a strong transitional care program and lead to broader adoption of such efforts in the region.
 - The use of reentry case management and CHWs to demonstrate the efficacy of nontraditional health workers will lead to more widespread use of such workers and increased career pathways.
 - HealthierHere will work with MCOs and providers to adjust payment models to include payment for CHW time and interventions, such as accompanying clients to appointments.
 - The value of a coordinated approach could facilitate an increase in bundled payments, VBP, and other types of reimbursement models.
 - If demonstrated success of the Transitional Care Project offsets costs in other areas, such as criminal justice costs to King County government, savings could be redirected to invest further in transitional care activities as well as the community-based services and supports necessary to make this project successful (e.g., affordable housing).

Project 2D: Diversion Interventions

1. Transformation Strategies and Approaches

2. Target Populations

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

3. Expansion or Scaling of Transformation Strategies and Approaches

Project 3A: Addressing the Opioid Use Public Health Crisis

1. Transformation Strategies and Approaches

a. Evidence-based Approaches

HealthierHere and its partnering providers will implement the following evidence-based approaches to address the opioid use public health crisis through:

1. Prevention of opioid-related overdoses
2. Expanding access to opioid treatment
3. Promoting opioid prescribing practices

1. Prevention of Opioid-related Overdoses

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County’s transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

primary care providers, behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.

- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Screen for OUD and individuals at risk of overdose in medical and behavioral health settings as part of a robust person-centered care approach.
 - Organizations should use a recognized screening tool and have a standard protocol for screening.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification.
- Establish protocols for referring individuals with OUD to the appropriate modality of medication-assisted treatment (MAT) -- opioid treatment programs or office-based opioid treatment.
- Utilize motivational interviewing to encourage individuals to participate in treatment, as appropriate.
- Refer individuals to community support specialists (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide overdose education to individuals seen or at risk for opioid overdose.
- Provide all individuals seen or at risk for opioid overdose with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals who are ready to begin recovery to a community support specialist with common lived

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

experience (e.g. a recovery coach or peer support specialist) who can assist individuals to regain control over their lives and their own recovery process. A community support specialist or a member of the integrated health care team will conduct in-person visits and follow-up by phone and/or telehealth options in service of the following goals:

- a. Increase self-management skills
- b. Ensure personal goals are congruent with individual's self-efficacy
- c. Improve continuity of care with primary care follow-up
- d. Ensure medication management and reconciliation with primary care or other providers including pharmacists
- e. Practice advocacy by identifying key questions for primary care providers/specialists
- f. Educate on health system navigation
- g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- Provide take-home naloxone kits to individuals seen for opioid overdose.
- Encourage individuals with OUD entering MAT to get a naloxone kit or prescription.
- Identify community partners, social service organizations, and other organizations who come into contact with individuals at risk of opioid overdose and partner with those organizations and provide them with training and access to naloxone kits.
- Encourage partners to safely distribute naloxone kits to prevent overdose deaths due to OUD.
- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g. transportation, food, shelter).
- For applicable individuals, the community support specialist will communicate with primary care provider and/or specialist(s) regarding the individual's treatment and progress. In such cases, the community support specialist will follow-up after referrals to determine whether resources are accessed and needs are met.

2. Expanding Access to Opioid Treatment

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and the services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers, behavioral health providers, social service providers (e.g. supportive housing providers), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Screen for OUD in medical and behavioral health settings as part of a robust person-centered care approach.
- Utilize motivational interviewing to encourage individuals to participate in treatment, as appropriate.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification (members could include a nurse care manager, recovery coach, peer support specialist, or other appropriate provider.)
- Link individuals with OUD to a primary care medical home with an integrated care team.
- Increase low-barrier access points for treatment induction and access to MAT through onsite providers

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

and/or new partnerships with treatment providers.

- [Expand access to buprenorphine](#) in primary care and behavioral health settings by increasing the number of waived prescribers (physicians, nurse practitioners, physician assistants) and the number of new prescriptions originating in office-based settings.
- Expand access to OTP providers (e.g. methadone treatment) by increasing the number of referrals to OTP for individuals who are most appropriate for that treatment modality.
- Refer individual to community support specialist (e.g. recovery coach, peer support specialist), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide all individuals with OUD with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals who are ready to begin recovery to a community support specialist with common lived experience (e.g. a recovery coach or peer support specialist) who can and assist individuals to regain control over their lives and their own recovery process. A community support specialist or a member of the integrated health care team will conduct in-person visits and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with primary care or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for primary care providers/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g. transportation, food, shelter).
- The integrated care team will work with the individual and community support specialists to support selected activities. For applicable individuals, the community support specialist will communicate with primary care provider and/or specialist(s) regarding the individual's treatment and progress. In such cases, the community support specialist will follow-up after referrals to determine whether resources are accessed and needs are met.

3. Opioid Prescribing Practices

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based on the [Washington State Medical Association](#) and [Washington State Hospital Association's Opioid Pain Management clinical guidance](#), implementing partners will utilize the following key strategies.

Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Promote the use of the [Prescription Monitoring Program](#) (PMP) and its linkage into electronic health record systems to increase the number of providers regularly using the PMP.
- Distribute the Washington State Medical Association/Washington State Hospital Association/Health Care Authority opioid-prescribing variance reports with prescribers. Use of these variance reports allows prescribers to evaluate their prescribing practices relative to others in the state and to update and improve their practice.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Support adoption of non-opioid pain management strategies where appropriate.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification.
- Improve practice management of patients on chronic opioid therapy by adopting best practices such as the [Six Building Blocks](#).
 - Make [Six Building Blocks](#) experts and practice coaches available for individual consultation and practice-level assistance.
- Improve opioid prescribing practices in EDs.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Link to Community Resources:

- Promote [safe storage and disposal](#) of opioids and other medication, making those resources available and accessible to individuals who may have unused prescription opioids.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g. transportation, food, shelter).
- The integrated care team will work with the individual and community support specialists to support selected activities. For applicable individuals, the community support specialist will communicate with primary care provider and/or specialist(s) regarding the individual's treatment and progress. In such cases, the community support specialist will follow-up after referrals to determine whether resources are accessed and needs are met.

(See *Appendix D. Clinical Summaries* for more information on transformation strategies and approaches).

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

4. Target Populations

HealthierHere used a population health lens to understand target and “focus” populations across its portfolio and within individual projects. The analysis began by identifying 533,929 King County residents who had at least one day of Medicaid coverage between April 1, 2016, and March 31, 2017. To align with official inclusion criteria used by HCA in calculating pay-for-performance measures for each ACH region, HealthierHere removed individuals with a greater than 30-day gap in continuous coverage or any dual Medicare eligibility during the measurement period, reducing the cohort size to 304,406 individuals.

The majority of members had no emergency department (ED) visits (74%), hospital stays for med/surg reasons (98%), or behavioral health-related hospital stays (99%) during the measurement period. Of the members, 5.1% had three or more ED visits, and these members accounted for 49% of all ED visits in the cohort during the measurement period. Further, 6,085 members had one or more med/surg hospital stays, accounting for 100% of all med/surg hospital stays. Similarly, 4,139 members had one or more behavioral health-related hospital stays, accounting for 100% of all such hospital stays.

Members who had three or more ED visits or one or more of either a med/surg or behavioral health-related hospital stay comprise the “hot spot” cohort – this includes 20,357 members. Compared to the larger cohort, the hot spot cohort includes a higher percentage of members ages 25-64 and a smaller percentage of members ages 5-17. Hot spot members were also more likely to be American Indian/Alaska Native, black, and white, and more likely to report English as a preferred written or spoken language.

From previous analyses done as part of the project plan, HealthierHere knows there are approximately 12,000 Medicaid beneficiaries with OUDs in King County. While HealthierHere awaits further definition of this project’s metrics from HCA, it is using these 12,000 Medicaid beneficiaries as its hot spot, or focus, population.

Partnering providers will be asked to focus their efforts on individuals who fit the following profiles:

Prevention of Opioid-related Overdoses: Medicaid members who are at risk for prescription and non-prescription opioid abuse or who have a history of opioid-related overdoses as well as the individuals and service providers who are likely to encounter them.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Expanding Access to Opioid Treatment: Medicaid members with or suspected of having OUD (i.e. presenting with signs/symptoms of OUD in emergency departments, needle exchanges, primary care settings, behavioral health centers, etc.). Individuals may not yet be identified as having OUD but through system engagement can be screened, diagnosed, provided with a pathway to treatment.

Promoting Opioid Prescribing Practices: Medicaid members age 18 and older who are receiving a new opioid prescription and emergency departments (ED), primary care practices, and dental practices serving a high volume of Medicaid members.

HealthierHere's analysis also confirmed that Medicaid hot spot members are likely to exist in multiple focus populations. Of note, 69% of hot spot members are included in two or more project focus populations and 40% are in three or more focus populations. HealthierHere anticipates that many of the members with one of the diagnoses above will also have or be at risk for chronic disease conditions (e.g., diabetes) that are the focus of other HealthierHere projects or be transitioning from a care setting of interest (e.g., jail, inpatient). Therefore, HealthierHere will require its partners to approach all beneficiaries through an integrated whole person care approach, meaning there will essentially be "no wrong door" to entering treatment and all beneficiaries will undergo comprehensive screening. Under this approach, for example, a beneficiary with a SUD will benefit from providers' efforts to integrate physical and behavioral health as well as their efforts to enhance care for chronic conditions.

Finally, consistent with its health equity mission, HealthierHere will make a concerted effort to identify members in what HealthierHere refers to as "hidden" populations. These members may seek services through non-Medicaid providers and therefore are not represented in the claims-level analysis, or they may not seek services at all due to lack of access or other reasons. HealthierHere believes this hidden population likely has high needs, similar to the needs of the hot spot and focus populations, and will work with its CBO partners to identify and reach out to members who may otherwise be hidden from the Medicaid health care ecosystem.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

1. Expansion or Scaling of Transformation Strategies and Approaches

Inherent to the “hot spotting” approach described above is a target-population expansion strategy. Initially, HealthierHere will focus MTP activities on Medicaid beneficiaries in hot and hidden spots, and over the course of the MTP, transformation strategies and approaches will be expanded to members in warm spots. Warm spots include members with lower utilization of services than members in hot spots, such as members with one or two ED visits per year. Importantly, all members who present at a partner with critical needs and conditions will be treated using an increasingly team-based and integrated whole person care approach. See Figure 11, Hot Spotting Approach.

HealthierHere will achieve this expansion by:

- Engaging a broader provider community – HealthierHere will take a phased approach to provider engagement, informed by both its capacity to meaningfully support providers and providers’ capacity to implement projects. All providers interested in the MTP and who wish to participate will have access to training opportunities with HealthierHere, learning collaboratives focused on the evidence-based models and best practices, and potential access to some system-level investments (e.g., HIE) as they become available. As partners become ready to engage in HealthierHere projects they will have the opportunity to access partner-level infrastructure investments as well as project-specific investments (e.g., training) to ensure their success. HealthierHere is in the process of identifying these levels of partner engagement and support.
- Deepening CBO engagement – As HealthierHere partners with increasing numbers of CBOs, it will be better positioned to serve populations who are currently underutilizing services; today, these individuals likely receive social or other services from CBOs and consider them to be trusted entities in their communities.
- Spreading best practices – HealthierHere will work with its partnering providers to identify and scale innovative approaches implemented through the MTP projects; partnering providers will share these practices through project-specific learning collaboratives and other stakeholder convenings.
- Aligning strategies with commercial payers and Medicare – HealthierHere will work with the state, commercial payers, and Medicare to align transformation strategies and corresponding VBP models.

HealthierHere envisions many of the transformation strategies described above being expanded across the ACH

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

region in later Delivery System Reform Incentive Payment (DSRIP) years through participation of new providers and existing providers and their use of the strategies with new patients. For example:

- Sustainability of transformation in prescribing practices will occur through robust and comprehensive training of many physicians, dentists, and other prescribers who prescribe pain medication on the AMDG guidelines and partnering with providers to develop policies in line with these guidelines.
- Offering providers effective and efficient non-opioid pain management supports can help avoid initial opioid prescriptions. Once these non-opioid pain management strategies are learned, they can be offered to new and existing clients.
- HealthierHere will work closely with MCOs and other partners to consider how payment models can be developed to sustain these new structures, particularly around low-barrier access to MAT. Both the care coordination and bi-directional integration of care strategies can also promote sustainability of expanded treatment approaches.
- The initiative to develop MAT treatment infrastructure will develop resources that currently are not available and eventually will be Medicaid reimbursable, leading to sustainability. Although MAT is already a covered benefit through Medicaid, the project will help eliminate the staffing and capacity barriers to developing new MAT programs.
- Developing naloxone distribution mechanisms will lead to an ongoing practice of distributing this overdose prevention medication through health, behavioral health, housing, criminal justice, and other organizations. This practice, coupled with enhanced treatment and conservative prescribing practices, will prevent deaths, treat OUD, and prevent the disorder in the first place.

Project 3B: Reproductive and Maternal/Child Health

1. Transformation Strategies and Approaches

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

2. Target Populations

3. Expansion or Scaling of Transformation Strategies and Approaches

Project 3C: Access to Oral Health Services

1. Transformation Strategies and Approaches

2. Target Populations

3. Expansion or Scaling of Transformation Strategies and Approaches

Project 3D: Chronic Disease Prevention and Control

1. Transformation **a. Evidence-based Approaches**

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Strategies and Approaches

HealthierHere and its partnering providers will implement the chronic disease prevention and control project with a focus on:

1. Asthma and COPD
2. Cardiovascular Disease
3. Diabetes

1. Asthma and COPD

The following interventions are strongly recommended for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [Chronic Care Model](#), NHLBI & NAEPF recommendations, and Global Initiatives for Asthma & COPD recommendations, implementing providers will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Ensure that registry is in place to allow for identification of target population, and establish a process for adding appropriate individuals to registry (e.g individuals who have asthma and/or COPD without a corresponding ICD-10 code on the problem list).
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- Whole person care needs include the following: physical health, substance use, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Identify individuals with asthma and COPD, and assess and monitor their severity levels using spirometry.
- Control conditions with appropriate treatment (e.g. medication, pulmonary rehabilitation, etc.).
- Make referrals to asthma specialists for individuals with uncontrolled asthma and/or individuals in need of Step 4 or higher treatment.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a social worker, community support specialist, or other appropriate provider.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.
- For individuals with asthma, create an Asthma Action Plan and support individuals in self-monitoring of asthma symptoms.

Provide Self-Management Support:

- Provide all individuals with asthma or COPD should with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- A community support specialist should assess the home environment and work with individuals on remediation (e.g. allergen and irritant exposure control).

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- Refer individuals at highest risk for complications from asthma and/or COPD to a community support specialist (e.g. community health worker, peer educator, or health coach) who will conduct in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can “teach back” expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services and/or chronic disease self-management programs.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual's needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and a community support specialist to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

2. Cardiovascular Disease

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Based upon the [Chronic Care Model](#) and the [Million Hearts 2022](#) treatment protocols, implementing providers will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Ensure that a registry is in place to allow for identification of focus population, and establish a process for adding appropriate individuals to registry (e.g. individuals who have CVD without a corresponding ICD-10 code on the problem list).
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Identify and risk stratify individuals with diabetes.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a registered dietician, social worker, or other appropriate provider.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Ensure each member of the focus population has a planned CVD visit in which their CVD risk factors are assessed. This assessment should also include behavioral health, oral health, and social determinants of health. Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide all individuals with CVD with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals at highest risk for complications from CVD to a community support specialist (e.g. community health worker, peer educator, or health coach) who will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services and/or chronic disease self-management programs.
- To address the social determinants of health, the integrated care team will connect the individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and a community support specialist to support selected activities. In such cases, the community support specialist will communicate with primary care providers and/or specialist(s) regarding the individual's treatment and progress.

3. Diabetes

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [Chronic Care Model](#) and the [American Diabetes Association Standards of Medical Care in Diabetes](#) recommendations, implementing providers will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers, behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Ensure that registry is in place to allow for identification of target population, and establish a process to for adding appropriate individuals to registry (e.g. individuals who have diabetes without a corresponding ICD-10 code on the problem list).
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Identify and risk stratify individuals with type 1 or type 2 diabetes.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a registered dietician, social worker, or other appropriate provider.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- Ensure each member of the focus population has a planned diabetes visit in which their glycemic control, cardiovascular risk factors, and end-organ damage are assessed. This assessment should also include behavioral health, oral health, and social determinants of health.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally relevant treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide all individuals with diabetes with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals at highest risk for complications from diabetes to a community support specialist (e.g., community health worker, peer educator, or health coach) who will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with primary care or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for primary care providers/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services and/or chronic disease self-management programs.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

individual’s needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and a community support specialist to support selected activities. In such cases, the community support specialist will communicate with primary care providers and/or specialist(s) regarding the individual’s treatment and progress.

(See *Appendix D. Clinical Summaries* for more information on transformation strategies and approaches).

2. Target Populations

HealthierHere used a population health lens to understand target and “focus” populations across its portfolio and within individual projects. The analysis began by identifying 533,929 King County residents who had at least one day of Medicaid coverage between April 1, 2016, and March 31, 2017. To align with official inclusion criteria used by HCA in calculating pay-for-performance measures for each ACH region, HealthierHere removed individuals with a greater than 30-day gap in continuous coverage or any dual Medicare eligibility during the measurement period, reducing the cohort size to 304,406 individuals.

The majority of members had no emergency department (ED) visits (74%), hospital stays for med/surg reasons (98%), or behavioral health-related hospital stays (99%) during the measurement period. Of the members, 5.1% had three or more ED visits, and these members accounted for 49% of all ED visits in the cohort during the measurement period. Further, 6,085 members had one or more med/surg hospital stays, accounting for 100% of all med/surg hospital stays. Similarly, 4,139 members had one or more behavioral health-related hospital stays, accounting for 100% of all such hospital stays.

Members who had three or more ED visits or one or more of either a med/surg or behavioral health-related hospital stay comprise the “hot spot” cohort – this includes 20,357 members. Compared to the larger cohort, the hot spot cohort includes a higher percentage of members ages 25-64 and a smaller percentage of members ages 5-17. Hot spot members were also more likely to be American Indian/Alaska Native, black, and white, and more likely to report English as a preferred written or spoken language.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

HealthierHere then used the hot spot cohort to define the focus population aligned with each project. For purposes of this project, HealthierHere identified members with an asthma, COPD, diabetes, or cardiac diagnosis, defined as:

- Asthma: Members with an asthma diagnosis any time after January 1, 2012
- COPD: Members with a COPD diagnosis any time after January 1, 2012
- Diabetes: Members with a diabetes diagnosis any time after January 1, 2012
- Cardiac: Members with a diagnosis of ischemic heart disease, heart failure, or hypertension any time after January 1, 2012

Partnering providers implementing this project, will be asked to focus their efforts on:

Asthma and COPD: Medicaid members age 5 and older with uncontrolled asthma or COPD, defined as having one or more ED visit or hospitalization for the condition(s) in the past 12 months.

Cardiovascular Disease: Medicaid members age 18 and older with an ICD-10 code on the problem list diagnosing CVD. Individuals with CVD are considered at high risk for complications if they are not currently taking aspirin or a statin, have uncontrolled blood pressure $\geq 140/90$, and/or are smokers.

Diabetes: Medicaid members age 18 and older with an ICD-10 code on the problem list diagnosing type 1 or type 2 diabetes. Individuals with diabetes are considered at high risk for complications with one or more of the following: HbA1c $>9\%$, blood pressure $\geq 140/90$, history of cardiovascular disease, one or more emergency department visits in past 12 months related to diabetes, and history of smoking/tobacco use.

HealthierHere's analysis also confirmed that Medicaid hot spot members are likely to exist in multiple focus populations. Of note, 69% of hot spot members are included in two or more project focus populations and 40% are in three or more focus populations. HealthierHere anticipates that many of the members with one of the diagnoses above will also have or be at risk for chronic disease conditions (e.g., diabetes) that are the focus of other HealthierHere projects or be transitioning from a care setting of interest (e.g., jail, inpatient). Therefore, HealthierHere will require its partners to approach all beneficiaries through an integrated whole person care

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

approach, meaning there will essentially be “no wrong door” to entering treatment and all beneficiaries will undergo comprehensive screening. Under this approach, for example, a beneficiary with a SUD will benefit from providers’ efforts to integrate physical and behavioral health as well as their efforts to enhance care for chronic conditions.

Finally, consistent with its health equity mission, HealthierHere will make a concerted effort to identify members in what HealthierHere refers to as “hidden” populations. These members may seek services through non-Medicaid providers and therefore are not represented in the claims-level analysis, or they may not seek services at all due to lack of access or other reasons. HealthierHere believes this hidden population likely has high needs, similar to the needs of the hot spot and focus populations, and will work with its CBO partners to identify and reach out to members who may otherwise be hidden from the Medicaid health care ecosystem.

3. Expansion or Scaling of Transformation Strategies and Approaches

Inherent to the “hot spotting” approach described above is a target population expansion strategy. Initially, HealthierHere will focus MTP activities on Medicaid beneficiaries in hot and hidden spots, and over the course of the MTP, transformation strategies and approaches will be expanded to members in warm spots. Warm spots include members with lower utilization of services than members in hot spots, such as members with one or two ED visits per year. Importantly, all members who present at a partner with critical needs and conditions will be treated using an increasingly team-based and integrated whole person care approach. See Figure 11, Hot Spotting Approach.

HealthierHere will achieve this expansion by:

- Engaging a broader provider community – HealthierHere will take a phased approach to provider engagement, informed by both its capacity to meaningfully support providers and providers’ capacity to implement projects. All providers interested in the MTP and who wish to participate will have access to training opportunities with HealthierHere, learning collaboratives focused on the evidence-based models and best practices, and potential access to some system-level investments (e.g., HIE) as they become available. As partners become ready to engage in HealthierHere projects they will have the opportunity to access partner-level infrastructure investments as well as project-specific investments (e.g., training) to ensure their success. HealthierHere is in the process of identifying these levels of partner engagement and support.

Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

- Deepening CBO engagement – As HealthierHere partners with increasing numbers of CBOs, it will be better positioned to serve populations who are currently underutilizing services; today, these individuals likely receive social or other services from CBOs and consider them to be trusted entities in their communities.
- Spreading best practices – HealthierHere will work with its partnering providers to identify and scale innovative approaches implemented through the MTP; partnering providers will share these practices through project-specific learning collaboratives and other stakeholder convenings.
- Aligning strategies with commercial payers and Medicare – HealthierHere will work with the state, commercial payers, and Medicare to align transformation strategies and corresponding VBP models.

The project will help providers incorporate community-based care coordination and chronic disease management into how they do business so that this practice becomes “the new norm” across King County. CHWs and other program elements will reduce clinical costs, and the savings can be funneled back into the program, including paying for services currently not funded by Medicaid. During the project, HealthierHere and its partners will track services and outcomes to identify how financial support for CHWs affects which services are used and whether health is improved. This information can be used to build VBP arrangements that will support ongoing chronic disease management activities.

Successful project strategies can be incorporated into care delivery across disease conditions and payers. The project will transform how care is provided for all individuals and create a healthier county and state population by incorporating CHWs as key treatment team partners in care delivery, and building strong partnerships between clinical care teams and community-based services. CHWs will help bring people into care, improve the cultural and linguistic responsiveness of care, and support self-management. These improvements will help reduce costs, allowing further investment in appropriate care that values outcomes over number of services for all people seeking care in Washington.

4. What specific outcomes does the ACH expect to achieve by the end of the Transformation if the ACH and its partnering providers are successful? How do these outcomes support regional transformation objectives?

ACH Response:

HealthierHere has articulated five core values that embody what the organization aims to achieve by the end of the MTP.

Figure 12. **HealthierHere Core Values**

Equity. HealthierHere leads with equity. We work to eliminate disparities in health and well-being and address the current power dynamic and structural racism in our health care system that perpetuates inequities.

Partnership. Intentional partnerships between government agencies and community and partnering providers is critical. No one participant or sector controls the direction, agenda, and decision-making. We take a multisector, multipronged approach to make systemic change at the local, state, and federal levels.

Results. HealthierHere improves health outcomes across King County, with a particular focus on health equity and eliminating disparities. We prioritize resources and efforts to those most marginalized. We implement strategies that can scale for broader population health impact.

Community. Populations most impacted by health inequities play a substantive role in our work and are valued for their expertise. We ensure community members have what they need to engage effectively and develop formal, ongoing feedback processes for those making decisions to respond to and take action on consumer recommendations.

Innovation. HealthierHere commits to fundamental system transformation. We prioritize strategies that improve health care delivery and address population health, prevention, and the social determinants of health. We model continuous learning.

These core values led HealthierHere to identify three specific outcomes or “leave behinds” that will support regional transformation. HealthierHere views these outcomes as critical to sustainable health system transformation and is committed to achieving these through collaboration with its partners. Together, the core values and leave behinds inform everything HealthierHere does and will invest in.

The outcomes are:

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

2. Access to person-centered, multidisciplinary, culturally competent care teams – inclusive of social services – in health homes for everyone, regardless of where a person enters the system.
3. An infrastructure that provides an effective mechanism for meaningful community and consumer involvement and voice in the continuous improvement of the delivery system.

HealthierHere is designing and implementing its projects to advance these outcomes. Immediate and long-term project goals are below.

Figure 13. **Immediate and Long-Term Project Goals**

Project	Project Goals	
	Immediate	Long-Term
2A. Bi-Directional Integration of Physical and Behavioral Health through Care Transformation		
Integrated Whole Person Care in Community Behavioral Health Centers	Increase access to primary care services and improve screening rates for selected chronic conditions among individuals enrolled in behavioral health services.	Integrate primary care services into community behavioral health centers in King County.
Integrated Whole Person Care in Primary Care Settings	Improve identification of behavioral health needs and access to behavioral health services (both mental health and substance use treatment) for individuals being served in primary care settings.	Integrate behavioral health services into primary care practices in King County. Expand links to specialty behavioral health, including psychiatry.
2C. Transitional Care		
Transitions of Care from Jail	Implement an integrated whole person model of care that ensures safe and successful transitions from jails back into community settings.	Reduce avoidable emergency department (ED) visits and hospital readmissions, as well as readmissions to jail. Expand community-based support services for high-risk individuals leaving jails, including those individuals who experience homelessness.
Psychiatric Care Transitions from Hospital Settings	Implement an integrated whole person model of care that ensures safe and successful transitions from psychiatric hospitals back	Reduce preventable emergency department (ED) visits and hospital readmissions due to

Project Goals		
Project	Immediate	Long-Term
	into community settings, such as home or skilled nursing facilities.	behavioral health disorders. Ensure continuity of care.
Transitions of Care: Hospital Discharges for High-Risk Medicaid Clients	Implement an integrated whole person model of care that ensures safe and successful transitions from the hospital back into community settings, such as home or skilled nursing facilities.	Reduce avoidable emergency department (ED) visits and hospital readmissions. Ensure continuity of care and redirect resources available to focus on long-term prevention and promotion rather than short-term crisis response.
3A. Addressing the Opioid Use Public Health Crisis		
Prevention of Opioid-related Overdoses	Reduce opioid overdose deaths by providing at-risk individuals, and those who frequently interact with them, with take-home naloxone kits and supporting education and awareness around overdose prevention.	Reduce deaths, non-fatal overdoses, onset of opioid use disorder (OUD), and harm to King County residents from prescription and non-prescription opioids through promotion of safer use strategies and harm reduction.
Opioid Prescribing Practices	Increase the number of medical and dental providers trained on opiate prescribing practices such as Interagency Guideline on Prescribing Opioids for Pain and Dental Guideline on Prescribing Opioids for Acute Pain Management.	Reduce deaths, non-fatal overdoses, onset of opioid use disorder (OUD), and harm to King County residents from prescription opioids, while expanding use of non-opioid pain management.
Expanding Access to Opioid Treatment	Increase screening for opioid use disorder (OUD) and improve access and accessibility to appropriate and sustainable treatment including both modalities of medication-assisted treatment (MAT), office-based opioid treatment (OBOT) and opioid treatment programs (OTP).	Reduce deaths, non-fatal overdoses, onset of OUD, and harm to King County residents from prescription and non-prescription opioids.
3D. Chronic Disease Prevention and Control		
Chronic Disease Prevention – Asthma and COPD	Identify individuals with asthma and chronic obstructive pulmonary disease (COPD), stratify risk level, and improve	Decrease rates of asthma- and COPD-related complications in those with the diseases. Empower individuals to achieve successful

Project Goals		
Project	Immediate	Long-Term
	care coordination for highest risk individuals. Increase home-based services to manage the conditions.	self-management practices. Sustain home-based services to manage the conditions and reduce avoidable asthma- and COPD-related emergency department (ED) visits and hospital admissions.
Chronic Disease Prevention – Cardiovascular Disease	Identify individuals with cardiovascular disease (CVD), stratify risk level, and improve care coordination for highest risk individuals.	Decrease rates of CVD-related complications in those with the disease. Improve blood pressure control. Improve hyperlipidemia. Empower individuals with CVD to implement successful self-management practices.
Chronic Disease Prevention – Diabetes	Identify individuals with diabetes, stratify risk level, and improve care coordination for highest risk individuals.	Decrease rates of diabetes-related complications in those with the disease. Empower individuals with diabetes to implement successful self-management practices.

D. Milestone 4: Identification of Partnering Providers

This milestone is completed by executing Master Services Agreements (formally referred to as Standard Partnership Agreements) with partnering providers that are registered in the Financial Executor Portal. For submission of this Semi-Annual Report, HCA will export the list of partnering providers registered in the Portal as of June 30, 2018.

1. The state understands that not all ACH partnering providers participating in transformation activities will be listed in the Financial Executor portal export. In the attached Excel file, under the tab D.1, “Additional Partnering Providers,” list additional partnering providers that the ACH has identified as participating in transformation activities, but are not registered in the Financial Executor Portal as of June 30, 2018.

Complete item D.1 in the Semi-Annual Report Workbook.

Section 2: Standard Reporting Requirements

This section outlines requests for information that will be included as standard reporting requirements for each Semi-Annual Report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-Level Reporting Requirements

A. ACH Organizational Updates

1. **Attestations:** In accordance with the Transformation’s STCs and ACH certification requirements, the ACH attests to being in compliance with the items listed below during the reporting period.

	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
b. The ACH has an Executive Director.	X	
c. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: PCPs, behavioral health providers, health plans, hospitals or health systems, local public health jurisdictions, tribes/Indian Health Service (IHS) facilities/Urban Indian Health Programs (UIHPs) in the region, and multiple community partners and CBOs that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	X	
d. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.	X	
e. Meetings of the ACH’s decision-making body are open to the public.	X	

2. If unable to attest to one or more of the above items, explain how and when the ACH will come into compliance with the requirements. If the ACH checked “Yes” for all items, respond “Not Applicable.”

ACH Response: *Not Applicable*

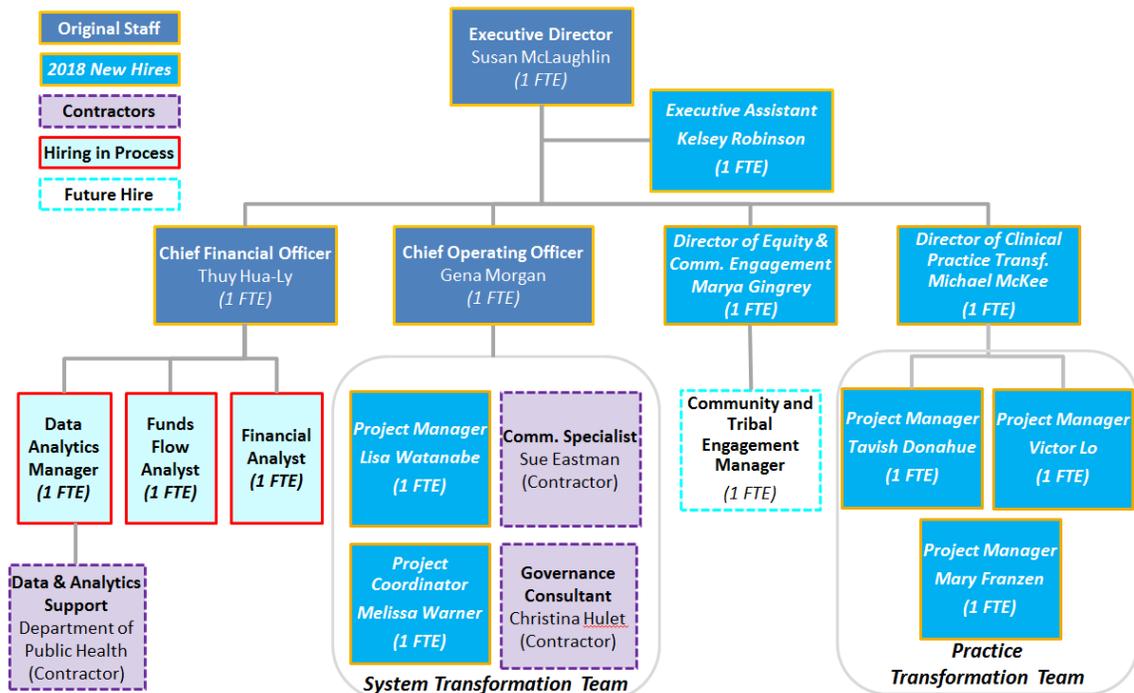
3. **Key Staff Position Changes:** Provide a current organizational chart for the ACH. Use ***bold italicized font*** to highlight changes, if any, to key staff positions during the reporting period. Place an “X” in the appropriate box below.

	Yes	No
Changes to Key Staff Positions during Reporting Period	X	

Insert or Include as an Attachment: Organizational Chart

The following organizational chart depicts the current HealthierHere organizational structure and changes to key staff positions in the reporting period.

Figure 14. **Organizational Chart**



B. Tribal Engagement and Collaboration

1. In the table below, provide a list of tribal engagement and collaboration activities that the ACH conducted during the reporting period. These activities may include relationship building between the ACH and tribal governments, IHS facilities, and UIHPs, or further engagement and collaboration on project planning and/or implementation. Add rows as needed.

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome/Next Steps
Seattle Indian Health Board Representation on Governing Board	Monthly meetings	Esther Lucero, Governing Board co-chair	Healthier Here staff and Governing Board	Strategic direction on opportunities for tribal engagement and participation	Continued input on Healthier Here's strategic direction and investments
Cowlitz Indian Tribe Participation on Governing Board	Monthly meetings	Stephen Kutz	Healthier Here staff and Governing Board	Strategic direction on opportunities for tribal engagement and participation	Continued input on Healthier Here's strategic direction and investments
Meeting with Cowlitz Tribe Leadership	May 23, 2018	Cowlitz leadership	Susan McLaughlin and Cowlitz leadership	Identify how the Cowlitz tribe and health center see themselves involved in the MTP	Determined next steps for continued engagement and collaboration
Meeting with Seattle Indian Health Board Leadership	June 14, 2018	Health Board leadership	Susan McLaughlin and Health Board leadership	Discuss how the tribes fit into the MTP and ACH activities	Additional collaboration on outreach to tribes
Outreach to Snoqualmie Tribe	Ongoing	Tribal leadership	Susan McLaughlin and Governing Board members	Introduce the ACH and opportunities for collaboration/funding	No response from tribe to date; ACH to continue outreach efforts
Outreach to Muckleshoot Tribe	Ongoing	Tribal leadership	Susan McLaughlin and Governing	Introduce the ACH and opportunities for	No response from tribe to date; ACH to continue outreach efforts

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome/Next Steps
			Board members	collaboration/funding	
Participation in HCA-Indian Health Services (IHS) Meetings	Twice a month	State officials, ACHs, ACH tribal representatives, and other stakeholders	State and county officials, ACHs, tribal representatives, and other stakeholders	Discuss IHS and tribal engagement and opportunities for alignment with ACH work	Continued engagement and identified opportunities for alignment in work; assistance with tribal engagement

Project Reporting Requirements

C. Project Status Update

1. Provide a status update that highlights Transformation planning progress by listing activities that have occurred during the reporting period in the table below. Indicate the project(s) for which the activity applies. If the activity applies to all projects, indicate as such. Are project activities progressing as expected? What are the next steps? Add rows as needed.

Examples of activities may include, but are not limited to the following:

- *The ACH secured Memoranda of Understanding (MOUs), change plans, or other agreements with partnering providers.*
- *Partnering providers have completed training on project interventions.*
- *Partnering providers have adopted and/or are using project tools/protocols.*
- *The ACH has invested in and/or provided technical assistance for partnering providers.*
- *The ACH has invested in and/or implemented new resources for project management (e.g. IT advancements).*
- *New services are being offered/provided to Medicaid beneficiaries.*

Project Status Update			
Key Activity	Associated Project Areas	Is Activity Progressing as Expected? (Y/N)	Next Steps
Convened monthly Partner Summits to familiarize stakeholders and partnering providers with the MTP activities/requirements, HealthierHere projects, timelines, and opportunities; meetings were facilitated in person through March 2018 and as webinars April through June	All projects	Y	Continue regular Partner Summits via webinar to share updates; webinars are open to all interested stakeholders and posted to HealthierHere's website
Established implementation work groups in March 2018 and facilitated meetings in March and May	All projects	Y	<p>Adjust work group rosters to ensure critical partnering providers are represented, especially partners' clinical and quality improvement leadership</p> <p>Augment work groups with subject matter experts as needed</p> <p>Continue shift to implementation planning through meeting agendas and materials</p> <p>Convene and coordinate with project-specific subgroups (see below)</p> <p>Identify potential cross-cutting needs/issues for elevation to Transformation Committee and Governing Board</p>
Established and convened project subgroups to refine target populations, evidence-	All projects	Y	Convene all project subgroups as needed to inform project

Project Status Update			
Key Activity	Associated Project Areas	Is Activity Progressing as Expected? (Y/N)	Next Steps
based approaches, project metrics, and innovative approaches			implementation plans and partnering provider change plans Coordinate with overarching project work groups
Developed a Project Specific Agreement (PSA) detailing partnering provider requirements and secured partners' commitments to projects	All projects	Y	Partners will sign PSA by July 30, 2018 HealthierHere will: <ul style="list-style-type: none"> • Issue partner payments • Develop PSA detailing DY2 partnering provider requirements
Developed project tools, including clinical summaries, evidence-based model handouts, timelines, and clinical pathways	All projects	Y	HealthierHere will: <ul style="list-style-type: none"> • Work with partners on implementation • Monitor and report on partners' project progress • Develop a change plan template and issue it to partners by mid-July Partners will develop change plans by mid-August and begin project implementation in the fall
Partners completed CSA and HIE/HIT Assessment, including project-specific questions relative to partners' capabilities; HealthierHere shared results of	All projects	Y	Continue to refine analysis of assessments through stakeholder feedback, and tweak

Project Status Update			
Key Activity	Associated Project Areas	Is Activity Progressing as Expected? (Y/N)	Next Steps
CSA and HIE/HIT Assessment with stakeholders via Partner Summit webinars			project and Domain 1 strategies as needed
1 on 1 meetings with Hospitals/Health Systems	All projects	Y	Complete initial set of meetings with hospitals/health systems and continue to engage with subject matter experts for project planning
Monthly Meetings with Behavioral Health Network	FIMC transition	Y	Continue to meet with behavioral network to advise on transition to FIMC and coordinate and align ACH programmatic activities
Quarterly Meetings with Community Health Center Council	All Projects: FQHCs	Y	Continue to participate in meetings to discuss FQHC's role in projects and transformation activities

Portfolio-Level Reporting Requirements

D. Partnering Provider Engagement

1. During the reporting period, how has the ACH coordinated with other ACHs to engage partnering providers that are participating in projects in more than one ACH?

ACH Response:

HealthierHere has welcomed the opportunity to coordinate with other ACHs and has been both a convener and participant in cross-ACH activity. Highlights from the first half of DY2 are described below.

HealthierHere has been collaborating with the Health Innovation Leadership Network Equity Council and HCA tribal liaison coordinators throughout Washington state. Both collaborations share knowledge, information, and emerging practices designed to advance equity. The tribal liaison collaboration is an opportunity for HealthierHere to authentically engage with Tribal Nations. Through these collaborations, HealthierHere and other ACHs share lessons learned from working with Tribal Nations as well as tools to support outreach.

HealthierHere collaborated with the Pierce County ACH to develop and administer a single HIE/HIT Assessment to all partners who operate in both ACHs. The ACHs also coordinated on development of the CSA, but issued different assessments to their partners. HealthierHere and Pierce County are currently collaborating on the development of partner change plans. This coordination has included at least three meetings among the leadership of the ACHs to discuss approaches and common challenges.

HealthierHere Executive Director Susan McLaughlin regularly meets with other ACH leaders to identify and discuss opportunities for coordination, especially around Domain 1 strategies. One example of such coordination is HealthierHere's ongoing discussions with the Greater Columbia ACH and Olympic Community of Health regarding EDIE and PreManage.

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 coordinate with the state and statewide associations, such as WSHA. Similarly, HealthierHere's CFO Thuy Hua-Ly recently convened a meeting of her peer CFOs across the ACHs to share best practices and discuss payment triggers for DY1 funding. HealthierHere's COO Gena Morgan initiated a program leads work group and has been meeting bimonthly with other ACH program leads to discuss partner engagement strategies, share implementation and change plan approaches, and seek to better coordinate and align ACH programmatic activities. HealthierHere finds these opportunities to share information across ACHs valuable and plans to continue participating in and leading such forums as necessary.

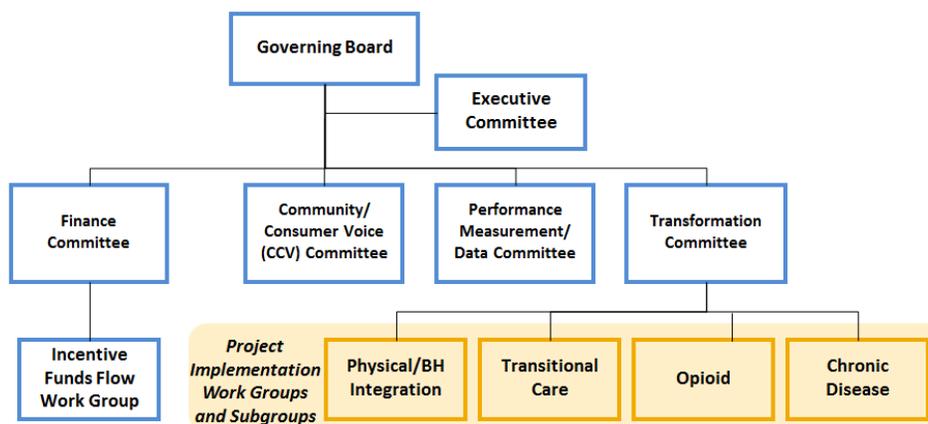
- Briefly describe the ACH's expectations for partnering provider engagement in support of transformation activities.

ACH Response:

HealthierHere's expectations for partnering provider engagement are detailed in the PSA that all partnering providers must sign (See *Appendix E. Medicaid Provider Project-Specific Agreement*). There are six categories of activities for Medicaid partnering provider participation in DY2:

- Completion of the CSA and HIE/HIT Assessment – Partnering providers were required to complete both the CSA and HIE/HIT Assessment by May 25, 2018.
- Development of an organizational-level change plan – Partnering providers will be required to develop an organizational-level change plan this summer. HealthierHere is in the process of developing the change plan template and will issue the change plan with instructions to select partnering providers for completion. In their responses, partnering providers will detail the action steps they will take to implement each project, including identifying responsible actors within the organization, key partners, deliverables, and timelines.
- Participation in the HealthierHere stakeholder process and registration in the financial executor (FE) web portal – Partnering providers must participate in the stakeholder process to inform project planning and implementation as well as Domain 1 strategies. Opportunities for participation include the Governing Board, the Finance Committee, project implementation work groups, the Transformation Committee, the CCV Committee, the Performance Measurement and Data Committee, and Partner Summits. Partnering providers must also register in the FE portal by July 30, 2018. The governance structure is depicted below.

Figure 15. HealthierHere Governance Structure



- Medicaid volume – Partnering providers will be eligible for tiered payments based on the number of unduplicated Medicaid patients they served in 2016 as reflected in Medicaid utilization data. The two tiers are 0-5,000 Medicaid patients and 5,001 or more Medicaid patients.

5. Signature of the PSA for DY2 – The Governing Board approved the DY2 PSA in early June, and partnering providers were required to sign the PSA by July 31, 2018.
6. Signature of the PSA for DY3 – Partnering providers will be required to sign the DY3 PSA by mid-December 2018 (exact date TBD).

A separate PSA was developed for tribal partners; this PSA includes the above categories of activities, except Medicaid volume.

In addition, partnering provider responsibilities for implementation are detailed in the clinical summaries currently under development with the project implementation work groups. These responsibilities are detailed in the response to Milestone 3.

3. Describe the ACH's efforts during the reporting period to engage partnering providers that are critical to success in transformation activities. What barriers to their participation have been identified, and what steps has the ACH taken to address those barriers? Include the steps has the ACH taken to reach partnering providers with limited engagement capacity.

ACH Response:

HealthierHere is actively working to mitigate barriers to partnering providers as well as community participation in the ACH.

Partnering Providers

The primary barrier to participation among partnering providers is capacity. Partnering providers are very busy with their everyday operational responsibilities and organizational initiatives, and many have limited staff. Capacity limitations make it difficult for partnering providers to fully engage in project implementation planning as needed. HealthierHere is acutely aware of this issue and is working with providers to understand what capacity they need to be fully engaged in the MTP and their respective projects. As mentioned above, participation in HealthierHere stakeholder process is a payment point under the PSA and these funds can help offset staffing costs associated with the planning process. Moreover, HealthierHere is considering subsidizing transformation leads within critical provider organizations.

HealthierHere is meeting partnering providers at their organizations and associations. For example, HealthierHere Executive Director Susan McLaughlin regularly meets with the FQHC Council and Behavioral Health Network Association. Participating in these groups' monthly meetings affords HealthierHere a valuable opportunity to communicate critical information to stakeholders in person, build relationships, and host individual follow-up meetings with other participants as needed. HealthierHere Governing Board members and staff also routinely provide updates at the King County Hospitals for a Healthier Community quarterly meeting. HealthierHere leadership has conducted one-on-one meetings with hospitals and other partnering providers throughout King County.

Community Members, Medicaid Consumers, and CBOs

HealthierHere is developing a small grants program to further increase community members', Medicaid consumers', and CBOs' voices in driving transformation in the region. The program is intended to increase participation in HealthierHere community engagement, planning, and implementation activities, including reaching out to CBOs' respective focus populations, especially non-English-speaking populations.

HealthierHere is continuing to make participation in ACH stakeholder activities as accessible and easy as possible. Partner Summits are now conducted via webinar, recorded, and posted to HealthierHere's website for stakeholders unable to attend in real time. Governing Board meetings are open to the public, and the meeting materials, including summaries of all meetings, are posted to HealthierHere's website.

4. For 2019 mid-adopter regions, describe the ACH's process to assess current capacity and readiness of Medicaid behavioral health providers to transition to fully integrated managed care (FIMC). How has the ACH identified, or plan to identify, the needs of Medicaid behavioral health providers?

ACH Response:

HealthierHere assessed behavioral health providers' capacity and readiness for FIMC through the CSA and HIE/HIT Assessment. As described under Milestone 1, the CSA and HIE/HIT Assessment results indicated BHAs lag behind hospitals/health systems and FQHCs in adoption of quality improvement processes, EHRs, chronic disease registries, VBPs, and team-based care models. HealthierHere is actively developing strategies to support BHAs in closing these gaps so they are prepared for the transition to FIMC as well as to be active participants in the MTP.

HealthierHere has built a strong partnership with the King County BHO, which is managing the transition to FIMC and convening stakeholders through eight committees. HealthierHere is a regular and important participant in these committees. The Executive Director sits on the executive committee as well as at a leadership table comprised of county leadership and MCOs. Key HealthierHere staff – the COO, CFO, Director of Equity and Community Partnerships, and Director of Clinical Practice Transformation – sit on the clinical, finance, joint operations, and early warning systems committees. The Executive Director is also actively meeting with BHAs to understand their needs, plan for incentive funding, and inform how the ACH can support the transition to FIMC.

The King County BHO is in the process of developing a comprehensive set of outcome measures to be used as the basis for incentives to BHAs in a VBP environment. As the King County BHO transforms into an independent practice association (IPA), HealthierHere will work with the King County BHO, managed care organizations, and providers to align all efforts in order to advance VBP.

E. Community Engagement

Community engagement refers to outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.

1. In the table below, list the ACH's community engagement activities that occurred during the reporting period. Add rows as needed.

Community Engagement Activities for the Reporting Period						
Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
MIDD Advisory Committee	February 15, 2018	Introduce ACH and its work	County health and human services and criminal justice communities	All	Stakeholder engagement	N
CCV Committee Meeting	February 26, 2018	Convene CCV Committee and kick off activities for DY2	CCV Committee members	All	Advancement of health equity strategies	N
Office of Consumer Partnerships Integration Forum	February 27, 2018	Introduce ACH and its work	Social services, BHAs, and peer support specialists	All, with a focus on bi-directional and opioid-related projects	Stakeholder engagement	N
Office of Consumer Partnerships Integration Forum	March 27, 2018	Update on ACH and its work	Social services, BHAs, and peer support specialists	All	Stakeholder engagement	N

Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Asian Pacific Islander (API) Health Board/White Center Community Development Association	April 23, 2018	Introduce ACH; identify opportunities for engagement	API Health Board and community	All	Stakeholder engagement	N
Regional Collaboration for Racial Equity	April 23, 2018	Introduce ACH; identify opportunities for engagement	Regional health equity stakeholders	All	Advancement of health equity strategies	N
PWI South King County	April 26, 2018	Introduce ACH; identify opportunities for engagement	Community stakeholders	All	Advancement of health equity strategies	N
Rainier Beach Action Coalition	April 27, 2018	Introduce ACH; identify opportunities for engagement	Community stakeholders	All	Information sharing; identified opportunities for collaboration	N
CCV Committee Meeting	April 30, 2018	Convene CCV Committee under leadership of new Director of Equity and Community Partnerships; kick-start community engagement	CCV Committee members	All	Advancement of health equity strategies	N

Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
LW Tech Health Fair	May 2, 2018	Introduce ACH; identify opportunities for engagement	Community members	All	Information sharing; identified opportunities for collaboration	N
Puget Sound Sage – Community Leadership Institute	May 4, 2018	Introduce ACH; identify opportunities for engagement	Program leadership	All	Identified opportunities for collaboration in workforce issues and projects	N
CCV Committee Meeting	May 21, 2018	Continue to advise on health equity and community engagement	CCV Committee members	All	Advancement of health equity strategies	N
King County Behavioral Health IPA Planning Meetings	Twice monthly	Input and strategizing on behavioral health IPA transition	County	2A	Strategic alignment and collaboration	N
King County Hospitals for a Healthier Community	Quarterly	Update on ACH and its work	Hospital leaders	All	Strategic alignment and collaboration	N
Meeting with Executive Director of NAMI Seattle	April 9, 2018	Update on ACH and its work and discuss engagement	Behavioral health partner	2A and 3A	Strategic alignment and collaboration	N
Meeting with Executive Director of the Recovery Alliance	March 29, 2018	Update on ACH and its work and discuss	Behavioral health partner	3A	Strategic alignment and collaboration	N

Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
		engagement of people in recovery				

2. Describe how the ACH and its partnering providers have reached out to populations with limited proficiency in English.

ACH Response:

HealthierHere is working through its CBO partners to reach populations with limited proficiency in English. HealthierHere believes organizations with established trust among the target populations are best positioned to engage directly with Medicaid beneficiaries. These trusted organizations include Tribal Nations, CBOs that serve the target population, CBOs that are also providers, and groups that work upstream and at the grassroots level.

Through the community-based small grants program, HealthierHere intends to provide support and resources to community groups and organizations that serve a large number of clients with limited proficiency in English so that they can engage with their clientele as a means of sharing information about HealthierHere's project portfolio, identify real-time barriers to services, and obtain qualitative data to better understand and/or ground efforts in quantitative data around health outcomes and access to health care in King County. HealthierHere has partnered with a trusted CBO, the Center for Multicultural Health, to administer these small grants in partnership with the CCV Committee. It is anticipated that activities pursuant to these outreach grants will be conducted during Q3 of DY2, with preliminary information gathered through the associated outreach efforts to inform project implementation planning.

In addition to conducting direct outreach, HealthierHere launched its website – <https://www.healthierhere.org/> – in Q2 of DY2. Central to the launch of this website was ensuring that it is consumer friendly and provides multiple opportunities for consumers and partners to obtain information necessary to effectively engage with HealthierHere. Information on the website is accessible to individuals with disabilities and in multiple languages through a translation feature.

3. Focusing on community groups that may be underrepresented in Transformation efforts, identify challenges to engagement that have occurred; describe the strategies the ACH and its partnering providers have undertaken to address these challenges.

ACH Response:

Community groups that are underrepresented in transformation efforts often do not have the resources to actively participate in the MTP; they also have many competing priorities and lack overall awareness of the MTP. To address these challenges, HealthierHere is taking several steps, including:

- Developing a community engagement framework and plan detailing HealthierHere's approach to community engagement; the plan will be published on HealthierHere's website and shared with stakeholders to encourage awareness of the MTP, provide assistance in developing strategies to address health equity through the MTP, and encourage support of HealthierHere's community engagement goals
- Reconstituting the CCV Committee to be a formal committee of the Governing Board with representation from critical sectors across King County
- Developing a small grants program to compensate consumers, community members, community groups, CBOs, and social service agencies for participation in HealthierHere activities
- Providing stipends to certain stakeholders (e.g. some governing board members) for participation in ACH activities, which may be used to help support childcare and transportation, among other things
- Identifying trusted advocates/advisors within the community and compensating them for participation in implementation planning; these trusted

advocates/advisors would participate in project work groups alongside partnering providers to share a community- and equity-based perspective

- Administering a CBO assessment to understand CBO and social service agency readiness to participate in the MTP, interest in HealthierHere's project portfolio, and ability to address the needs of HealthierHere's focus populations
- Incorporating community voice in HealthierHere's planning and decision-making processes through representation on the Governing Board and the Planning and Advisory committees, and through information sharing

F. Health Equity Activities

Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

1. Provide an example of a decision the ACH and its partnering providers have made about project planning or implementation based on equity considerations.

ACH Response:

HealthierHere actively considers health equity in all major decision-making. Two examples of decisions based on equity considerations are (1) the Governing Board's decision to distribute half of DY1 incentive funding to non-traditional providers (CBOs) and tribes and (2) HealthierHere's identification of and approach to serving focus populations. Both are described briefly below.

(1) The Governing Board directed HealthierHere to distribute half of DY1 incentive funding to traditional providers (e.g., FQHCs, hospitals/health systems, and behavioral health agencies). The remaining half of DY1 incentive funding will go to CBOs or non-traditional providers and tribes. The decision to allocate half of the incentive funding to non-traditional providers and tribes reflects HealthierHere's commitment to health equity. The Governing Board and staff feel strongly that non-traditional providers and tribes must be involved in transformation efforts to reach address the social determinants of health and support community-based care. HealthierHere is in the process of determining payment triggers for non-traditional providers, an effort that is also being informed by equity and evaluated through the health equity tool.

(2) HealthierHere used a health equity lens to understand target and "focus" populations across its portfolio and within individual projects. The analysis began by identifying 533,929 King County residents who had at least one day of Medicaid coverage between April 1, 2016, and March 31, 2017. To align with official inclusion criteria used by HCA in calculating pay-for-performance measures for each ACH region, HealthierHere removed individuals with a greater than 30-day gap in continuous coverage or any dual Medicare eligibility during the measurement period, reducing the cohort size to 304,406 individuals.

The majority of members had no ED visits (74%), hospital stays for medicine/surgery reasons (98%), or behavioral health-related hospital stays (99%) during the measurement period. Of the members, 5.1% had three or more ED visits, and these members accounted for 49% of all ED visits in the cohort during the measurement period. Further, 6,085 members had one or more med/surg hospital stays, accounting for 100% of all med/surg hospital stays. Similarly, 4,139 members had one or more behavioral health-related hospital stays, accounting for 100% of all such hospital stays.

Members who had three or more ED visits or one or more of either a med/surg or behavioral health-related hospital stay comprise the "hot spot" cohort – this includes 20,357 members. While hot spot members represent only 6% of Medicaid members, they are accountable for 60% of ED visits. Compared to the larger cohort, the hot spot cohort includes a higher percentage of members ages 25-64 and a smaller percentage of members ages 5-17. Hot spot members were also more likely to be American Indian/Alaska Native, black, and white, and more likely to report English as a preferred written or spoken language.

HealthierHere then used the hot spot cohort to define the focus population aligned with each project. The focus populations were defined based on specific diagnoses or patient settings as outlined in the toolkit.

HealthierHere's analysis also confirmed that Medicaid hot spot members are likely to exist in multiple focus populations. Of note, 69% of hot spot members are included in two or more project focus populations and 40% are in three or more focus populations. HealthierHere anticipates that many of the members will have or be at risk for chronic disease conditions (e.g., diabetes) that are the focus of HealthierHere projects or will be

transitioning from a care setting of interest (e.g., jail, inpatient). Therefore, HealthierHere will require its partners to approach all beneficiaries through an integrated whole person care approach, meaning there will essentially be “no wrong door” to entering treatment and all beneficiaries will undergo comprehensive screening. Under this approach, for example, a beneficiary with a SUD will benefit from providers’ efforts to integrate physical and behavioral health as well as their efforts to enhance care for chronic conditions.

Finally, HealthierHere will make a concerted effort to identify members in what HealthierHere refers to as “hidden” populations. These members may seek services through non-Medicaid providers and therefore are not represented in the claims-level analysis, or they may not seek services at all due to lack of access or other reasons. HealthierHere believes this hidden population likely has high needs, similar to the needs of the hot spot and focus populations, and will work with its CBO partners to identify and reach out to members who may otherwise be hidden from the Medicaid health care ecosystem.

2. How will the ACH and its partnering providers assess and prioritize community health equity issues in the region during the Medicaid Transformation?

ACH Response:

To support HealthierHere’s transformation objectives, the CCV Committee developed an equity tool for use in HealthierHere project planning, implementation, and decision-making processes. HealthierHere and its partners will use the tool along with the RHNI and other available data to assess and prioritize health equity issues in King County during the MTP. This tool addresses health equity knowledge/skills gaps as well as unintended consequences of programming and decisions. The tool was utilized in the project application process and will be further utilized in the project planning and implementation processes as well as budgeting and resource allocation decisions. HealthierHere has recently employed the tool to inform its work identifying focus populations.

The Governing Board and staff are focused on applying a health equity lens to all decision making. The tool directs its users to consider:

- Scope of project or decision and intended equity outcomes
- Social determinants of health affected
- Population(s) affected and known disparities
- Potential impacts
- Equitable alternatives
- Implementation, including accountability and communication

3. What steps has the ACH taken to provide the ACH board/staff/partnering providers with tools to address health equity? How will the ACH monitor the use of health equity tools by partnering providers?

ACH Response:

Every HealthierHere Governing Board meeting has proactively addressed health equity. For example:

- Governing Board meeting agendas were restructured to reflect an equity centered approach and elevate the voice of the community e.g., adding additional public comment periods, including one at the top of the agenda and adding community-based and equity focused items for discussion.
- Governing Board members and outside experts have presented to the Governing

Board on health equity and how HealthierHere can lead with its values.

- The Governing Board frequently hears directly from providers dedicated to caring for underserved, vulnerable, and complex populations on the challenges they face in meeting their patients' needs.
- The Governing Board's composition directly reflects the organization's commitment to health equity; more than 50% of the Governing Board represents non-Medicaid providers and the King County community.
- The Governing Board has heard stories from the community, including from Medicaid clients.
- The Governing Board is exploring available data to develop an equity dashboard that will allow the ACH to monitor its progress on addressing health disparities.

In February 2018, Abigail Echo-Hawk from the Urban Indian Health Institute led the Governing Board through an equity learning session. Abigail has prolific experience serving on and supporting boards in facilitating equity. During the learning session, the Governing Board had multiple opportunities to share its experience with bias and equity in a board-like setting. Abigail challenged the Governing Board to:

- Define and make equity actionable
- Make equity the foundation of every decision
- Have transparent and meaningful relationships with the Board/partners
- Have equitable partnerships

HealthierHere's Director of Equity and Community Engagement and members of the CCV Committee will conduct in-depth training on the application of the Equity Impact Assessment Tool for the Governing Board, staff, and committees of HealthierHere. The curriculum for this training is currently under development, and training sessions will be scheduled during the third and fourth quarters of 2018.

The tool is currently available on [HealthierHere's website](#), and partnering providers and HealthierHere's governance bodies are actively encouraged to use it. HealthierHere inquired about partners' use of health equity tools in the CSA and will collect information on their adoption of tools throughout the MTP. HealthierHere's CCV Committee will work with partnering providers to identify good tools and best practices, and spread those across partners. HealthierHere plans to regularly report on the organization's use of the health equity tool as well as request partners to report on their own use through annual reporting. HealthierHere is in the process of identifying other health equity-related reporting metrics for providers, such as partners' improvement on National CLAS Standards.

G. Budget and Funds Flow

Note: HCA will provide ACHs with a Semi-Annual Report Workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of June 30, 2018.

1. **Attestation:** The ACH organization or its equivalent fiscal sponsor has received a financial audit in the past year. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

- a. If the ACH checked “Yes” in item G.1, have all audit findings and questions been appropriately resolved? If not, please briefly elaborate as to the plan to resolve. If the ACH checked “No” in item G.1, respond “Not Applicable.”

ACH Response: All audit findings and questions have been appropriately resolved.

- b. If the ACH checked “No” in item G.1, describe the ACH’s process and timeline for financial audits. If the ACH checked “Yes” in item G.1, respond “Not Applicable.”

ACH Response: Not Applicable

2. Design Funds

Complete items outlined in tab G.2 of the Semi-Annual Report Workbook.

3. DY 1 Earned Incentives

Complete items outlined in tab G.3 of the Semi-Annual Report Workbook.

4. Integration Incentives

For early- and mid-adopter regions only, complete the items outlined tab G.4 of the Semi-Annual Report Workbook and respond to the following:

- a. Describe how the ACH has prioritized, or will prioritize, integration incentives to assist Medicaid behavioral health providers transitioning to FIMC. Include details on how Medicaid behavioral health providers and county government(s) have or will participate in discussions on the prioritization of these incentives.

ACH Response:

HealthierHere surveyed behavioral health providers regarding investments needed for the transition to FIMC. Respondents identified the following categories of need:

- Investment in EHRs
- IT infrastructure for registry and outcome-tracking functions
- EHR modifications: system interfaces/connections across provider types/HIE; integration of primary care training in collaborative care model and other evidence-based approaches
- Staff costs:
 - Database manager for programming
 - Planning capacity, including time for meetings and for development of policies and procedures
 - Administrative support for transition

- On-site primary health provider
- Hardware to support a mobile behavioral health workforce (laptops, mobile internet access to EHRs)
- Billing and coding (out-of-county SUD treatment center)
- Telehealth capacity (out-of-county SUD treatment center)
- Attorney fees for FIMC agreements

The responses were summarized and shared with the county. The county developed a proposal for the initial pool of FIMC funds, proposing approximately 50% of funds go to behavioral health providers. Under the proposal, the remaining funds would be used for EHRs, ACH-brokered training and TA, and county staffing to support the transition to FIMC.

HealthierHere shared the draft proposal with the behavioral health network and facilitated a conversation with the network about system-level investments. The proposal will be revisited over the summer and revised with stakeholder and county input to ensure funds can be distributed in a timely manner.

- b. Describe the decision-making process the ACH will use to determine the distribution of integration incentives. Include how the ACH will verify that providers receiving assistance or funding through the integration incentive funds will serve the Medicaid population at the time of implementation.

ACH Response:

HealthierHere is currently working with the King County BHO and all contracted behavioral health agencies to refine a proposal for distribution of the first portion of mid-adopter incentive funding. The proposal includes a majority of the funding going directly to BHAs for infrastructure investments to support the transition. Some funding will be utilized by HealthierHere to procure training and technical assistance as requested by BHAs. A recommendation for distribution of the mid-adopter funds will be brought to HealthierHere's Finance Committee in July. If approved, the distribution plan will be brought to the Governing Board for full vote and the funds will then be distributed. Once the framework for distribution is agreed upon, HealthierHere will work with the King County BHO and all contracted BHAs to apply the framework and distribute integration incentives to providers as well as develop specific training and TA plans and resources.

All mid-adopter incentive funds will be distributed to and/or benefit the network of community behavioral health agencies within the King County region who are contracted to serve Medicaid clients. Through its partnership with the King County BHO, HealthierHere will be able to ensure that the money is distributed only to providers who serve Medicaid clients.

5. Total Medicaid Transformation Incentives

The items outlined in tab G.5 of the Semi-Annual Report Workbook is informational only. ACHs are not required to complete any it

HealthierHere – Current State Assessment of Hospitals/Health Systems in King County – Continuing a Journey of Health Care Transformation

Welcome!

HealthierHere is the Accountable Community of Health for King County, a regional partnership committed to working in new ways to improve the health and well-being of King County residents. Our values include Equity, Community, Partnership, Innovation and Results.

This assessment of hospitals and health systems in King County will help HealthierHere and its partners develop an understanding of the current state of readiness for system transformation at your organization and ultimately in our region as a whole. Assessment results will be used to inform HealthierHere investment plans and project implementation plans, selection of providers for contracting, and ultimately, contribute to system-wide health care transformation. We will keep the information provided confidential and only share de-identified, aggregate data. HealthierHere designed this assessment to be completed by teams, with one lead HealthierHere contact gathering information and answers and entering the final responses into our online assessment at the end of that process. Thank you for your accurate and timely responses. This information will be integral to helping HealthierHere support planning and systems transformation across organizations serving Medicaid members in King County.

Instructions

- Please familiarize yourself with the Health Care Authority’s project toolkit, HealthierHere’s project overviews and project plan portfolio before completing your assessment.
- Please submit only one assessment for your hospital/health system. If you have questions about this please email Tavish Donahue at tdonahue@kingcountyach.org.
- When you complete the assessment please be intentional about answering with your participating sites in mind. **If your organization has multiple components, for example, 2 hospitals and 10 primary care clinics, please only respond for the campuses/clinics that serve a high proportion of Medicaid patients and will be participating in the Medicaid Transformation Projects, soliciting input from key staff in the relevant departments.**
- We strongly encourage you to complete the assessment as a team or gather team input to inform your responses. You may use this PDF of the assessment to preview the questions you will be answering. The PDF includes sections you might not need to answer depending on the projects you will be participating in. The assessment is adaptive to your responses and will guide you through only the questions that pertain to your organization.
- This assessment will take approximately one hour.
- A link to your assessment responses will be presented after completion of the assessment on the Thank You page. Please save the link to edit your responses in the future.

SurveyGizmo Tips & Tricks

- We recommend you complete the assessment on a computer device instead of a mobile device due to the length of the survey and survey experience.
- The Windows Explorer Back Arrow will take you out of the assessment and you will lose your responses if you have not saved your progress.
- To save your work, select “Save and continue later” in the upper right corner. This will allow you to save what you have completed so far and return later to complete the assessment. We recommend you save your work after completing the general information section. This will ensure you don’t lose your data in the event you encounter a technical issue with your browser while populating the survey.

Healthier Here: Current State Assessment - Hospital & Health System

General Information

1. What is the name of your organization? *

2. Who is/will be your organization's lead contact for HealthierHere?

First Name *

Last Name *

Title *

Company Name

Street Address *

Apt/Suite/Office

City *

State *

Zip *

Email Address *

Phone Number *

3. Which of the following types of services does your organization provide? (Select all that apply.)

- Primary Care
- Mental health counseling and/or treatment (outpatient or residential)
- Substance abuse counseling and/or treatment (outpatient or residential)
- Acute or emergency medical care
- Oral health care (e.g., fluoride varnish)
- Pharmacy
- Social services (e.g., housing, transportation). Please specify.- Write In (Required)

*

- Other - Write In (Required)

*

 Show/hide trigger exists.

4. What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

- 2A) Bi-directional Integration
- 2C) Transitional Care
- 3A) Addressing the Opioid Crisis
- 3D) Chronic Disease Prevention and Control

5. While HealthierHere is only requiring one survey to be completed for each hospital/health system, we understand that not all of your facilities may participate in the Medicaid Transformation Projects and that different components of your organization may participate in different projects. Please list the specific hospitals/facilities/clinics that will be participating and their corresponding projects using the table below. If your organization only has one site, please skip this question.

	Name of Location	Location Address	Projects			
			Bi-Directional Integration	Transitional Care	Addressing the Opioid Crisis	Chronic Disease Prevention
1	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Quality Improvement (QI)

6. For the purposes of the projects you've selected to participate in, does your organization have Quality Improvement (QI) processes in place?

- Yes
- No

7. Are your organization's participating primary care sites [Patient-Centered Medical Home \(PCMH\)](#) certified?

- Yes
- No

8. Select which option best describes your organization's Quality Improvement activities:

- Not organized or supported consistently
- Conducted on an ad hoc basis in reaction to specific problems
- Based on a proven improvement strategy in reaction to specific problems
- Based on a proven improvement strategy and used continuously in meeting organizational goals

9. Select which option best describes your organization's Performance Measures:

- Not available for clinical sites
- Available for clinical sites but limited in scope
- Comprehensive (including clinical, operational, and patient experience measures) and available for the practice, but not for individual providers
- Comprehensive (including clinical, operational, and patient experience measures) and fed back to individual providers

10. Who conducts QI activities in your organization?

- Centralized committee or department
- Topic specific QI committees
- Practice Teams supported by a QI infrastructure
- Practice Teams supported by a QI infrastructure with meaningful involvement of patients and families

11. Select which best describes your organization's use of an Electronic Health Record (EHR) that supports Meaningful Use. (Select all that apply.)

- Is not present or is being implemented
- Is in place and is being used to capture clinical data
- Is used routinely during patient encounters to provide clinical decision support and to share data with patients
- Is also used routinely to support population management and quality improvement efforts

Care Coordination

 Show/hide trigger exists.

12. For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care & **Specialty Care**?

- Yes
- No

LOGO Hidden unless: #12 Question "For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care & **Specialty Care**?" is one of the following answers ("Yes")

13. Who are your organization's major **Specialty Care** partners and what is the level of collaboration in that relationship?

	Organization Name	Location	Level of Collaboration on a scale of 1 to 5 (1 being minimal and 5 as extremely close symbiotic relationship such as co-located services)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>

LOGO Show/hide trigger exists.

14. For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Emergency Departments**?

- Yes
- No

LOGO Hidden unless: #14 Question "For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Emergency Departments**?" is one of the following answers ("Yes")

15. Who are your organization's major **Emergency Department** partners and what is the level of collaboration in that relationship?

	Organization Name	Location	Level of Collaboration on a scale of 1 to 5 (1 being minimal and 5 as extremely close symbiotic relationship such as co-located services)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>

LOGO Show/hide trigger exists.

16. For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Oral Health**?

- Yes
- No

LOGO Hidden unless: #16 Question "For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Oral Health**?" is one of the following answers ("Yes")

17. Who are your organization's major **Oral Health** partners and what is the level of collaboration in that relationship?

	Organization Name	Location	Level of Collaboration on a scale of 1 to 5 (1 being minimal and 5 as extremely close symbiotic relationship such as co-located services)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>

LOGO Show/hide trigger exists.

18. For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Behavioral Health**?

- Yes
- No

LOGO Hidden unless: #18 Question "For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Behavioral Health**?" is one of the following answers ("Yes")

19. Who are your organization's major **Behavioral Health** partners and what is the level of collaboration in that relationship?

	Organization Name	Location	Level of Collaboration on a scale of 1 to 5 (1 being minimal and 5 as extremely close symbiotic relationship such as co-located services)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>

LOGO Show/hide trigger exists.

20. For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Reproductive Health**?

- Yes
- No

LOGO Hidden unless: #20 Question "For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Reproductive Health**?" is one of the following answers ("Yes")

21. Who are your organization's major **Reproductive Health** partners and what is the level of collaboration in that relationship?

	Organization Name	Location	Level of Collaboration on a scale of 1 to 5 (1 being minimal and 5 as extremely close symbiotic relationship such as co-located services)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>

LOGO Show/hide trigger exists.

22. For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Social Services** (housing, transportation, food assistance, etc.)?

- Yes
- No

LOGO Hidden unless: #22 Question "For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Social Services** (housing, transportation, food assistance, etc.)?" is one of the following answers ("Yes")

23. Who are your organization's major **Social Services** (housing, transportation, food assistance, etc.) partners and what is the level of collaboration in that relationship?

	Organization Name	Location	Level of Collaboration on a scale of 1 to 5 (1 being minimal and 5 as extremely close symbiotic relationship such as co-located services)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>

LOGO Show/hide trigger exists.

24. For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Community Based Organizations (CBOs)**?

- Yes
- No

LOGO Hidden unless: #24 Question "For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Community Based Organizations (CBOs)**?" is one of the following answers ("Yes")

25. Who are your organization's major **Community Based Organization (CBO)** partners and what is the level of collaboration in that relationship?

	Organization Name	Location	Level of Collaboration on a scale of 1 to 5 (1 being minimal and 5 as extremely close symbiotic relationship such as co-located services)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>

LOGO Show/hide trigger exists.

26. For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Pharmacies**?

- Yes
- No

 Hidden unless: #26 Question "For your facilities/sites that serve Medicaid, underserved populations, does your organization have formal referral, follow-up, and coordination relationships between Primary Care and **Pharmacies**?" is one of the following answers ("Yes")

27. Who are your organization's major **Pharmacy** partners and what is the level of collaboration in that relationship?

	Organization Name	Location	Level of Collaboration on a scale of 1 to 5 (1 being minimal and 5 as extremely close symbiotic relationship such as co-located services)
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>

28. For your organization's Medicaid primary care patients, **Medical and Surgical Specialty** services are:

- Difficult to obtain reliably
- Available from community specialists but are not timely or convenient
- Available from community specialists and are timely and convenient
- Are readily available from specialists who are members of the care team or who work in an organization with which your organization has a referral protocol or agreement

29. For your organization's Medicaid primary care patients, **Behavioral Health** services are:

- Difficult to obtain reliably
- Available from behavioral health specialists but are not timely or convenient
- Available from behavioral health specialists and are timely and convenient
- Are readily available from behavioral health specialists who are members of the care team or who are on-site members of the care team or who work in a community organization with which your organization has a referral protocol or agreement

30. For your organization's Medicaid primary care patients in need of **specialty care, hospital care, or supportive community-based resources**:

- Cannot reliably obtain needed referrals to partners with whom the practice has a relationship
- Can obtain needed referrals to partners with whom the practice has a relationship
- Can obtain needed referrals to partners with whom the practice has a relationship and relevant information is communicated in advance
- Can obtain needed referrals to partners with whom the practice has a relationship, relevant information is communicated in advance, and timely follow-up after the visit occurs

31. For your organization's Medicaid primary care patients, follow-up by the primary care practice with patients seen in the **Emergency Room or Hospital**:

- Generally does not occur because the information is not available to the primary care team
- Occurs only if the ER or hospital alerts the primary care practice
- Occurs because the primary care practice makes proactive efforts to identify patients
- Is done routinely because the primary care practice has arrangements in place with the ER and hospital to both track these patients and ensure that follow-up is completed within a few days

32. For your organization's Medicaid primary care patients, linking patients to **supportive community-based resources**:

- Is not done systematically
- Is limited to providing patients a list of identified community resources in an accessible format
- Is accomplished through a designated staff person or resource responsible for connecting patients with community resources
- Is accomplished through active coordination between the health system, community service agencies and patients and accomplished by a designated staff person

LOGIC Show/hide trigger exists.

33. Are there workforce gaps that your organization will need to address to ensure successful project(s) execution?

- Yes
- No

LOGIC Hidden unless: #33 Question "Are there workforce gaps that your organization will need to address to ensure successful project(s) execution?" is one of the following answers ("Yes")

34. Please explain what workforce gaps exists in your organization that will need to be addressed to ensure successful project(s) execution:

LOGIC Show/hide trigger exists.

35. Are there barriers to team-based care in your organization?

- Yes
- No

LOGIC Hidden unless: #35 Question "Are there barriers to team-based care in your organization?" is one of the following answers ("Yes")

36. Please explain what the barriers are in your organization to team-based care:

Logic Hidden unless: (#33 Question "Are there workforce gaps that your organization will need to address to ensure successful project(s) execution?" is one of the following answers ("Yes") AND #35 Question "Are there barriers to team-based care in your organization?" is one of the following answers ("Yes"))

37. How might **HealthierHere** help your organization address these workforce gaps or barriers to team-based care?

38. What trainings should **HealthierHere** offer/develop to support your organization's staff in executing transformation efforts?

39. Are there other workforce resources (e.g., job descriptions, training materials, etc.) that would be helpful?

Logic Show/hide trigger exists.

40. Do your care teams include any of the following roles?(Select all that apply.)

- Case Managers
- Community Health Workers
- Navigators
- Peer Support Specialists
- Other - Write In

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Case Managers")

41. What is your organization's financing model for the **Case Manager** role?

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Case Managers")

42. What is your organization's client to **Case Manager** ratio?

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Case Managers")

43. What specific health issues do your organization's **Case Managers** serve?

- Diabetes
- Obesity
- Hypertension
- Behavioral health
- Heart disease
- Health literacy
- Nutrition
- Asthma
- Maternal/Child Health
- Other - Write In (Required)

*

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Case Managers")

44. What specific social issues do your organization's **Case Managers** address?

- Connect to resources
- Connecting to medical home/Primary Care Physician
- Food security
- Transportation
- Establishing/maintaining health insurance
- Human services
- Housing
- Education
- Income
- Employment
- Other - Write In (Required)

*

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Community Health Workers")

45. What is your organization's financing model for the **Community Health Worker** role?

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Community Health Workers")

46. What is your organization's client to **Community Health Worker** ratio?

 Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Community Health Workers")

47. What specific health issues do your organization's **Community Health Workers** serve?

- Diabetes
- Obesity
- Hypertension
- Behavioral health
- Heart disease
- Health literacy
- Nutrition
- Asthma
- Maternal/Child Health
- Other - Write In (Required)

*

 Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Community Health Workers")

48. What specific social issues do your organization's **Community Health Workers** address?

- Connect to resources
- Connecting to medical home/Primary Care Physician
- Food security
- Transportation
- Establishing/maintaining health insurance
- Human services
- Housing
- Education
- Income
- Employment
- Other - Write In (Required)

*

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Navigators")

49. What is your organization's financing model for the **Navigator** role?

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Navigators")

50. What is your organization's client to **Navigator** ratio?

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Navigators")

51. What specific health issues do your organization's **Navigators** serve?

- Diabetes
- Obesity
- Hypertension
- Behavioral health
- Heart disease
- Health literacy
- Nutrition
- Asthma
- Maternal/Child Health
- Other - Write In (Required)

*

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Navigators")

52. What specific social issues do your organization's **Navigators** address?

- Connect to resources
- Connecting to medical home/Primary Care Physician
- Food security
- Transportation
- Establishing/maintaining health insurance
- Human services
- Housing
- Education
- Income
- Employment
- Other - Write In (Required)

*

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Peer Support Specialists")

53. What is your organization's financing model for the **Peer Support Specialist** role?

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Peer Support Specialists")

54. What is your organization's client to **Peer Support Specialist** ratio?

 Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Peer Support Specialists")

55. What specific health issues do your organization's **Peer Support Specialists** serve?

- Diabetes
- Obesity
- Hypertension
- Behavioral health
- Heart disease
- Health literacy
- Nutrition
- Asthma
- Maternal/Child Health
- Other - Write In (Required)

*

 Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Peer Support Specialists")

56. What specific social issues do your organization's **Peer Support Specialists** address?

- Connect to resources
- Connecting to medical home/Primary Care Physician
- Food security
- Transportation
- Establishing/maintaining health insurance
- Human services
- Housing
- Education
- Income
- Employment
- Other - Write In (Required)

*

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Other - Write In")

57. What is your organization's financing model for the "**Other - Self reported staff role(s)**"?

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Other - Write In")

58. What is your organization's client to "**Other - Self reported staff role(s)**" ratio?

LOGIC Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Other - Write In")

59. What specific health issues do your organization's "**Other - Self reported staff role(s)**" serve?

- Diabetes
- Obesity
- Hypertension
- Behavioral Health
- Heart Disease
- Health Literacy
- Nutrition
- Asthma
- Maternal/Child Health
- Other - Write In (Required)

*

 Hidden unless: #40 Question "In the Care Coordination workforce, what type of staff does your organization employ? (Select all that apply.)" is one of the following answers ("Other - Write In")

60. What specific social issues do your organization's **"Other - Self reported staff role(s)"** address?

- Connect to resources
- Connecting to medical home/Primary Care Physician
- Food security
- Transportation
- Establishing/maintaining health insurance
- Human services
- Housing
- Education
- Income
- Employment
- Other - Write In (Required)

*

61. What are your organization's top three concerns when it comes to longevity and sustainability of the Care Coordination workforce?

- Funding uncertainty
- Staff Turnover
- Finding qualified CHWs or peers
- Management support for CHWs or peers
- Non-acceptance of CHW or peer role by other team members
- Other - Write In (Required)

*

62. Does your organization's mission statement or other guiding principles (e.g., vision, values) reflect an organizational commitment to providing culturally competent care?

- Yes
- No

63. Has your organization used the National Standards for Culturally and Linguistically Appropriate Services (CLAS) or other guidance to incorporate cultural competence into organizational planning?

- Yes
- No

64. Does your organization have policies and/or procedures that address the following:

	Yes	No
Reinforcing the importance of cultural sensitivity and effective communication in the provision of care?	<input type="radio"/>	<input type="radio"/>
Supporting the use of professional health care interpreters?	<input type="radio"/>	<input type="radio"/>
Discouraging the use of family, minors, or other untrained individuals as interpreters?	<input type="radio"/>	<input type="radio"/>
Suggesting which types of language services are appropriate for certain situations (e.g., on-site, telephone, video)?	<input type="radio"/>	<input type="radio"/>
Requiring the use of language services throughout the continuum of care?	<input type="radio"/>	<input type="radio"/>
Resolving or mediating any cross-cultural conflicts that may arise?	<input type="radio"/>	<input type="radio"/>

65. Does your organization have a formal and ongoing training program on cultural and language diversity?

Note: This may consist of either a stand-alone training program or several training components integrated into other types of training. These trainings may be voluntary and/or mandatory.

- Yes
- No

66. What interpreter services are available for clients speaking . . . ?

	None	Telephone Only	Bilingual/Face to Face	Bilingual/Video
Spanish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vietnamese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somali/Amharic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tagalog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text" value="Enter another option"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text" value="Enter another option"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text" value="Enter another option"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text" value="Enter another option"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text" value="Enter another option"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

67. Does your organization have a written policy and procedures about the use of:

	Yes	No
Bilingual staff as interpreters?	<input type="radio"/>	<input type="radio"/>
Face-to-face professional interpreters?	<input type="radio"/>	<input type="radio"/>
Face-to-face volunteer interpreters?	<input type="radio"/>	<input type="radio"/>
Family or friends as interpreters?	<input type="radio"/>	<input type="radio"/>

68. What type of written materials does your organization routinely provide to clients in languages other than English?

- Informed consent statements
- Medication instructions
- Discharge planning instructions
- Health education materials
- Other - Write In (Required)

*

69. Does your organization:

	Yes	No
Require an assessment of interpreter fluency in translating medical terms and procedures?	<input type="radio"/>	<input type="radio"/>
Require an assessment of interpreter accuracy and completeness?	<input type="radio"/>	<input type="radio"/>
Post signs providing directions in languages other than English?	<input type="radio"/>	<input type="radio"/>
Collect any ethnicity or racial data on individuals receiving services?	<input type="radio"/>	<input type="radio"/>
Collect data on the preferred language for individuals receiving services?	<input type="radio"/>	<input type="radio"/>
Routinely involve community representatives in the planning and design of client services for culturally diverse populations?	<input type="radio"/>	<input type="radio"/>
Routinely involve community representatives in the evaluation of existing services for culturally diverse populations?	<input type="radio"/>	<input type="radio"/>

Value Based Payments (VBP)

 Show/hide trigger exists.

70. Do your organization's current provider contracts include value based payments?

- Yes
- No

 Hidden unless: #70 Question "Do your organization's current provider contracts include value based payments?" is one of the following answers ("Yes")

71. What is the percentage of VBP contracts to your organization's total contracts (e.g., 50% if 50 of your total 100 contracts have VBP elements)?

72. Has your organization completed any planning or assessment of readiness to transition to Value Based Payments (VBP)?

- Yes
- No

73. What tool(s) did your organization use for any planning or assessment of VBP?

- [JSI/NAHC Payment Reform Readiness Toolkit](#)
- [AMA Steps Forward](#)
- [Rural Health Value Team's Value Based Care Strategic Planning Tool](#)
- Other - Write In (Required)

*

74. As your organization assess VBP capacities, which level is your organization at now?

	Low	Medium	High	N/A
Governance and organization (includes leadership buy-in, practice management, workforce development)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provider engagement (includes network identification and engagement, referral management, co-location)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Care coordination/management (includes shared care plans, patient engagement, evidence-based case management)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Population Health Management (includes data aggregation and exchange, patient stratification, performance monitoring)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Links to social determinants of health (includes member social needs assessment, knowledge of and referrals to available services and organizations, integration into care management protocols)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

75. Given the services your organization provides, and the population that you serve, please rate what are your organization's biggest barriers to success in Value Based Payment?

	Low	Medium	High	N/A
Patient engagement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Electronic health records	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Health information	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Care Coordination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic disease management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient Centered Medical Home transformation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physician alignment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Identifying/integrating with CBOs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Care transition between screenings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Post-acute care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Data analytics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial/cost accounting tracking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

76. Please use the list below to identify training and/or technical assistance your organization would like HealthierHere to provide to help your organization succeed under VBP. (Select all that apply.)

- Centralized care management
- Data analytics
- Care coordination
- Credentialing
- Practice transformation (Integrated Care)
- Population health management
- Quality improvement
- Support building new care models
- Patient engagement solutions
- Community partnerships
- Other - Write In

2A: Bi-Directional Integration

Page entry logic:

This page will show when: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

77. Select which model(s) your organization is planning to implement for this project.

(Select all that apply.)

- [Bree Collaborative's Behavioral Health Integration Recommendations](#)
- [Collaborative Care Model](#)
- [Enhanced Coordination](#)

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

78. Does your organization have a strategic plan or operational/implementation plan to delivering integrated care?

- Yes
- No

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

79. Does your organization need additional training or technical assistance for staff on how to deliver integrated care?

- Yes
- No

LOGIC Hidden unless: #79 Question "Does your organization need additional training or technical assistance for staff on how to deliver integrated care?" is one of the following answers ("Yes")

80. Indicate what type of staff and approximately how many would benefit from training or technical assistance for delivering integrated care.

Type of Staff

Approximate Number

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

81. Does your organization need additional training or technical assistance on population health management strategies?

- Yes
- No

LOGIC Hidden unless: #81 Question "Does your organization need additional training or technical assistance on population health management strategies?" is one of the following answers ("Yes")

82. Indicate what type of staff and approximately how many would benefit from training or technical assistance for population health management strategies.

Type of Staff

Approximate Number

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

83. Does your organization need additional training or technical assistance on quality improvement strategies?

Yes

No

LOGIC Hidden unless: #83 Question "Does your organization need additional training or technical assistance on quality improvement strategies?" is one of the following answers ("Yes")

84. Indicate what type of staff and approximately how many would benefit from training or technical assistance for quality improvement strategies.

Type of Staff

Approximate Number

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

85. Which (if any) of the following barriers or challenges limit your organization's ability to participate in integrated managed care (IMC)? (Select all that apply.)

- Health Information Technology (HIT) capacity
- Financial systems or billing capacity
- Contracting processes
- Other - Write In (Required)

*

 Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

86. Does your organization have behavioral health and medical providers either physically or virtually in one facility? (*Virtual means telehealth with direct patient interaction, not just e-consult or chart review.*)

- Yes
- No

 Hidden unless: #86 Question "Does your organization have behavioral health and medical providers either physically or virtually in one facility? (*Virtual means telehealth with direct patient interaction, not just e-consult or chart review.*)" is one of the following answers ("Yes")

87. Explain a little more about behavioral health and medical providers being physically or virtually in one facility:

	Yes	No
Are medical and behavioral health providers equally involved in the approach to patient care?	<input type="radio"/>	<input type="radio"/>
Do behavioral health and medical providers approach care in a standard way (i.e. with standard tools and resources) across all patients?	<input type="radio"/>	<input type="radio"/>
Are resources balanced, truly shared, and allocated across the whole practice?	<input type="radio"/>	<input type="radio"/>
Is patient information equally accessible and used by all providers to inform care?	<input type="radio"/>	<input type="radio"/>
Have all providers changed their practice to a new model of care?	<input type="radio"/>	<input type="radio"/>
Has leadership adopted and committed to integration as the model of care for the whole system?	<input type="radio"/>	<input type="radio"/>
Are all patients treated by a team?	<input type="radio"/>	<input type="radio"/>
Is there a single treatment plan for each patient?	<input type="radio"/>	<input type="radio"/>
Does the care team have access to the treatment plan?	<input type="radio"/>	<input type="radio"/>
Is population-based screening standard practice?	<input type="radio"/>	<input type="radio"/>
Is screening used to develop interventions for both populations and interventions?	<input type="radio"/>	<input type="radio"/>
Does the practice systematically track and analyze outcomes for accountability and quality improvement?	<input type="radio"/>	<input type="radio"/>

 Hidden unless: #86 Question "Does your organization have behavioral health and medical providers either physically or virtually in one facility? (*Virtual means telehealth with direct patient interaction, not just e-consult or chart review.*)" is one of the following answers ("No")

88. Do provider relationships go beyond increasing successful referrals with the intent to achieve shared patient care?

- Yes
- No

Logic Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

96. Communication With Patients About Integrated Care

	... does not occur.	... occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style.	... occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent.	... is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in how to communicate with patients about integrated care.
		2 3 4	5 6 7	8 9 10
Communication with patients about integrated care...	<input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>

0000 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

97. Follow-Up Of Assessments, Tests, Treatment, Referrals And Other Services

	... is done at the initiative of the patient/family members.	... is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up.	... is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments.	... is done by systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments.
		2 3 4	5 6 7	8 9 10
Follow-up of assessments, tests, treatment, referrals and other services...	<input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>

0000 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

98. Social Support (For Patients To Implement Recommended Treatment)

	... is not addressed.	... is discussed in general terms, not based on an assessment of patient's individual needs or resources.	... is encouraged through collaborative exploration of resources available (e.g., significant others, education groups, support groups) to meet individual needs.	... is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources.
		2 3 4	5 6 7	8 9 10
Social support (for patients to implement recommended treatment)...	<input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

103. Coordination of Referrals and Specialists

 is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team.	... occurs through teamwork and care management of recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care.	... is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement.
		2 3 4	5 6 7	8 9 10
Coordination of referrals and specialists...	<input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

104. Data Systems/Patient Records

	... are based on paper records only; separate records used by each provider.	... are shared among providers on an ad hoc bases; multiple records exist for each patient, no aggregate data used to identify trends or gaps.	... use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregate data to identify trends and launches QI projects to achieve measurable goals.	... has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process.
		2 3 4	5 6 7	8 9 10
Data systems/patient records...	<input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

105. Patient/Family Input To Integration Management

	... does not occur.	... occurs on an ad hoc basis; not promoted systematically; patients must take initiative to make suggestions.	... is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate.	... is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information.
		2 3 4	5 6 7	8 9 10
Patient/family input to integration management...	<input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/>

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2A) Bi-directional Integration")

107. Funding Sources/Resources

	... do not support integration; no shared resources streams.	... separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies.			... separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training.			... fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly.		
		2	3	4	5	6	7	8	9	10
Funding sources/resources...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2C: Transitional Care

Page entry logic:

This page will show when: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

108. Which of the three Transitional Care populations is your organization planning on serving as part of your HealthierHere work? (Select all that apply.)

- Medicaid clients returning to the community from jail
- Medicaid clients with serious mental illness or substance use disorder discharged from inpatient care
- High-risk (PRISM score of 1.5 and above) Medicaid clients transitioning from hospitals, including older adults and people with disabilities

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

109. Does your organization currently partner with jails or is your organization planning to as part the Transitional Care project?

- Yes
- No

LOGIC Show/hide trigger exists. Hidden unless: #109 Question "Does your organization currently partner with jails or is your organization planning to as part the Transitional Care project?" is one of the following answers ("Yes")

110. Do providers/staff in your organization use the [APIC](#) (Assess, Plan, Identify, and Coordinate) model for Medicaid clients returning to the community from jail?

- Yes
- No

LOGIC Hidden unless: #110 Question "Do providers/staff in your organization use the [APIC](#) (Assess, Plan, Identify, and Coordinate) model for Medicaid clients returning to the community from jail?" is one of the following answers ("Yes")

111. How many providers/staff use this model?

LOGIC Hidden unless: #110 Question "Do providers/staff in your organization use the [APIC](#) (Assess, Plan, Identify, and Coordinate) model for Medicaid clients returning to the community from jail?" is one of the following answers ("Yes")

112. How many providers/staff in your organization would need to be trained on the APIC model in order to reach scale?

LOGIC Hidden unless: #110 Question "Do providers/staff in your organization use the [APIC](#) (Assess, Plan, Identify, and Coordinate) model for Medicaid clients returning to the community from jail?" is one of the following answers ("No")

113. What model or promising practice (if any) does your organization use for clients transitioning from jail?

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

114. Do providers/staff in your organization use the [Peer Bridger](#) model for clients with serious mental illness or substance use disorder discharged from inpatient care?

- Yes
- No

LOGIC Hidden unless: #114 Question "Do providers/staff in your organization use the [Peer Bridger](#) model for clients with serious mental illness or substance use disorder discharged from inpatient care?

" is one of the following answers ("Yes")

115. How many providers/staff use this model?

LOGIC Hidden unless: #114 Question "Do providers/staff in your organization use the [Peer Bridger](#) model for clients with serious mental illness or substance use disorder discharged from inpatient care?

" is one of the following answers ("Yes")

116. How many providers/staff in your organization would need to be trained on the Peer Bridger model in order to reach scale?

LOGIC Hidden unless: #114 Question "Do providers/staff in your organization use the [Peer Bridger](#) model for clients with serious mental illness or substance use disorder discharged from inpatient care?

" is one of the following answers ("No")

117. What model or promising practice (if any) does your organization use for clients transitioning from inpatient psychiatric?

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

118. What are the biggest barriers your organization faces when transitioning patients back to the community?

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

119. Does your organization have more patients that could be discharged if there were alternatives (e.g., additional places to discharge patients to)?

- Yes
- No

LOGIC Hidden unless: #119 Question "Does your organization have more patients that could be discharged if there were alternatives (e.g., additional places to discharge patients to)?" is one of the following answers ("Yes")

120. How many (estimated) additional patients per month could be discharged?

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

121. What strategies are being worked on in your organization to increase discharges?

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

122. Do providers/staff in your organization use the [Care Transitions Intervention/Coleman model](#) with clients returning to the community after an inpatient hospitalization?

- Yes
- No

LOGIC Hidden unless: #122 Question "Do providers/staff in your organization use the [Care Transitions Intervention/Coleman model](#) with clients returning to the community after an inpatient hospitalization?" is one of the following answers ("Yes")

123. How many providers/staff use this model?

LOGIC Hidden unless: #122 Question "Do providers/staff in your organization use the [Care Transitions Intervention/Coleman model](#) with clients returning to the community after an inpatient hospitalization?" is one of the following answers ("Yes")

124. How many providers/staff in your organization would need to be trained on the Care Transitions Intervention/Coleman model in order to reach scale?

LOGIC Hidden unless: #122 Question "Do providers/staff in your organization use the [Care Transitions Intervention/Coleman model](#) with clients returning to the community after an inpatient hospitalization?" is one of the following answers ("No")

125. What model or promising practice (if any) does your organization use for clients transitioning from inpatient hospital settings?

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

126. For patients that have been discharged from the hospital, which of the following elements has your organization adopted?

- Clinical case management for high risk, complex patients
- Medication reconciliation
- Patient and caregiver education, using the "teach back" method
- Follow-up visit with primary care or behavioral health provider within seven (7) days of patient discharge
- Risk stratification
- Patient and family engagement in treatment plan
- Other - Write In (Required)

*

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

127. What are the biggest barriers your organization faces when transitioning patients back to the community?

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

128. Does your organization have more patients that could be discharged if there were alternatives (e.g., additional places to discharge patients to)?

- Yes
- No

LOGIC Hidden unless: #128 Question "Does your organization have more patients that could be discharged if there were alternatives (e.g., additional places to discharge patients to)? " is one of the following answers ("Yes")

129. How many additional (estimated) patients per month could be discharged?

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("2C) Transitional Care")

130. What strategies are being worked on in your organization to increase discharges?

3A: Addressing the Opioid Crisis

Page entry logic:

This page will show when: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

131. Do providers in your organization prescribe opioids to treat patients for chronic pain?

- Yes
- No

LOGIC Hidden unless: #131 Question "Do providers in your organization prescribe opioids to treat patients for chronic pain?" is one of the following answers ("Yes")

132. How many patients are currently being treated for chronic pain with opioids?

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

133. Does your organization's strategy for managing opioid prescribing align with the "[six building blocks](#)?"

- Yes
- No

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

134. For patients with chronic pain, do providers conduct an assessment of **patient suitability for an opioid prescription** to treat pain?

- Yes
- No

LOGIC Hidden unless: #134 Question "For patients with chronic pain, do providers conduct an assessment of **patient suitability for an opioid prescription** to treat pain?" is one of the following answers ("Yes")

135. What risks do providers assess? (Select all that apply.)

- Respiratory risk
- Substance use disorder
- History of opioid overdose
- Pattern of aberrant behaviors

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

136. Do all providers screen patients for **opioid misuse or opioid use disorder, or risk for opioid addiction and substance abuse** prior to prescribing opioids?

- Yes
- No

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

137. What tools do providers in your organization use? (Select all that apply.)

- [Opioid Risk Tool](#)
- [CAGE-AID](#)
- [SOAPP-R](#)
- [COMM](#)
- [DIRE](#)
- Other - Write In (Required)

*

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

138. Do providers first prescribe non-opioid medications and/or alternative treatments like physical therapy, acupuncture for pain management?

- Yes
- No

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

139. How often do providers . . .

	All of the time	Most of the time	Sometimes	Never
Use patient/provider agreements for patients with opioid prescriptions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide opioid addiction risk education to patients with opioid prescriptions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide overdose education to patients with opioid prescriptions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide information to patients about safe use, storage and disposal of opioids?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

 Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

140. How often does your organization co-prescribe naloxone with prescription opioids?

- Always
- Sometimes
- Never

LOGIC Hidden unless: #140 Question "How often does your organization co-prescribe naloxone with prescription opioids?"

" is one of the following answers ("Always","Sometimes")

141. What tools or criteria do providers use to assess appropriateness for naloxone co-prescription? (Select all that apply.)

- MED level
- Mental Health disorder per DSM 5
- Family or personal history of substance use disorder
- Any time any Opioid is prescribed
- Medical condition that could increase sensitivity to opioid-related side effects
- Current use of benzodiazepines
- Tobacco use
- Other - Write In (Required)

*

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

142. Which opioid prescribing guidelines has your organization adopted? (Select all that apply.)

- [Bree Collaborative Guidelines](#)
- [CDC Guideline for Prescribing Opioids for Chronic Pain](#)
- [AMDG Interagency Guideline on Prescribing Opioids for Pain](#)
- This practice has not adopted opioid prescribing guidelines
- Other - Write In

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

143. How many prescribing providers have been trained on opioid prescribing guidelines?

- All
- Most
- Some
- None

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

144. During the last 12 months, what percentage of providers in your organization Continuing Medical Education (CME) on safe opioid prescribing?

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

145. Does your organization monitor opioid prescribing practices for your organization's prescribing providers?

- Yes
- No

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

146. Which of the following steps has your organization taken to implement opioid prescribing guidelines and ensure safe opioid prescribing practices? (Select all that apply.)

- Built guidelines into EHR (such as recommended default doses)
- Training for providers
- Enrolling in Prescription Monitoring Program (PMP)
- Documentation in patient records
- Patient/provider agreements
- Providing patient education and communication tools
- Other - Write In

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

147. What barriers have providers encountered to implementing opioid prescribing guidelines? (Select all that apply.)

- Leadership buy-in
- Patient resistance
- Difficulty accessing Prescription Monitoring Program (PMP)
- Lack of EHR interoperability
- Inability to customize EHR
- Lack of knowledge or training
- Other - Write In

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

148. How many prescribing providers in your organization are registered users of the Prescription Monitoring System (PMP)?

- All providers
- Most providers
- Some providers
- None

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

149. When prescribing opioids, how often do providers in your organization use the PMP to review patients' opioid history?

- All the time
- Most of the time
- Sometimes
- Never

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

150. Is the PMP built into your organization's EHR system?

- Yes
- No

LOGIC Hidden unless: #150 Question "Is the PMP built into your organization's EHR system?"

" is one of the following answers ("No")

151. Does your organization have plans to build the PMP into your organization's EHR system?

- Yes
- No

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

152. What barriers exist to using the PMP? (Select all that apply.)

- Leadership buy-in
- Provider resistance
- Quality and usefulness of Prescription Monitoring Program (PMP) information
- Lack of EHR interoperability
- Lack of knowledge or training
- Additional process/steps take too much time
- Other - Write In

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

153. Are opioid prescribing guidelines built into the organization's EHR system?

- Yes
- No

LOGIC Hidden unless: #153 Question "Are opioid prescribing guidelines built into the organization's EHR system?" is one of the following answers ("No")

154. Are there any plans to build the opioid prescribing guidelines into the organization's EHR system?

- Yes
- No

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

155. Does the organization receive information when a patient with an opioid prescription has an emergency department visit?

- Yes
- No

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

156. Does your organization provide Substance Use Disorder (SUD) treatment?

- Yes
- No

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

157. Does your organization refer to Substance Use Disorder (SUD) treatment providers?

- Yes
- No

LOGIC Hidden unless: #157 Question "Does your organization refer to Substance Use Disorder (SUD) treatment providers?" is one of the following answers ("Yes")

158. Which SUD treatment providers does your organization refer to?

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3A) Addressing the Opioid Crisis")

159. Does your organization provide Medication Assisted Treatment (MAT)?

- Yes
- No

LOGIC Hidden unless: #159 Question "Does your organization provide Medication Assisted Treatment (MAT)? " is one of the following answers ("Yes")

160. Which of the following types of MAT are providers in the organization certified to provide? (Select all that apply.)

- Buprenorphine
- Methadone
- Other - Write In

LOGIC Hidden unless: #159 Question "Does your organization provide Medication Assisted Treatment (MAT)? " is one of the following answers ("Yes")

161. Is this provided at all sites?

- Yes
- No

LOGIC Hidden unless: #159 Question "Does your organization provide Medication Assisted Treatment (MAT)? " is one of the following answers ("Yes")

162. Are all the waived prescribers (buprenorphine) at your organization at capacity?

- Yes
- No

LOGIC Hidden unless: #159 Question "Does your organization provide Medication Assisted Treatment (MAT)? " is one of the following answers ("Yes")

163. Which of the following types of MAT are providers in your organization currently providing? (Select all that apply.)

- Buprenorphine
- Methadone
- Other - Write In

LOGIC Hidden unless: #159 Question "Does your organization provide Medication Assisted Treatment (MAT)? " is one of the following answers ("Yes")

164. In providing MAT, does you organization provide the following evidence-based low barrier modalities?

	Yes	No
Treatment while a person may be using Stimulants?	<input type="radio"/>	<input type="radio"/>
Treatment while a person may be using Benzodiazepines?	<input type="radio"/>	<input type="radio"/>
Treatment while a person may be using Alcohol?	<input type="radio"/>	<input type="radio"/>
Treatment while a person may be using Marijuana?	<input type="radio"/>	<input type="radio"/>
Non-appointment Compliance based?	<input type="radio"/>	<input type="radio"/>
Open Access drop in?	<input type="radio"/>	<input type="radio"/>
Requirements for (MH or SUD) behavioral health counseling?	<input type="radio"/>	<input type="radio"/>

LOGIC Hidden unless: #159 Question "Does your organization provide Medication Assisted Treatment (MAT)? " is one of the following answers ("No")

165. If your organization does not provide MAT, do you have referral agreements with providers that do?

- Yes
- No

LOGIC Hidden unless: #159 Question "Does your organization provide Medication Assisted Treatment (MAT)? " is one of the following answers ("Yes")

166. What shared-decision making tools do providers in your organization use with patients receiving MAT?

3D: Chronic Disease Prevention and Control

Page entry logic:

This page will show when: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

167. Which chronic diseases is your organization interested in working on as part of your organization's participation in the chronic disease project? (Select all that apply.)

- Pediatric asthma
- Adult asthma
- Diabetes
- Cardiovascular disease

Logic Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

168. Does your organization empanel primary care patients?

- Yes
- No

Logic Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

169. Does your organization maintain a chronic disease registry or registries?

- Yes
- No

Logic Hidden unless: #169 Question "Does your organization maintain a chronic disease registry or registries?" is one of the following answers ("Yes")

170. What format is your organization's registry?

- Electronic (part of the EHR)
- Electronic (Excel or Access file)
- Paper
- Combination
- Electronic (separate software) - Use Other to describe
- Other - Write In

LOGIC Hidden unless: #169 Question "Does your organization maintain a chronic disease registry or registries?" is one of the following answers ("Yes")

171. What diseases are included in your organization's registry?

- Asthma
- Diabetes
- Other - Write In

LOGIC Hidden unless: #169 Question "Does your organization maintain a chronic disease registry or registries?" is one of the following answers ("No")

172. Does your organization plan to establish a registry? If so, when and for what condition?

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

173. Does your organization use a comprehensive care plan for patients with chronic diseases?

- Yes
- No

LOGIC Hidden unless: #173 Question "Does your organization use a comprehensive care plan for patients with chronic diseases?" is one of the following answers ("Yes")

174. Which of the following elements does your comprehensive care plan include? (Select all that apply.)

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice will be directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan

LOGIC Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.)

(Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

175. Do your organization's providers routinely prescribe Asthma Action Plans to Medicaid patients?

- Yes
- No

LOGIC Hidden unless: #175 Question "Do your organization's providers routinely prescribe Asthma Action Plans to Medicaid patients?" is one of the following answers ("Yes")

176. How often are the Asthma Action Plans updated?

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

177. Do your organization's care team include the following roles? (Select all that apply.)

- Community Health Workers
- Chronic Care Coordinators
- Social Workers
- Pharmacists
- Registered Dieticians

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

178. If your organization's care teams include non-traditional, non-billable roles (like Community Health Workers) what strategies does your organization use to make those positions financially sustainable?

LOGIC Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

179. If your organization's care teams do not include the non-traditional roles, what are the top three barriers to adding those positions to your care teams?

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

180. For your patients with chronic conditions, are their self-management goals recorded in their medical record?

- Yes, routinely
- Yes, occasionally
- No
- Not sure

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

181. Does your organization offer on-site self-management support programs for patients with chronic diseases?

- Yes
- No

 Show/hide trigger exists. Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

182. Does your organization partner with community-based organizations to offer community-based (e.g. off-site) self-management supports for patients with chronic diseases?

- Yes
- No

 Hidden unless: #182 Question "Does your organization partner with community-based organizations to offer community-based (e.g. off-site) self-management supports for patients with chronic diseases?" is one of the following answers ("Yes")

183. Who are your organization's community-based organization partners to offer community-based (e.g. off-site) self-management support for patients with chronic diseases?

 Hidden unless: #4 Question "What project(s) is your organization interested in? (Select all that apply.) (Note: Your answer will determine which sections of the current state assessment survey will appear for your organization.)

" is one of the following answers ("3D) Chronic Disease Prevention and Control")

184. What type of self-management support (on-site and off-site) is routinely provided to your organization's Medicaid patients? (Select all that apply.)

[Stanford Chronic Disease Self-Management Program](#)

[National Diabetes Prevention Program](#)

Other - Write In (Required)

*



HealthierHere

The Accountable Community for Health of King County

Current State Assessment

June (revised), 2018



Overview

- Respondents
- Infrastructure for waiver work
- Workforce
- VBP
- Project-specific information
 - Bi-Directional Care
 - Transitional Care
 - Opioids
 - Chronic Disease

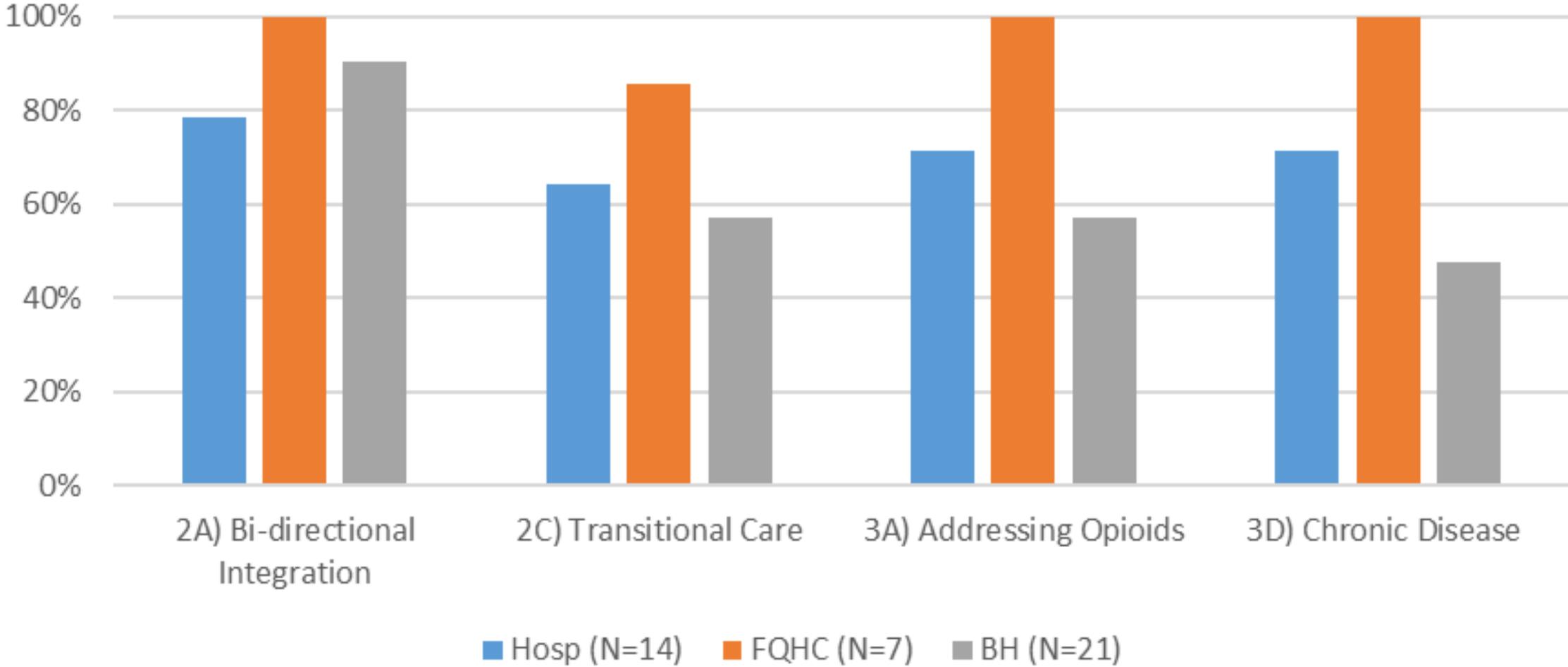
Respondents

- Hospitals – 14 of 14
- FQHC – 7 of 7
- BHAs – 21 of 26

Organizations that cross settings self-identified as follows:

- SeaMar and SIHB – FQHC
- Harborview, Seattle Children's, Multicare, and Evergreen – Hospital system
- Navos consortium members are not included as BHAs (and not reported at all in this summary) unless they returned a CSA and are direct contractors with the BHO (N=2)
- Cascade and Fairfax hospitals are included as BHAs

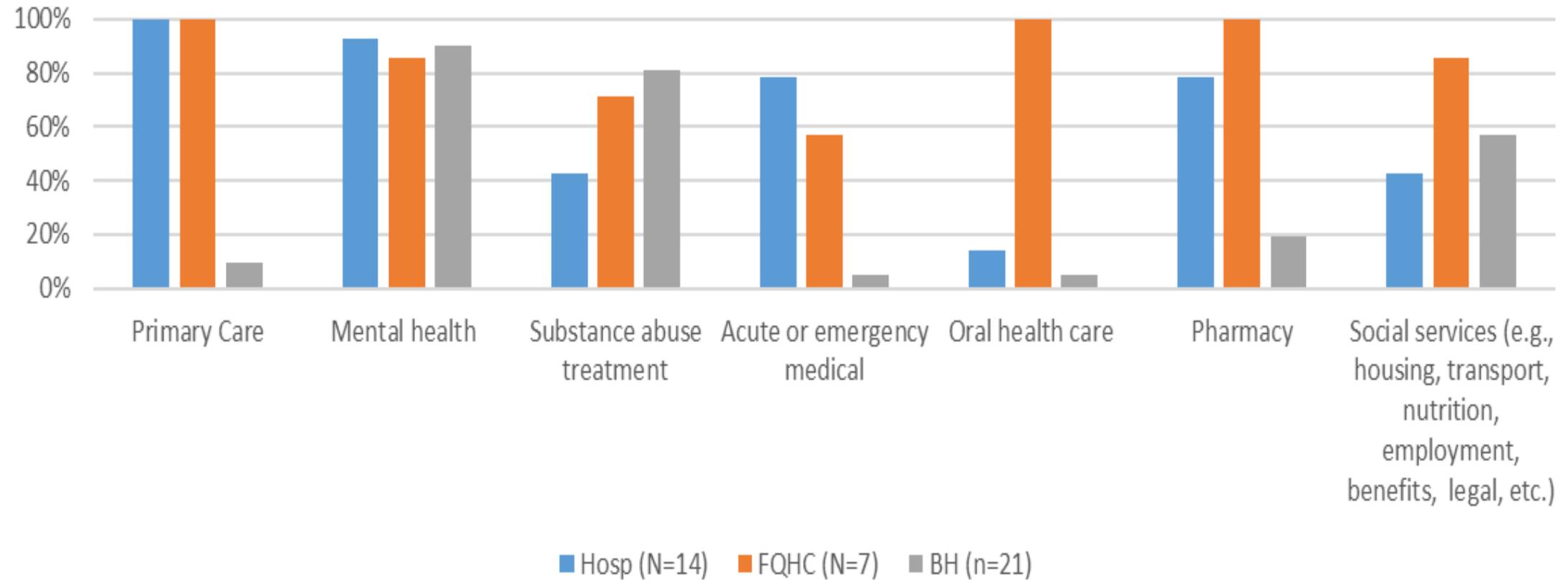
Project interest level is high across projects



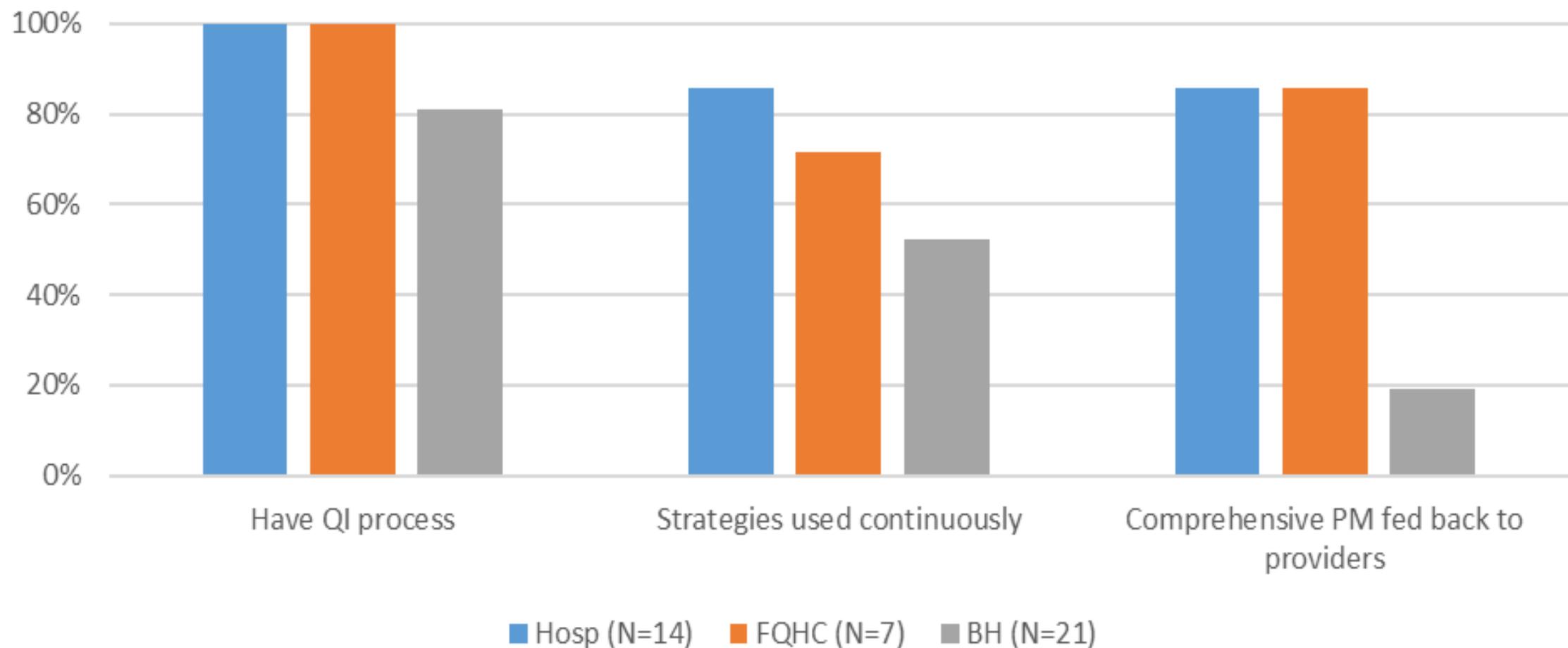
Infrastructure for waiver work



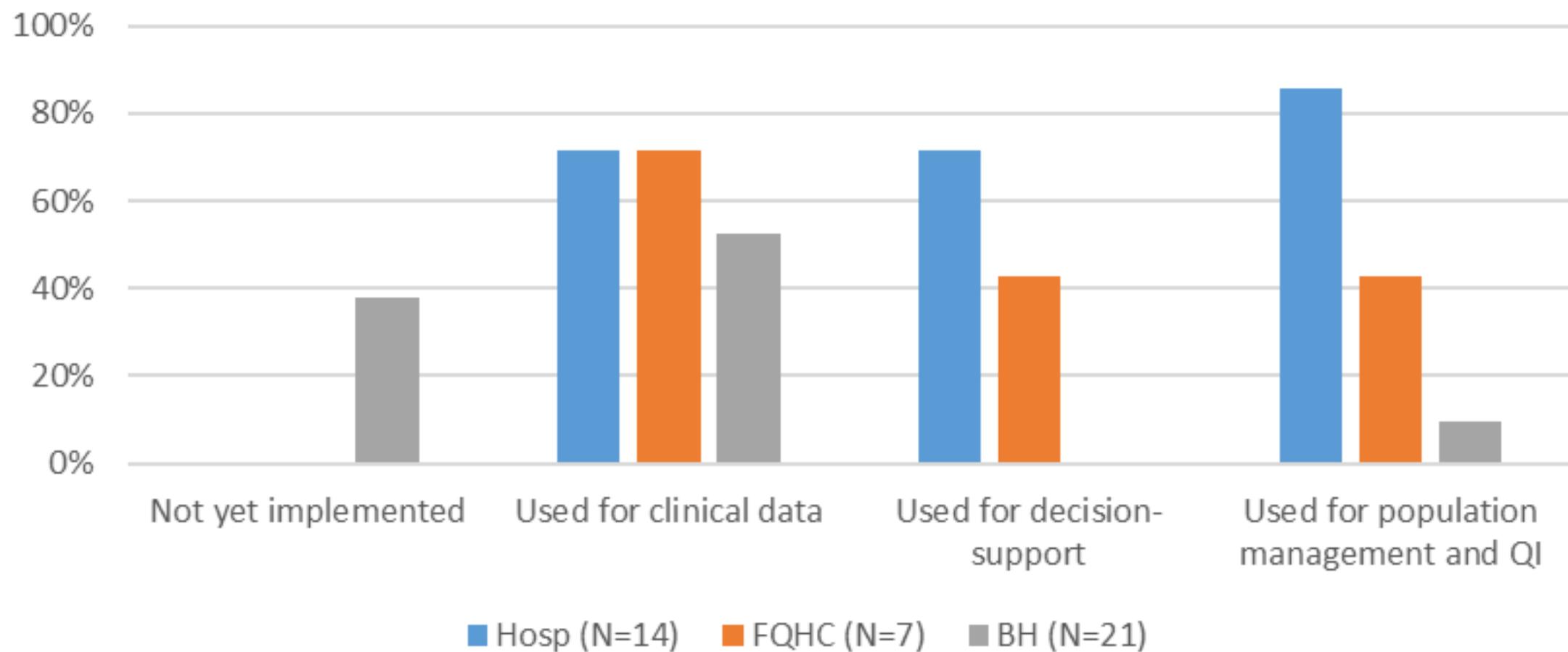
Services vary by setting



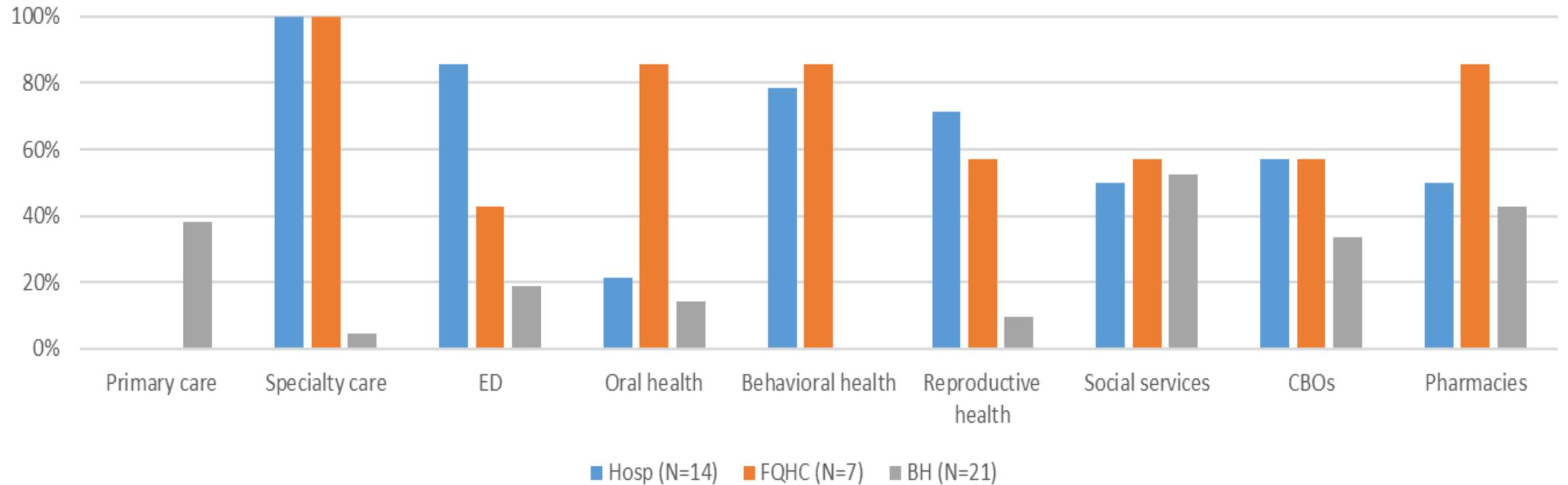
QI/PM less comprehensive at BH agencies



EMR use less well-developed at BH agencies



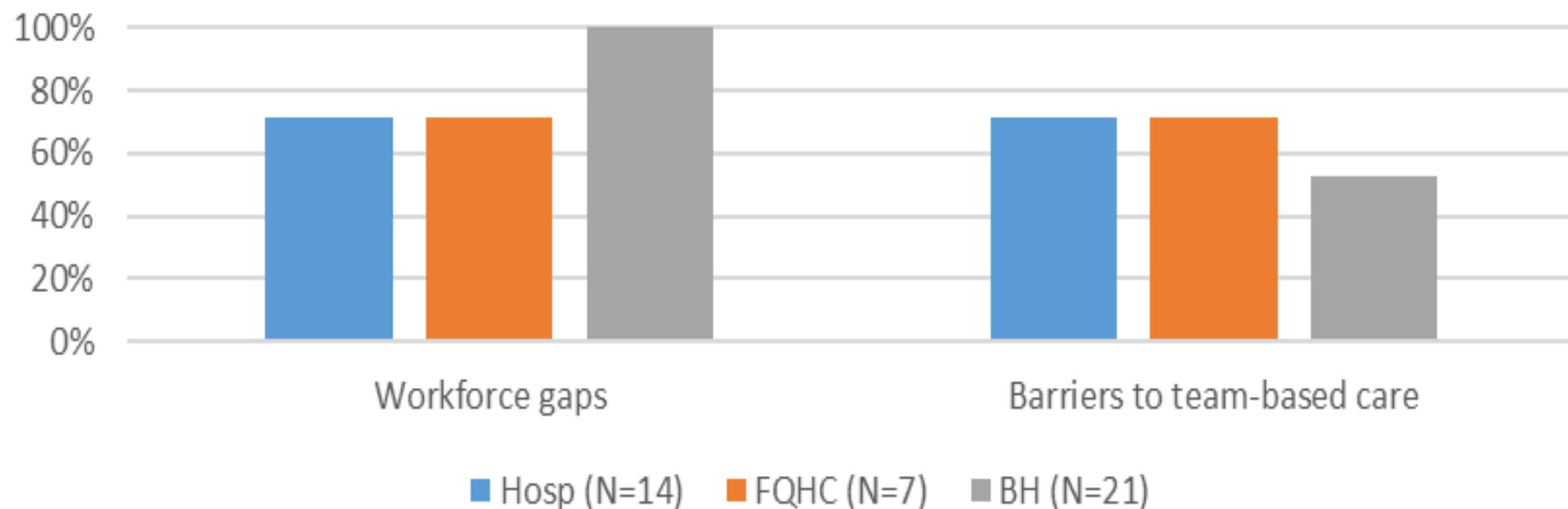
Formal care coordination relationship rates vary by setting



Workforce



Workforce gaps and barriers are ubiquitous



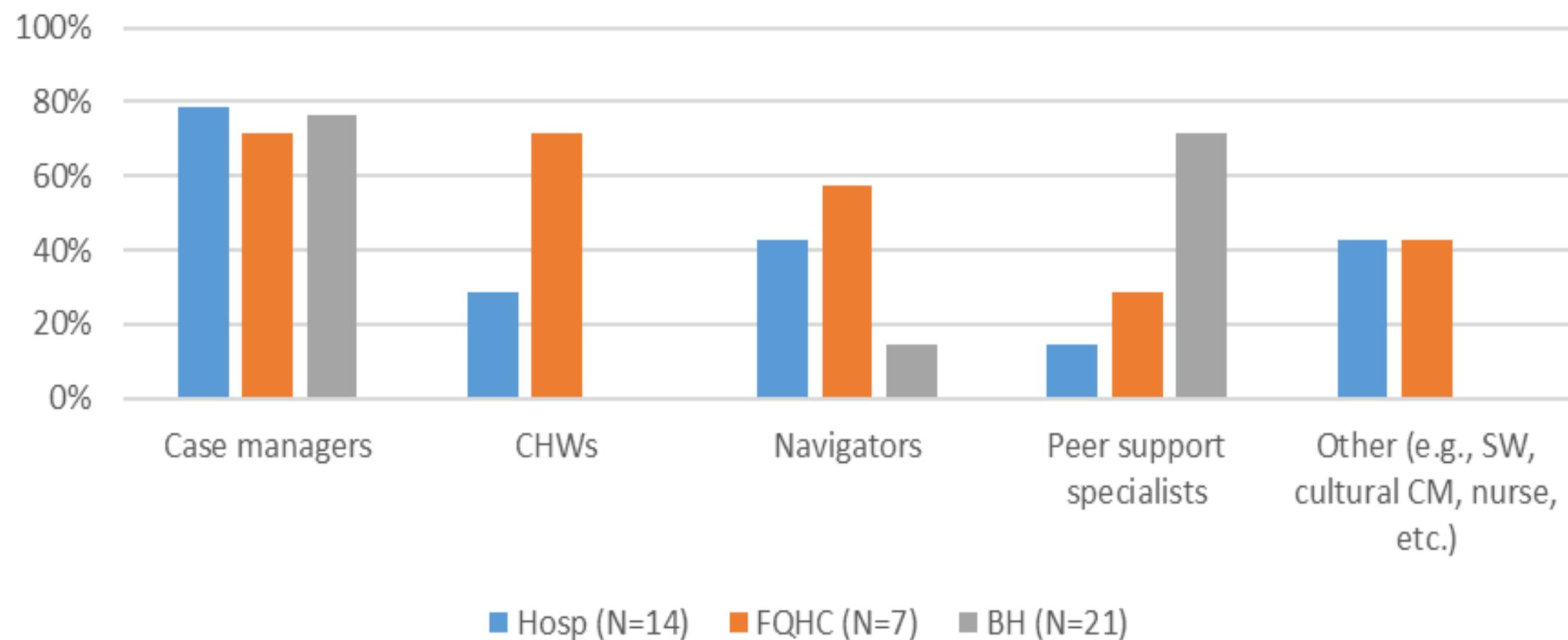
Workforce gaps

- Staff shortages
 - CHW and peers
 - Medical staff - PCPs, nursing levels, MAs
 - Care coordinators; care managers; care navigators
 - Social workers, BH professionals – especially SUD
- Training
- EMRs that support care coordination - HIE; shared care plans

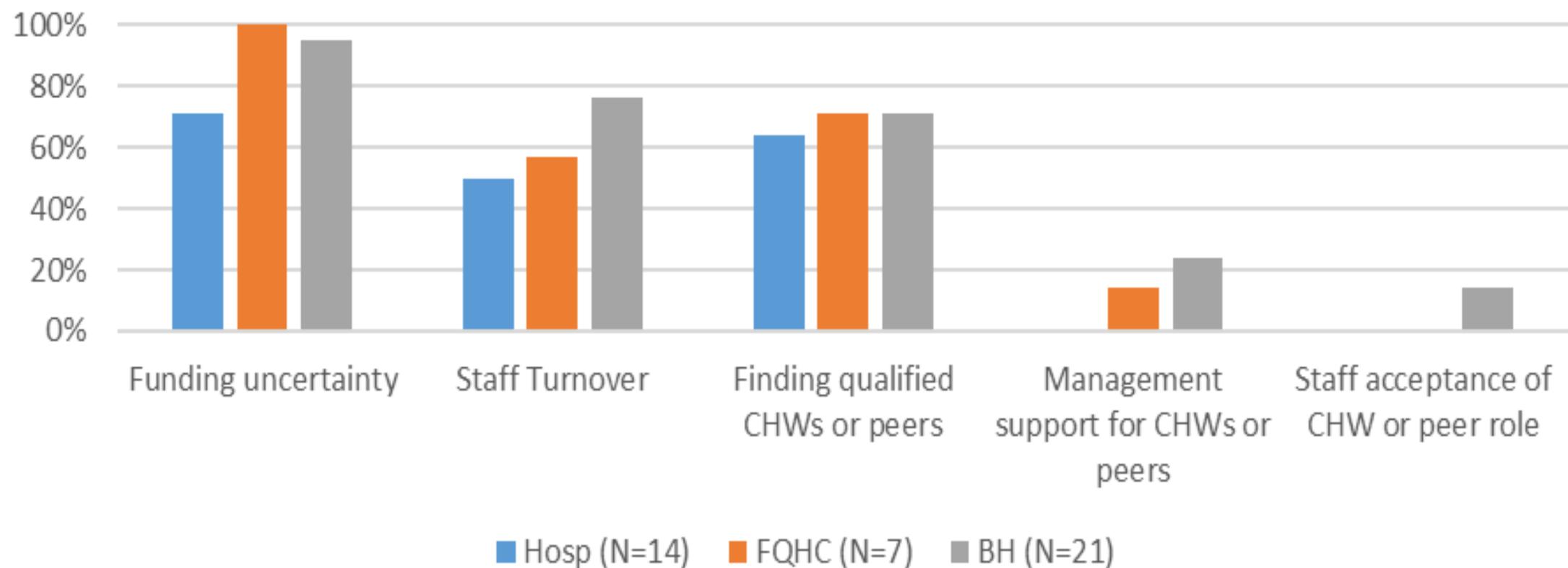
Barriers to team-based care

- Staffing issues
 - Staffing of all roles on team (esp. PCPs, nurses)
 - Training
 - Funding for staffing and reimbursement for roles
 - BH and outreach staff
- EMRs with interoperability; info sharing; shared care plans
- Facilities designed for teamwork and consultation
- Large geographic regions to serve
- Culture/paradigm shift to break down siloes

Team composition varies by setting



Funding and retaining/finding staff are workforce concerns across settings



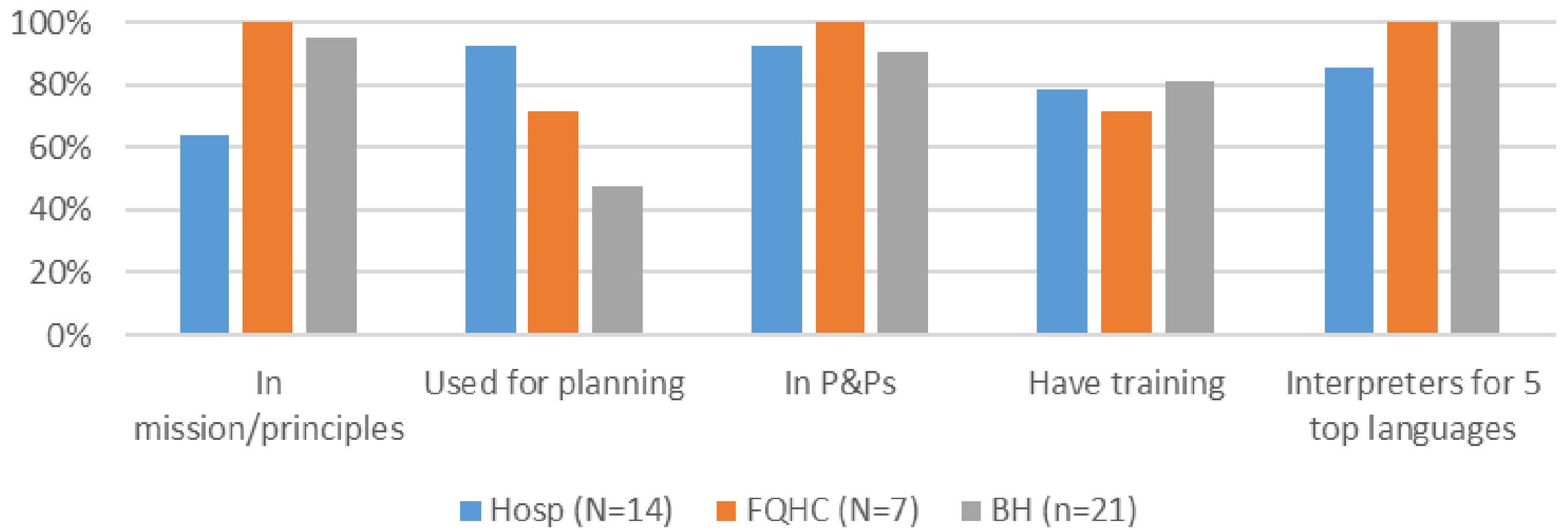
How might HealthierHere help?

- Funding – for hiring, wages/benefits, payment models
- Training – in team-based Collab Care roles/tasks, CHWs roles, chronic disease, project models, etc.
- HIE – tech for team communication, CBOs, shared care plans
- Role clarification and standards (e.g., for models, care plans, etc.)
- Assistance with recruitment – partner with educators for pipeline
- Forum for shared learnings and relationship-building
- On-site TA/coaching to support implementation

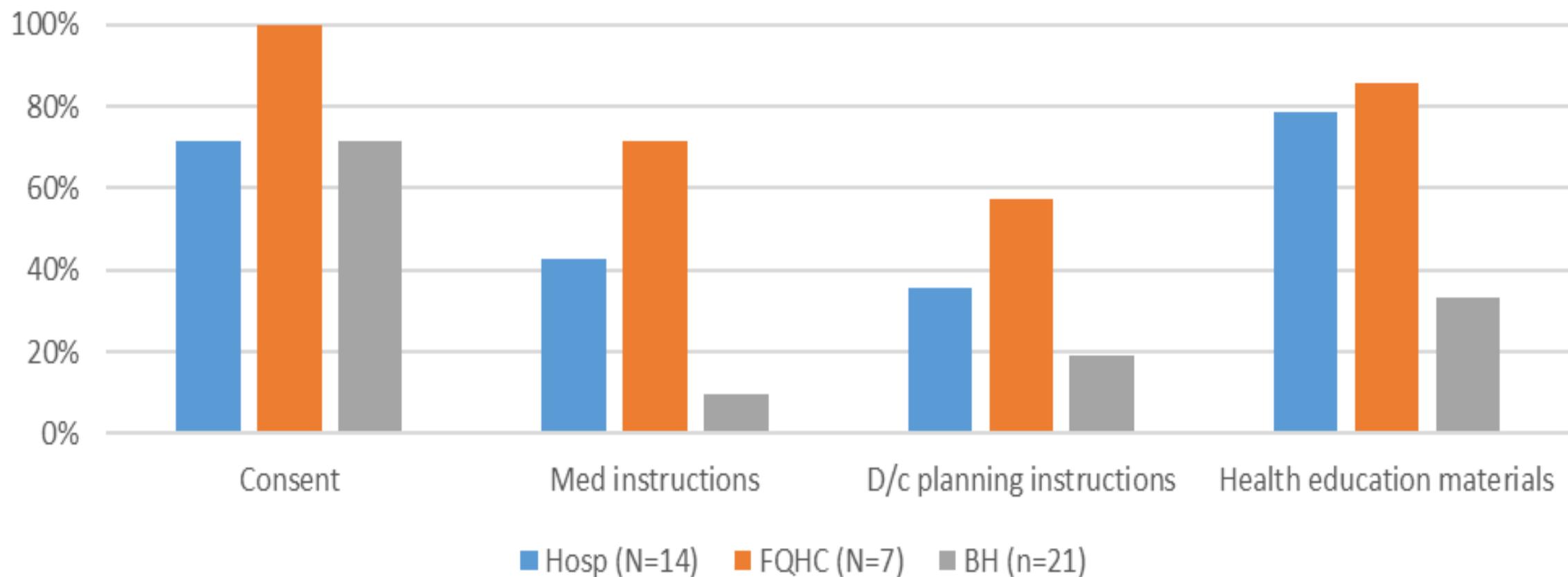
Culturally and Linguistically Appropriate Services



Use of Culturally and Linguistically Appropriate Services (CLAS) is high



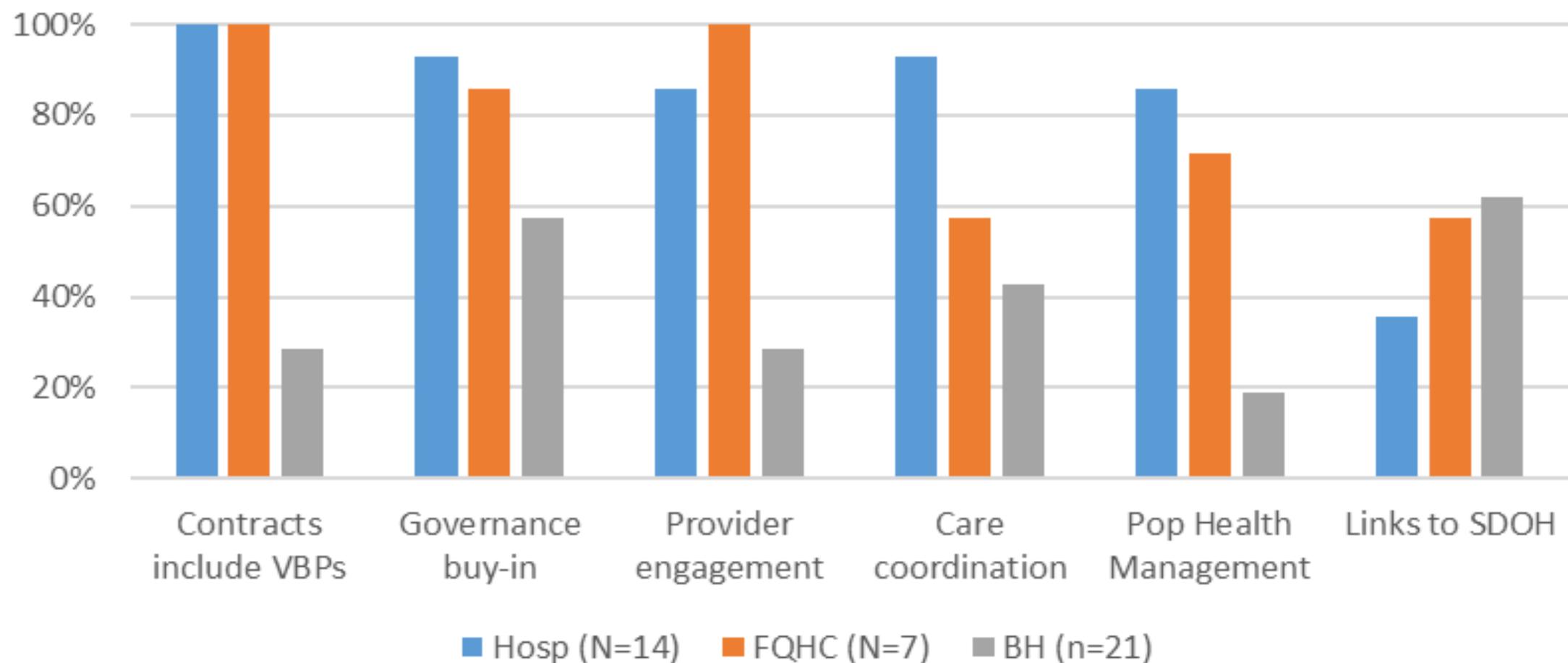
...although materials are not consistently translated



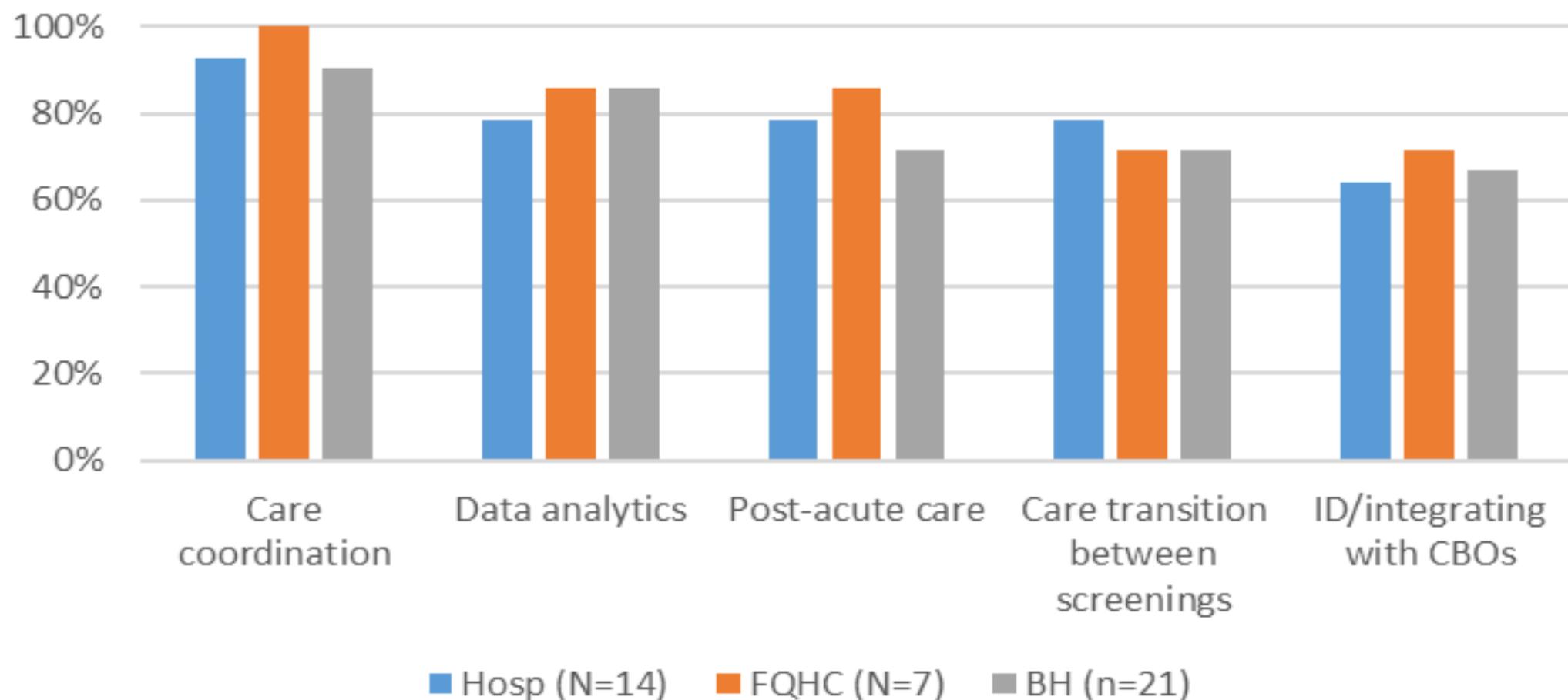
Value-based Payment



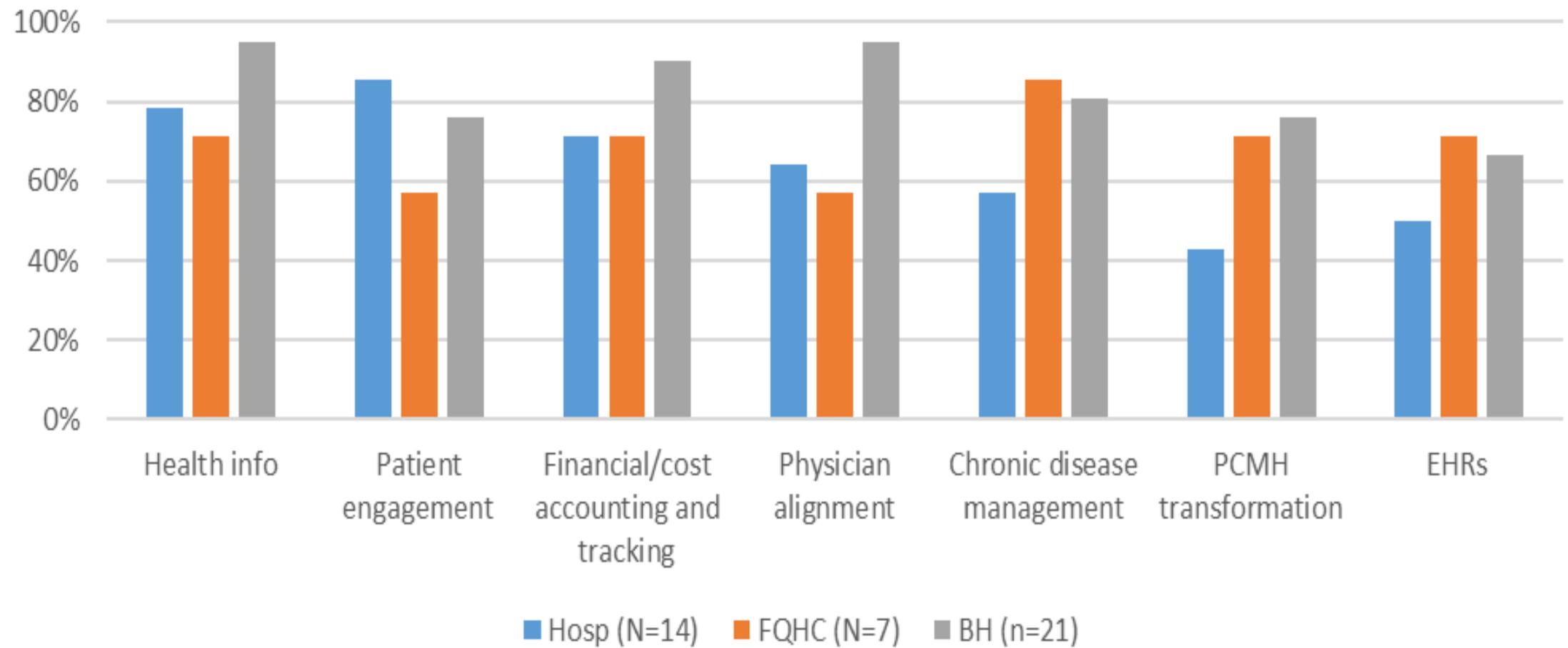
VBP readiness - BH agencies; links to SDOH lag



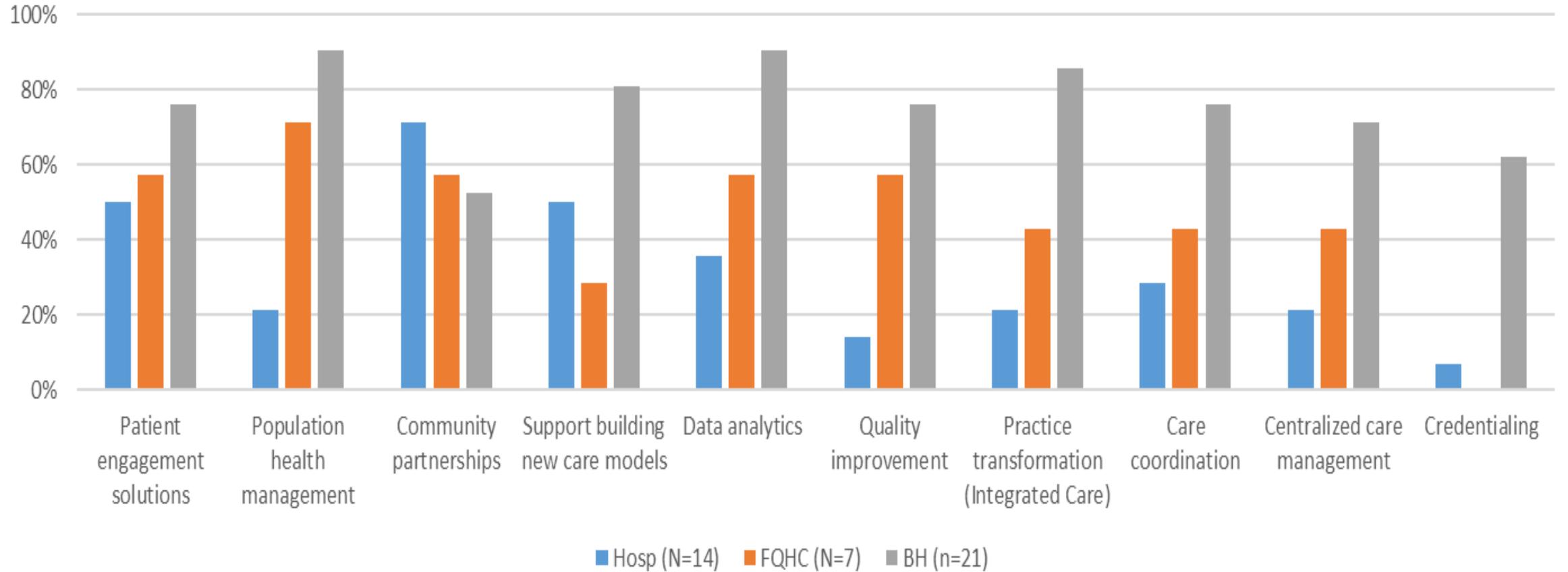
Some VBP barriers cut across settings



...while other VBP barriers vary by setting



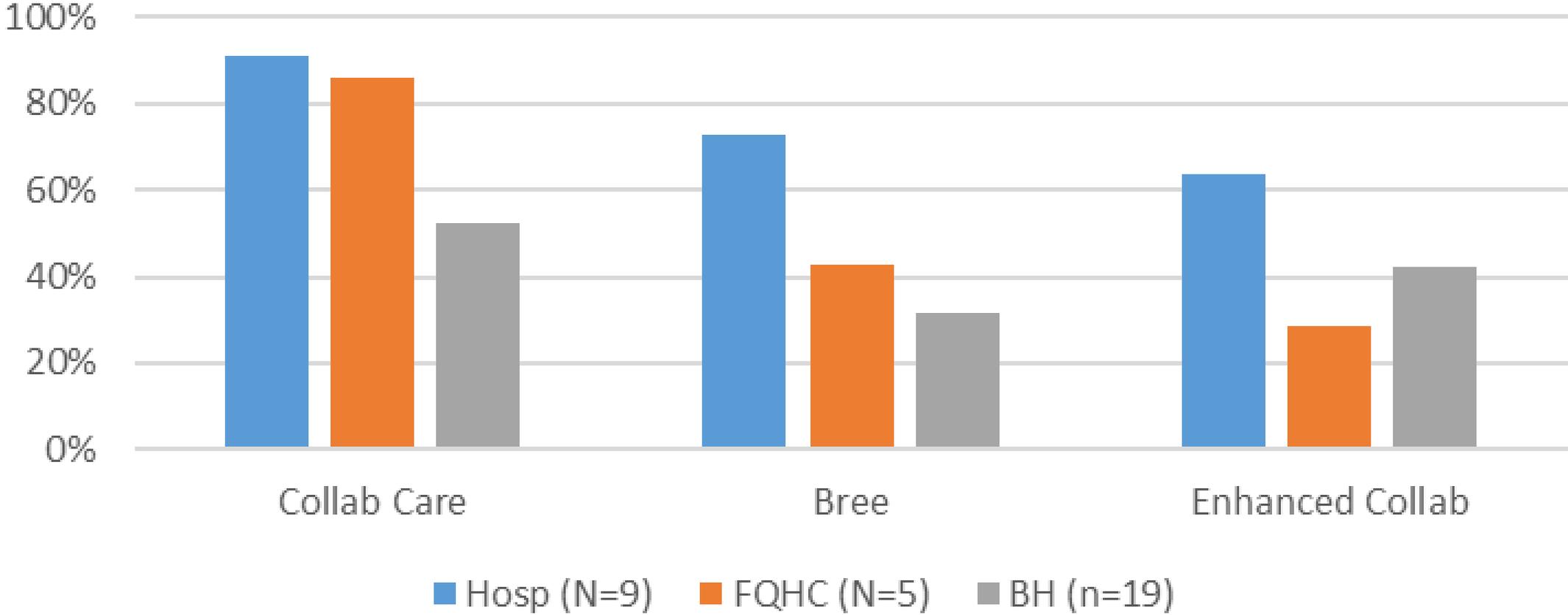
VBP training topics: BH agencies more likely to report needs across topics



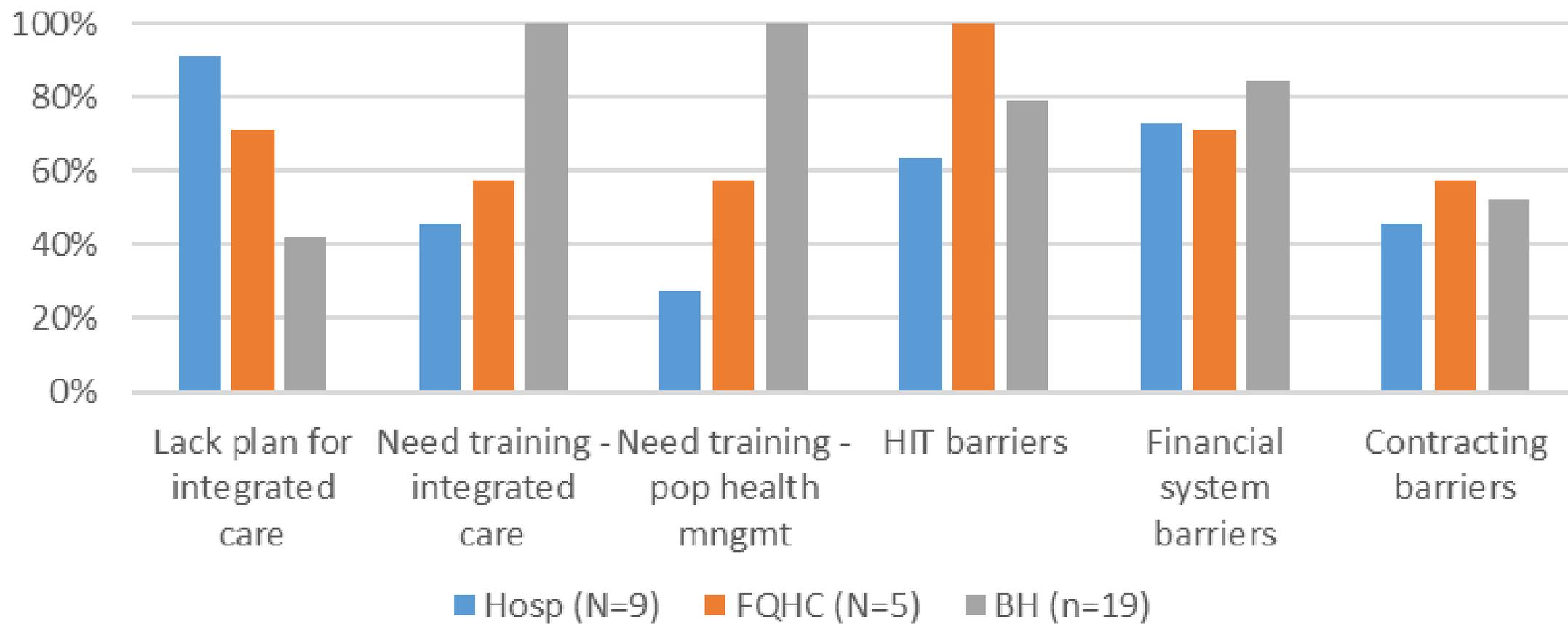
Bi-Directional Care



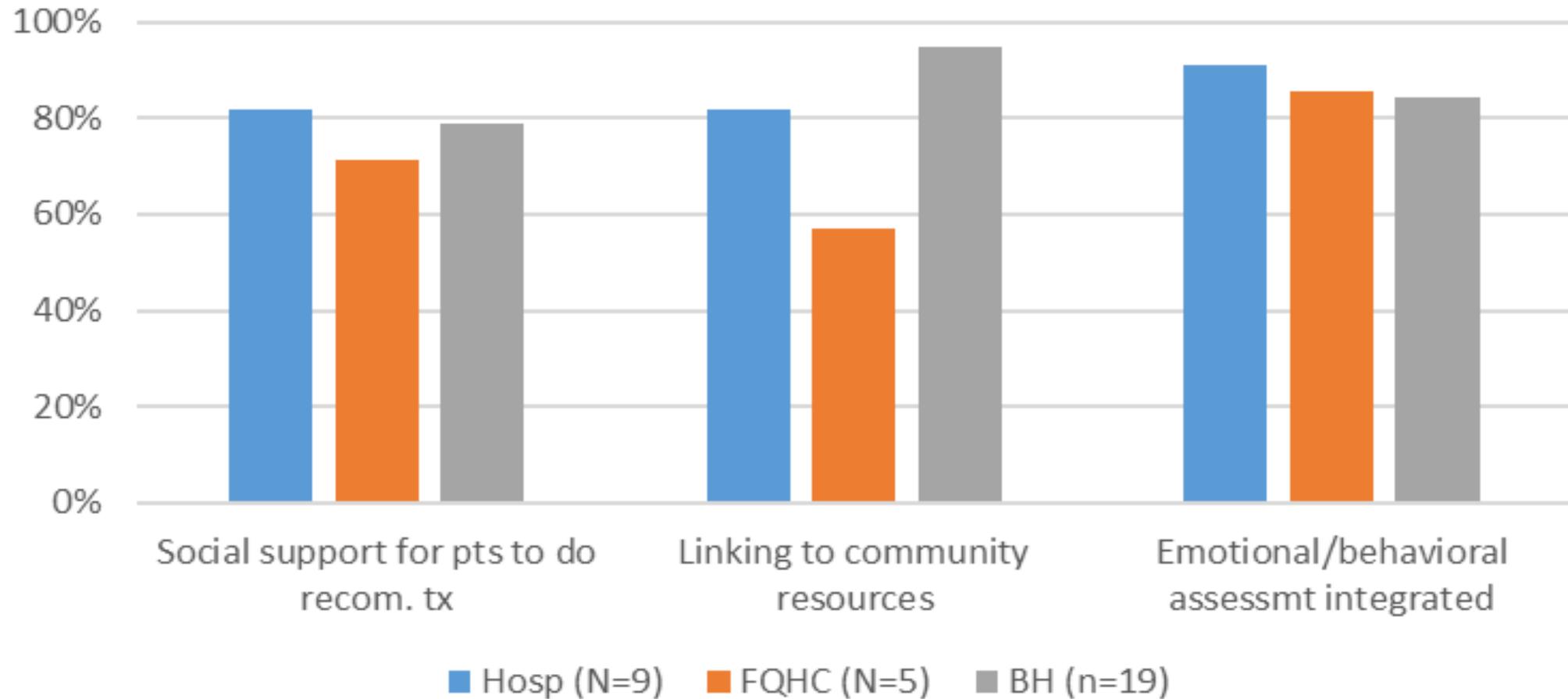
Bi-Directional Care: Collaborative Care most common model for planned implementation



Training needs, HIT, financial and contracting barriers are common - especially for BH agencies

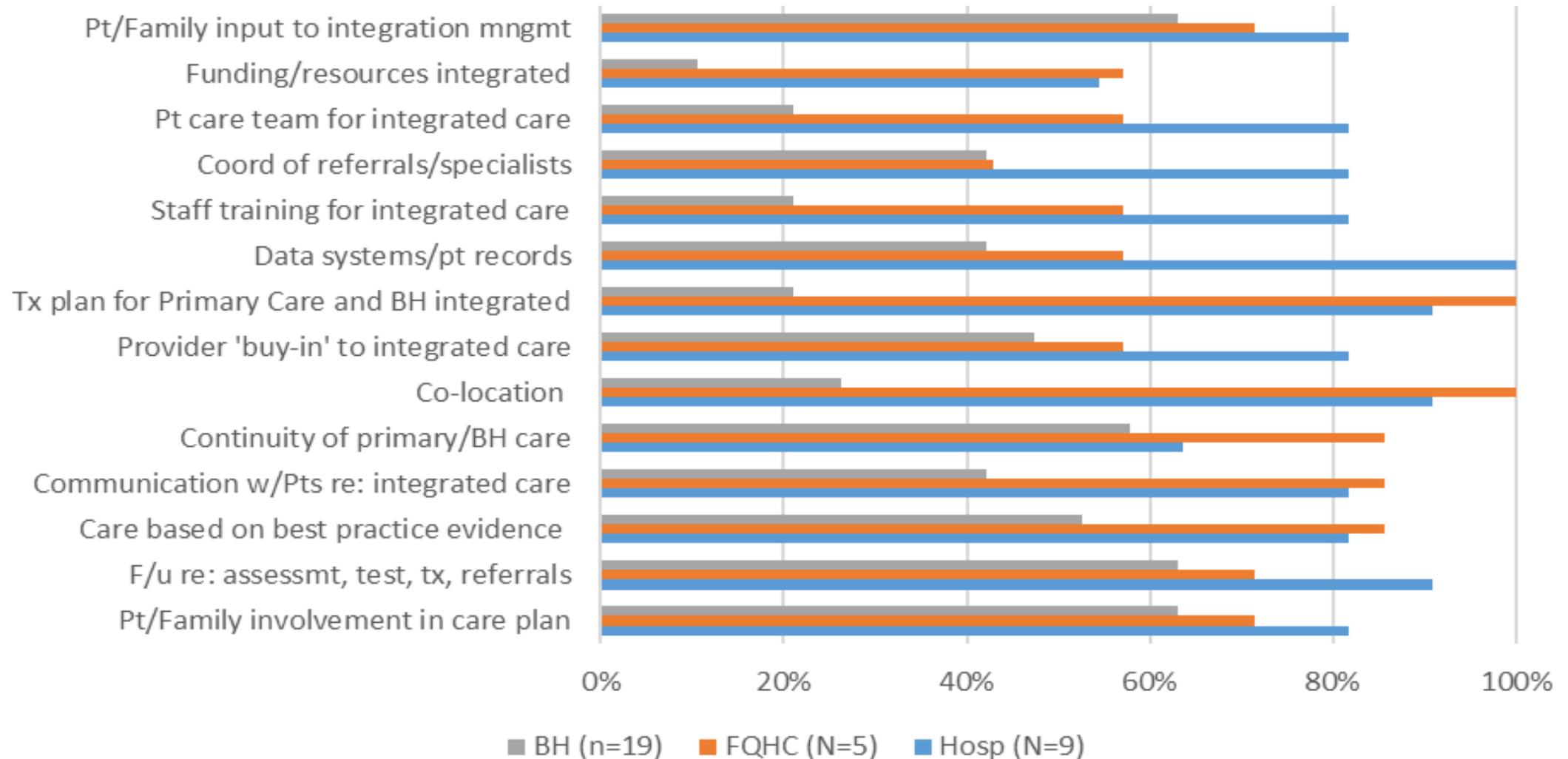


A few MeHaf areas show strength across settings...



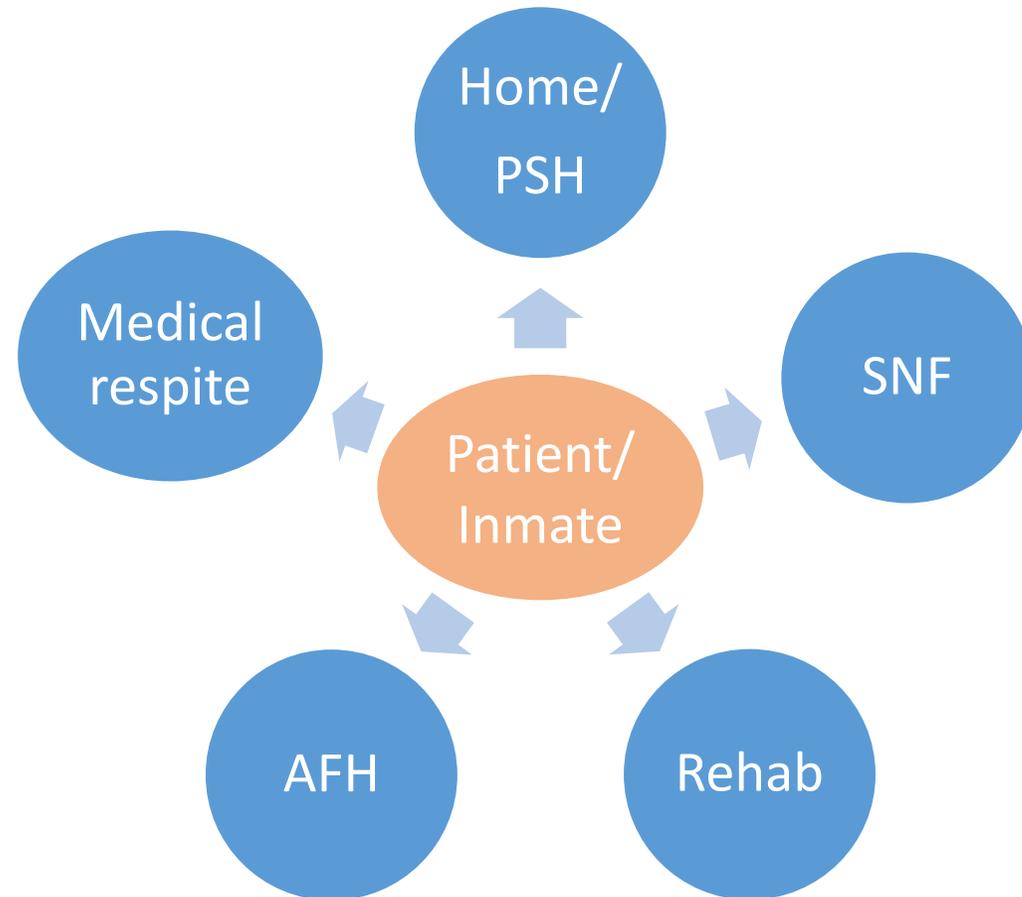
Graph indicates percentage of scores ≥ 5 indicating partial or full implementation

...but BH agencies lag in most MeHaf areas

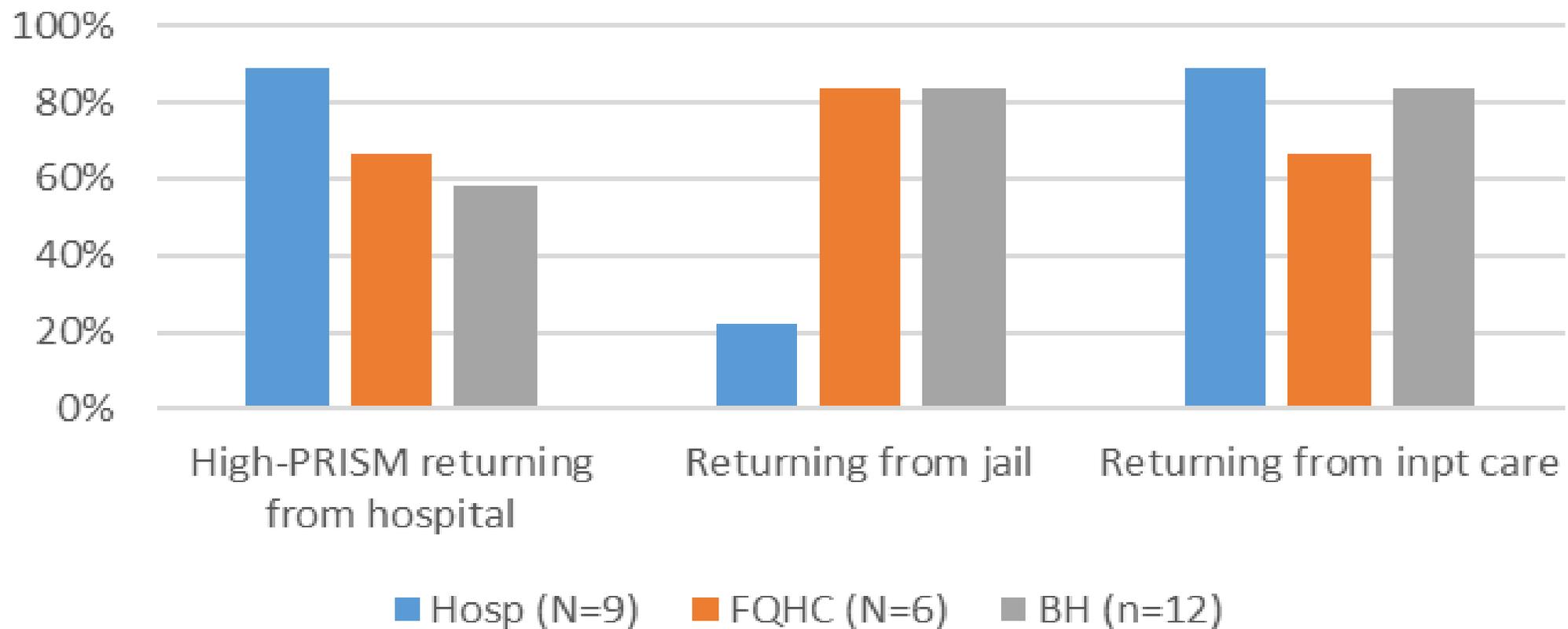


Graph indicates percentage of scores ≥ 5 indicating partial or full implementation

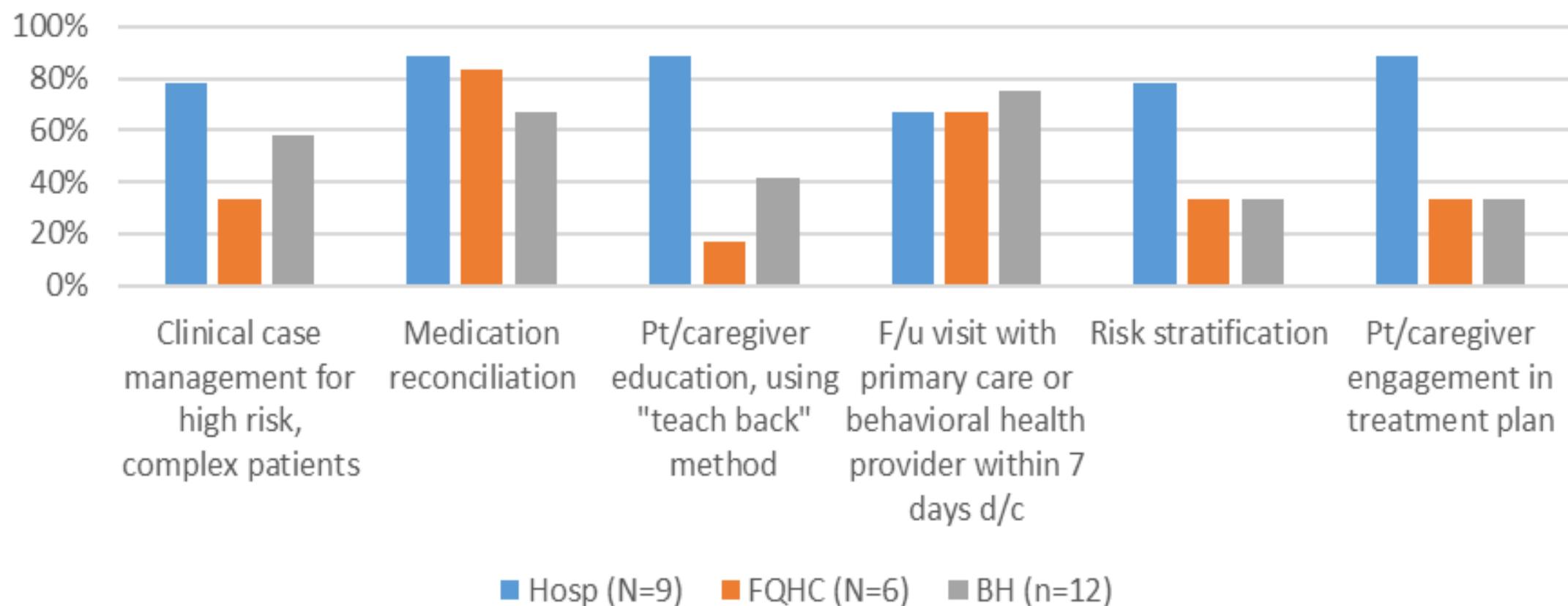
Transitional Care



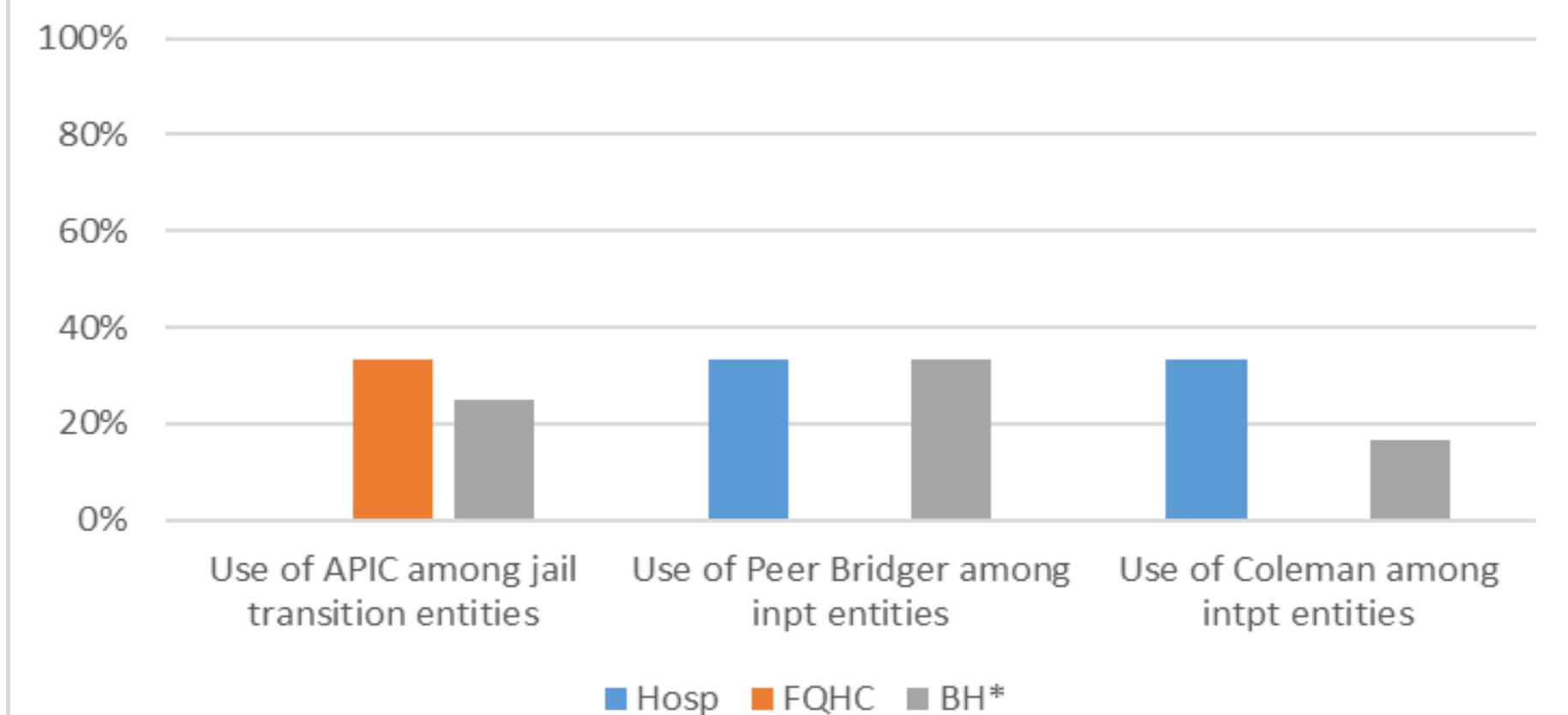
Interest in transitional care sub-populations predictably varies by setting



Services pre- and post- discharge are a strength of hospital systems



Use of evidence-base models is low



*Ns vary by interest in subpopulation

“Other” models

Jail transition: forensic steering committee, intensive case management with LEAD; components of APIC

Hospital transition: care coordination; assertive outreach; Coleman; peers; PACT; REACH; language-specific CM

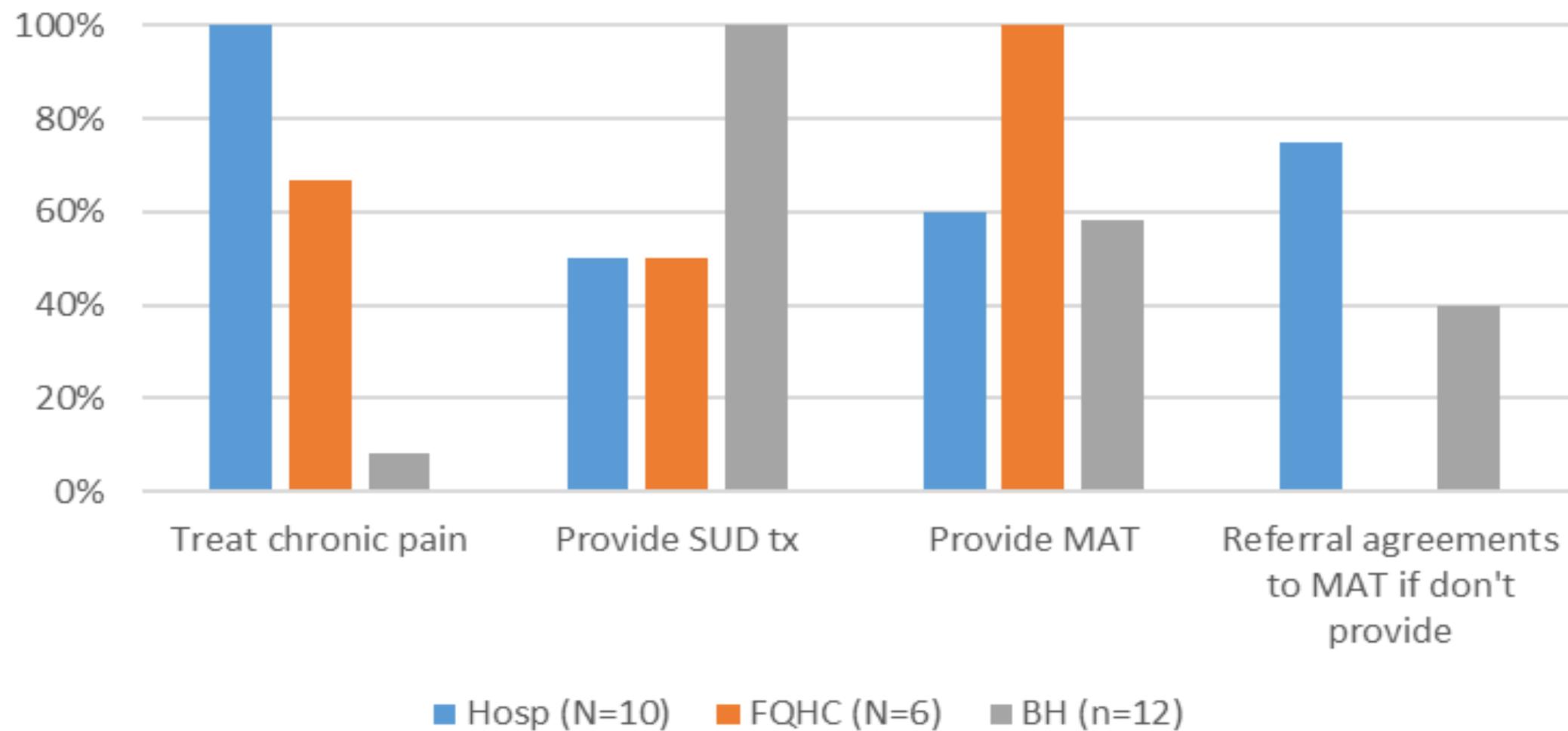
Barriers for transition care

- Housing
- Communication/collaboration; d/c info sharing
- Timely access to MH/SUD treatment, specialty care, clinics
- Funding – for outreach, CHWs, longer PCP appts.
- Staffing
- SNF and AFH funding models, beds, willingness to accept pts.

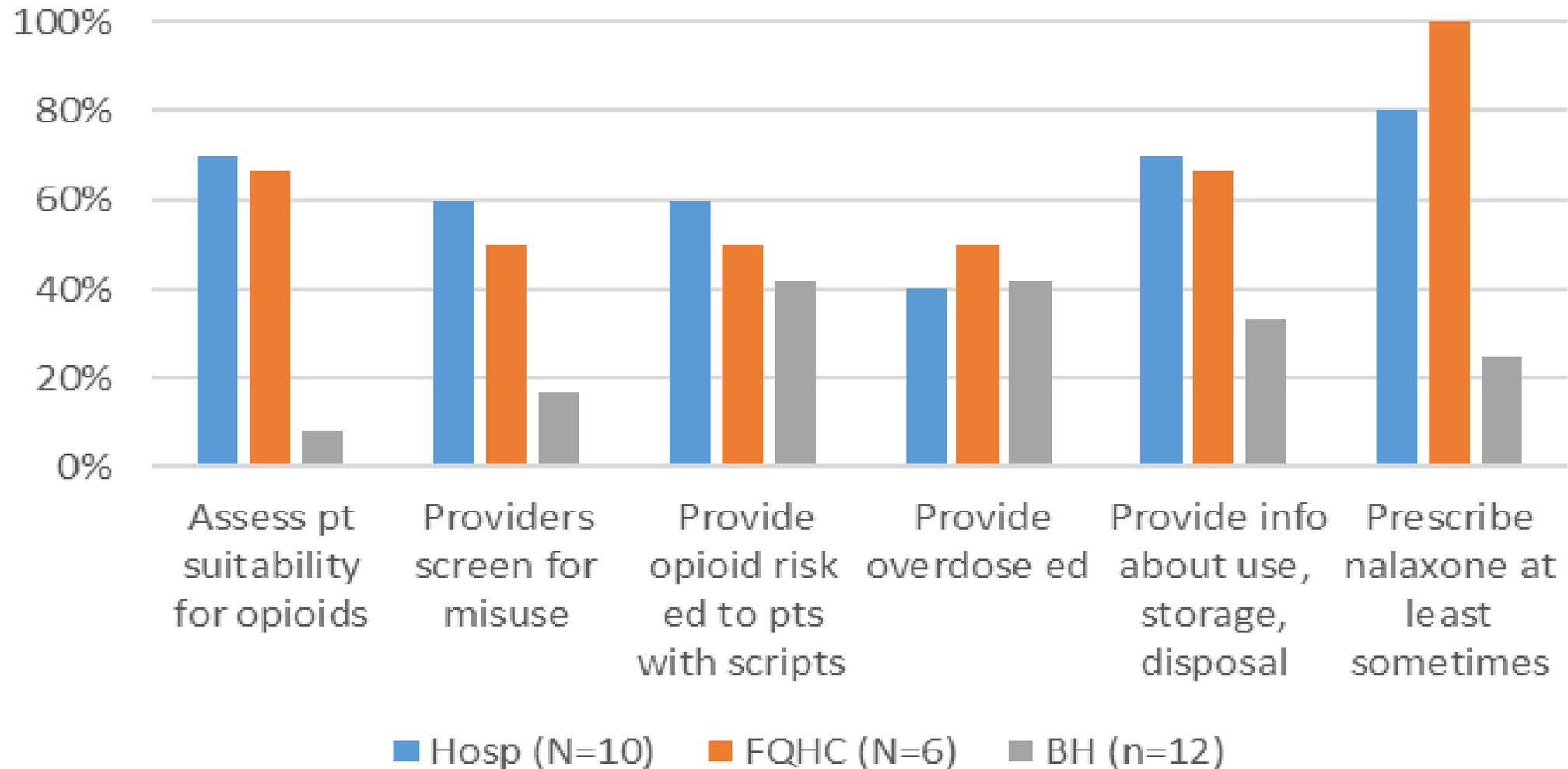
Opioids



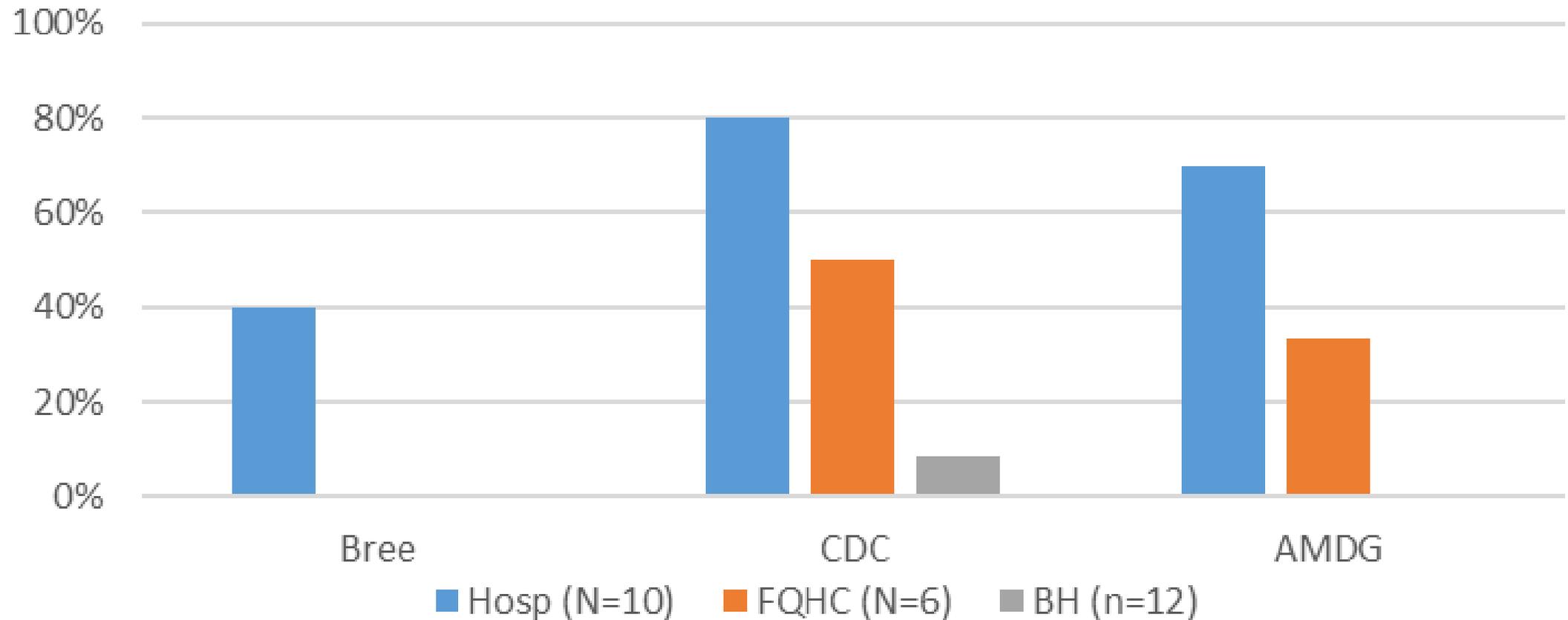
Scope of practice differs by setting



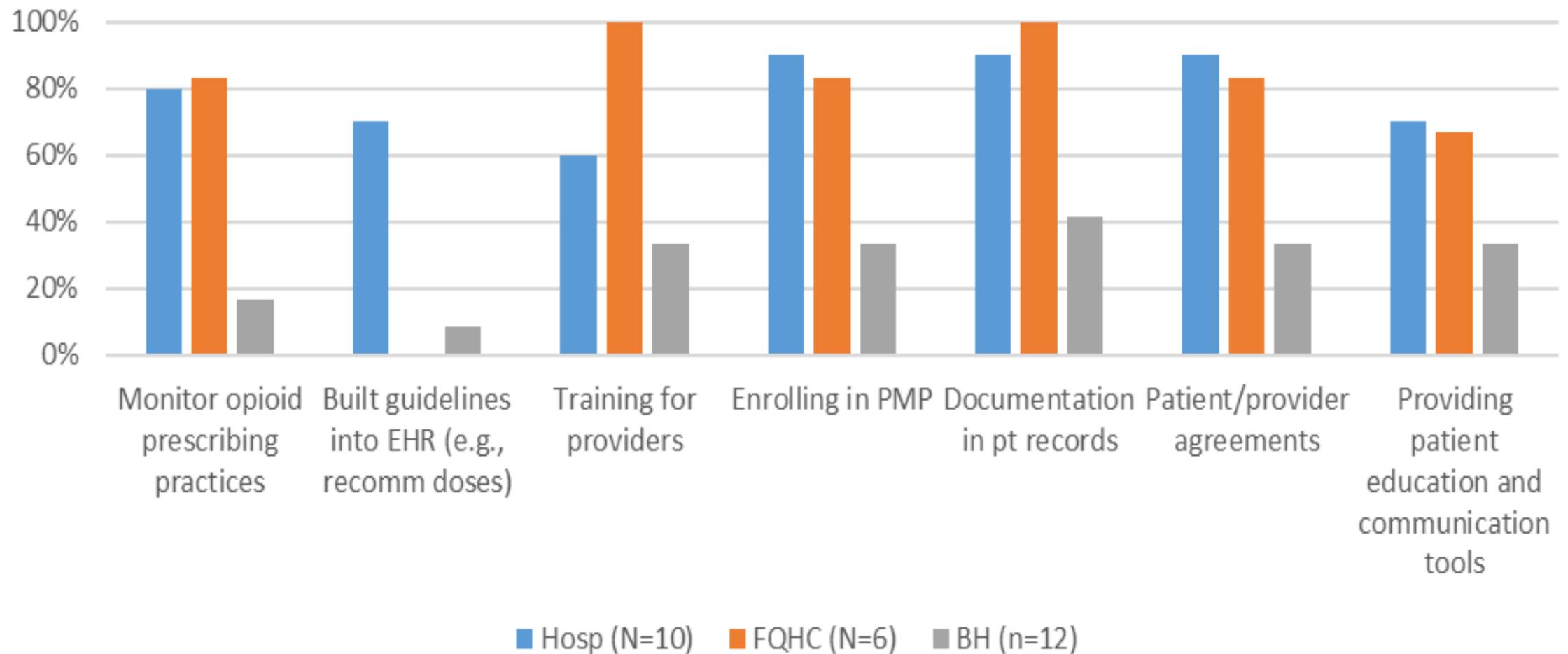
Opioid best practices are use inconsistently



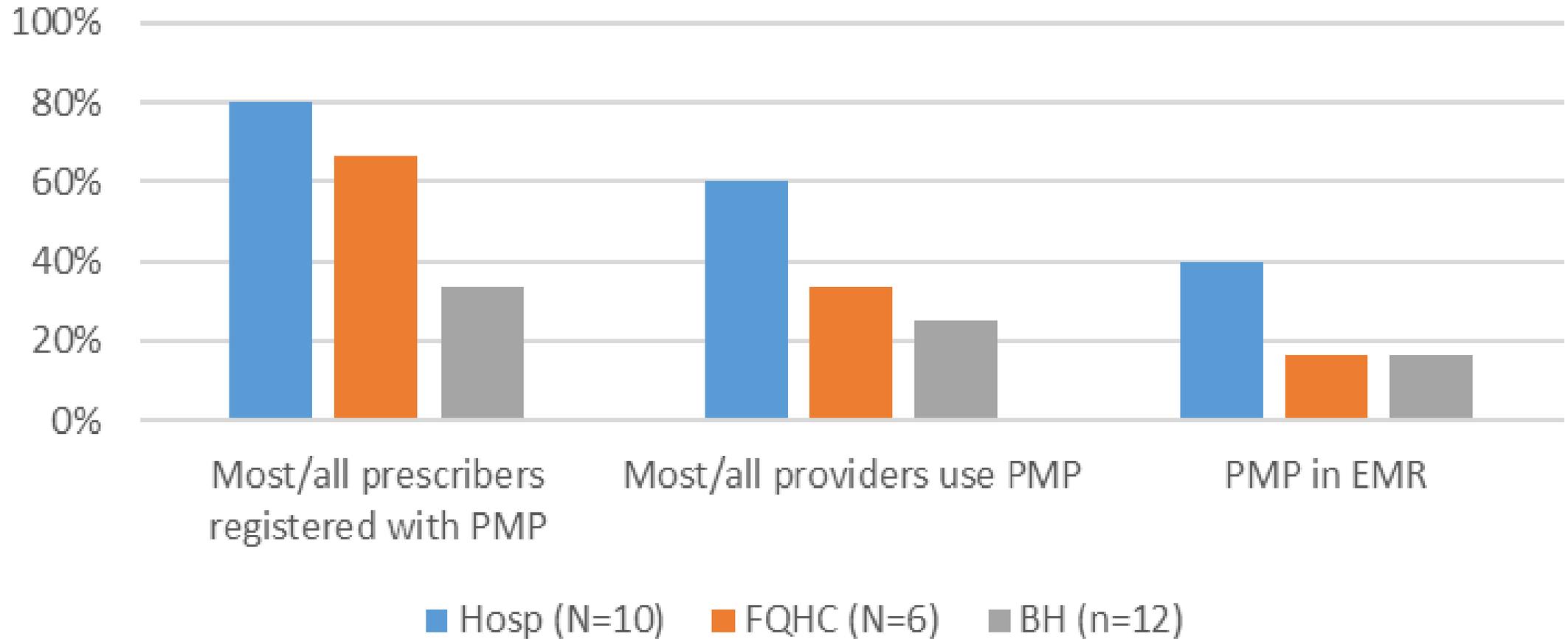
Hospital systems use opioid prescribing guidelines more than other settings



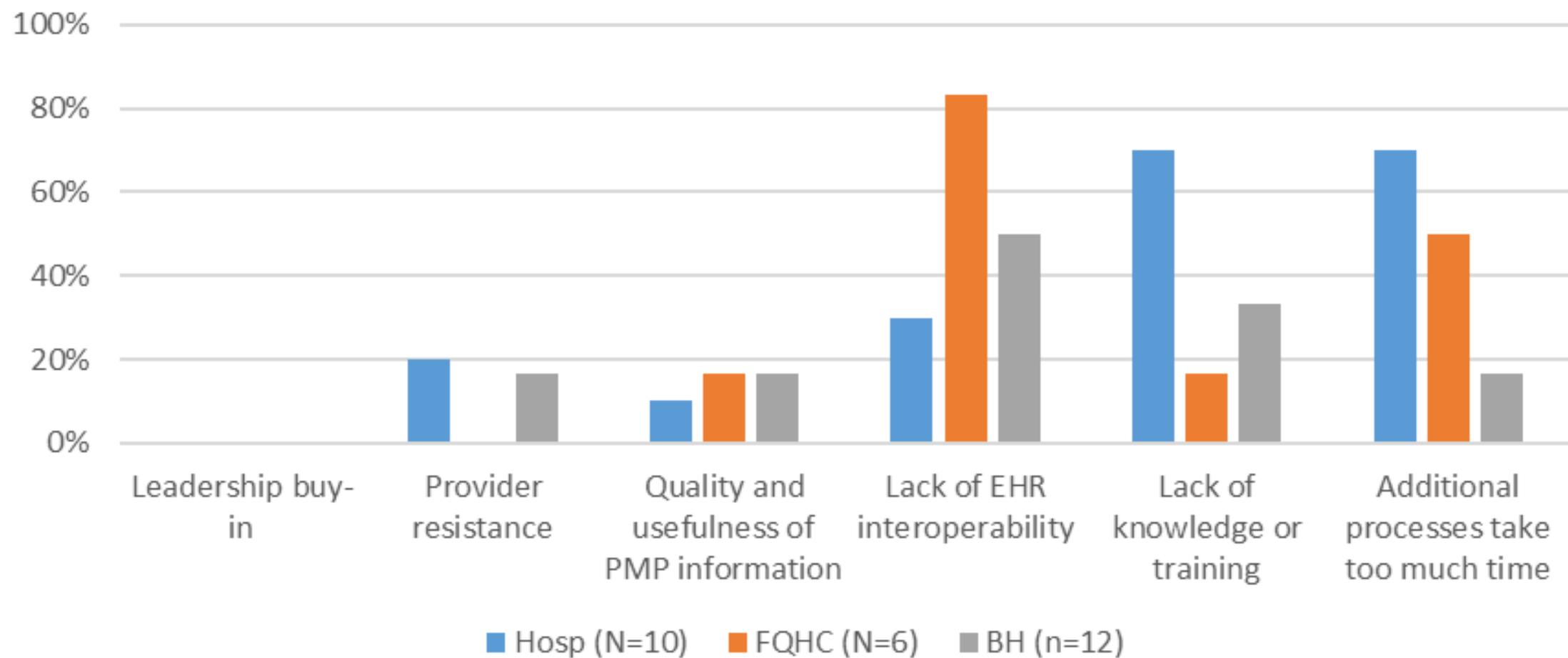
Hospitals and FQHCs have taken steps to implement guidelines



Use of PMP is inconsistent



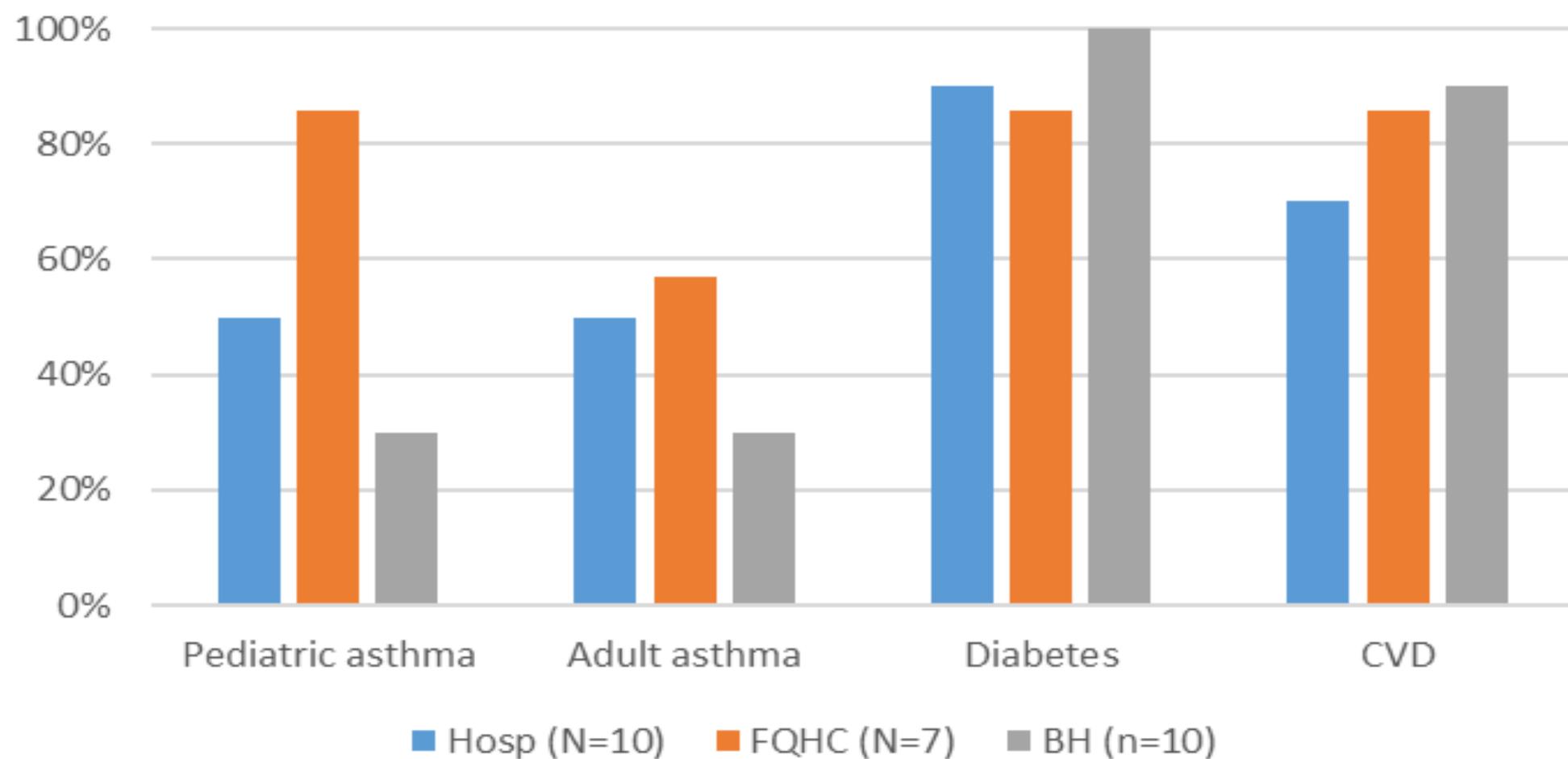
EHRs, training and added process are barriers to PMP use



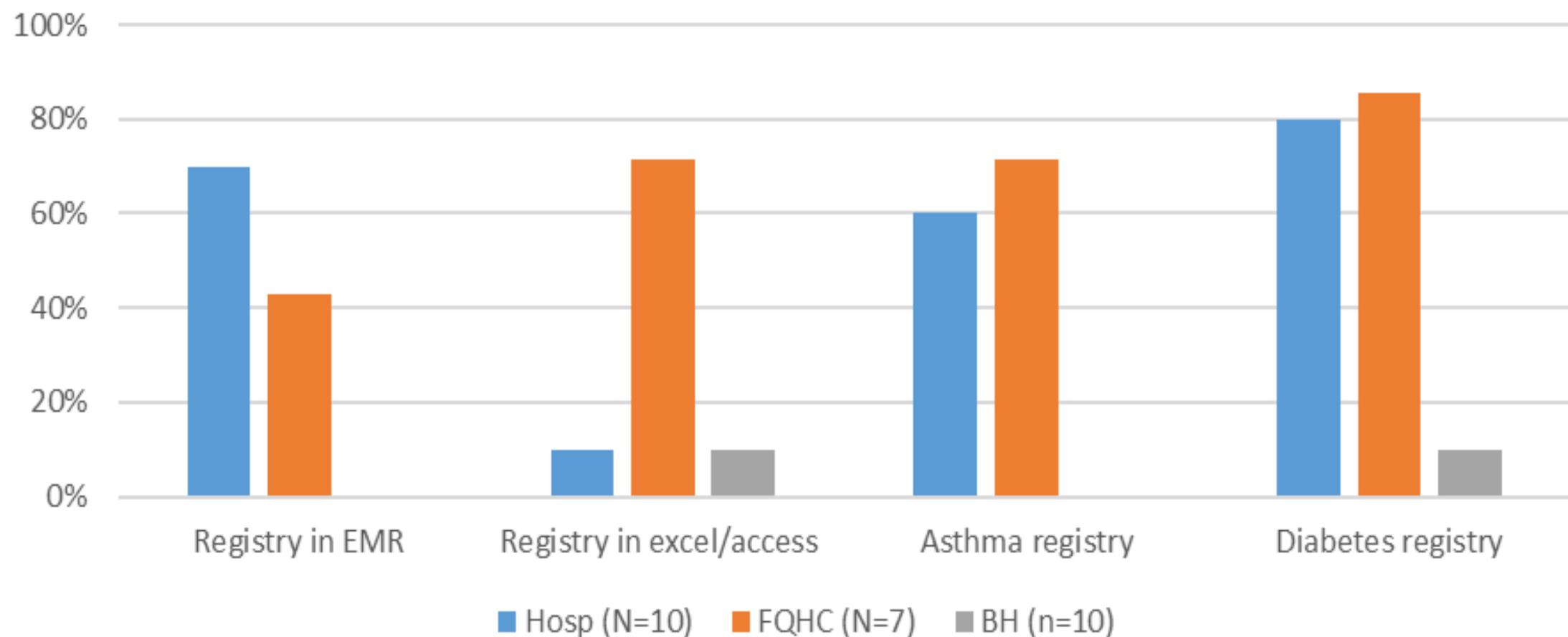
Chronic Disease



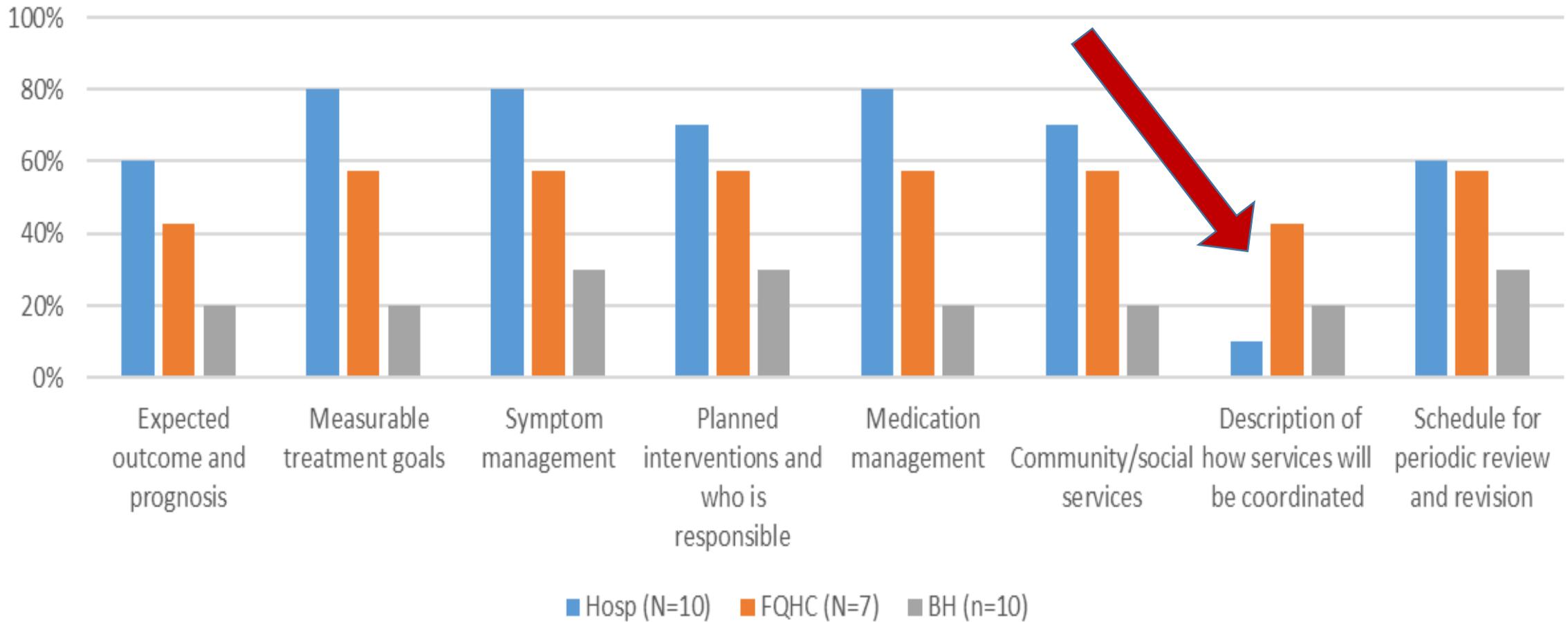
All settings have interest in Diabetes and CVD



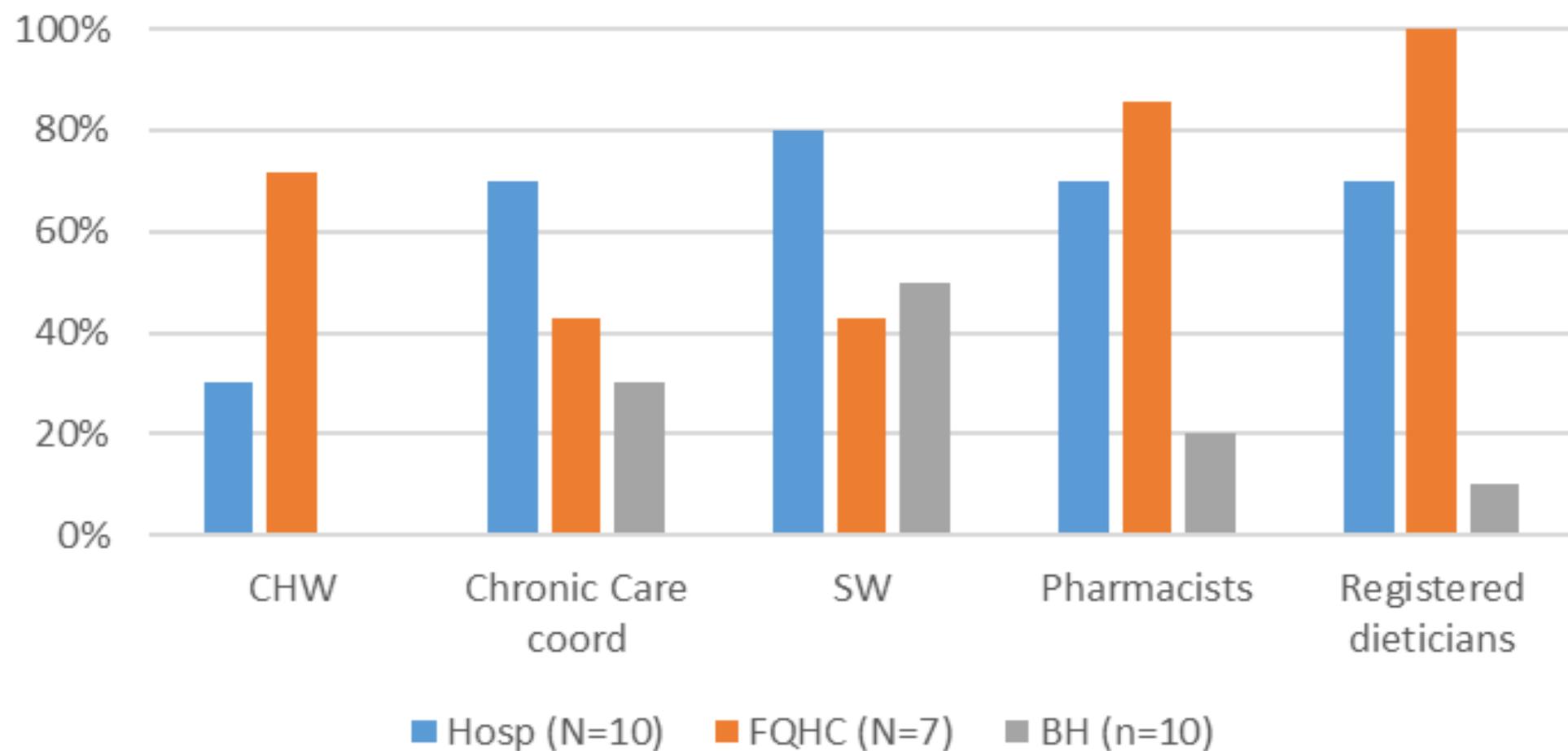
BH agencies lag in use of registries



Care plan content: inconsistent - and coordination is a notable gap



Chronic disease care team composition varies



Use of CHWs

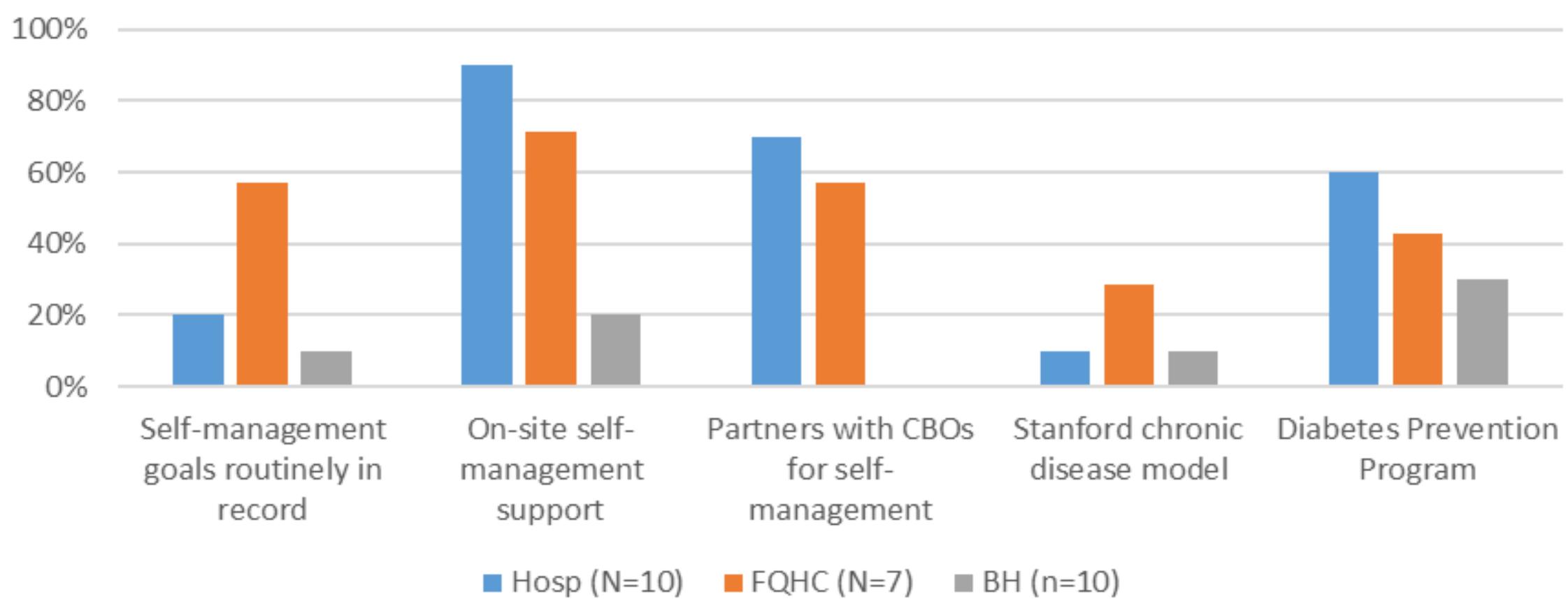
➤ Financing:

- Grants
- General operations
- Shared savings

➤ Barriers:

- Funding
- Integrating into existing workforce, workflow
- Space
- Training

Hospital systems are more likely to provide illness self-mngm't but use of specific models is low



Key Challenges for HH

- Staffing – need support for recruitment/retention of medical staff, behavioral health (especially substance use providers), CHWs, peers
- Care models - low use of Toolkit models, practice guidelines, disease self-management
- Training – need training across models, roles, care plans, patient engagement, population management
- EMRs - need interoperability and shared care plans – lack of these hampers team communication and population management
- Funding models – need models to support care coordination and transitional and aftercare, and certain staff (e.g., CHWs and peers)
- Linkages - need stronger linkages to housing and CBOs that support SDOH
- Behavioral health agencies may need extra support - lag in readiness in QI processes, EMRs, use of registries, VBP and care models



The Accountable Community of Health for King County

HIE/HIT Assessment Findings

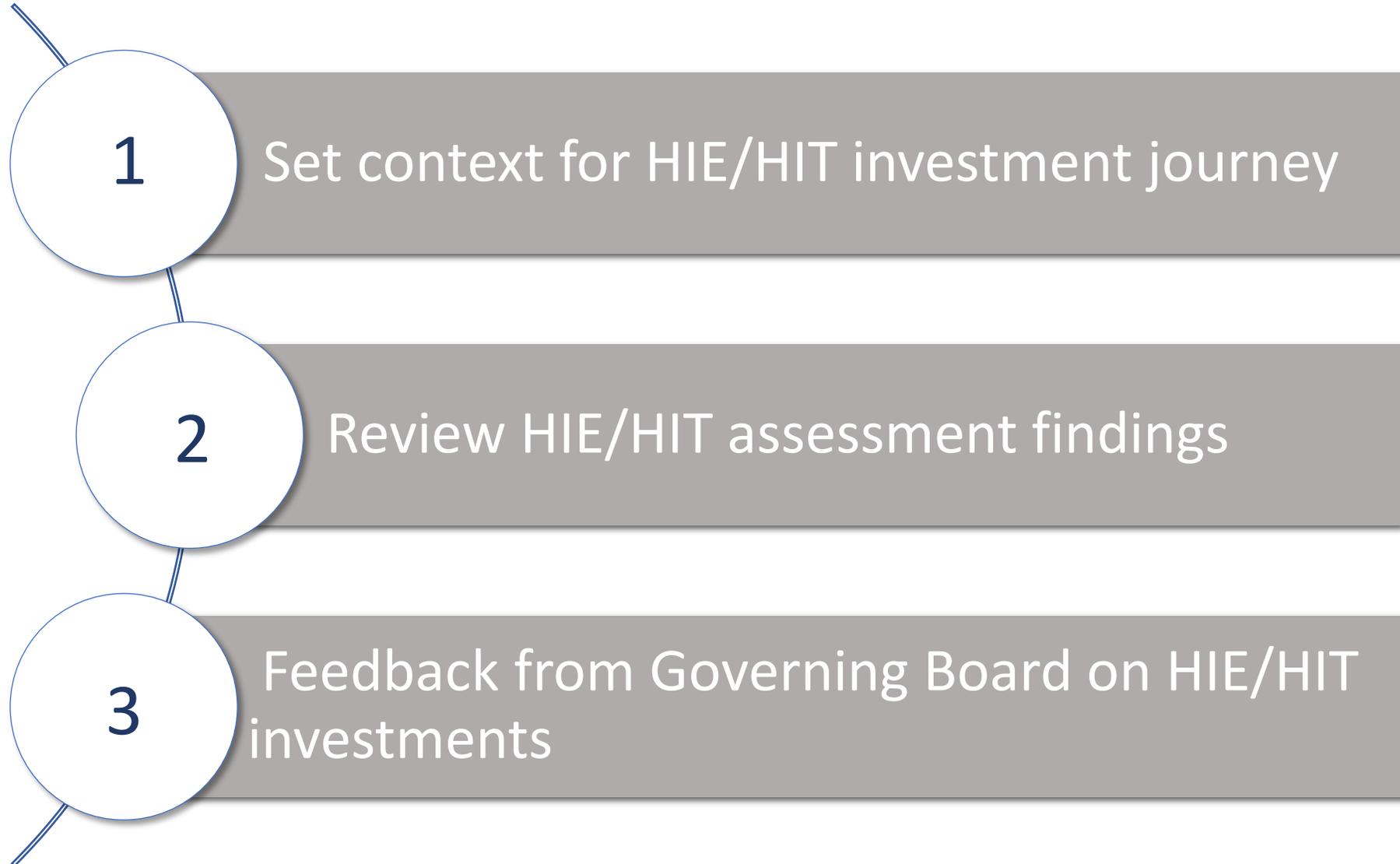
June 7, 2018

Governing Board Meeting





Meeting Goals





Core Leave Behinds

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

Access to person-centered, multi-disciplinary, culturally competent care teams -- inclusive of social services -- in health homes for everyone, regardless of where a person enters the system.

An infrastructure that provides an effective mechanism for meaningful community and consumer involvement and voice in the continuous improvement of the delivery system.

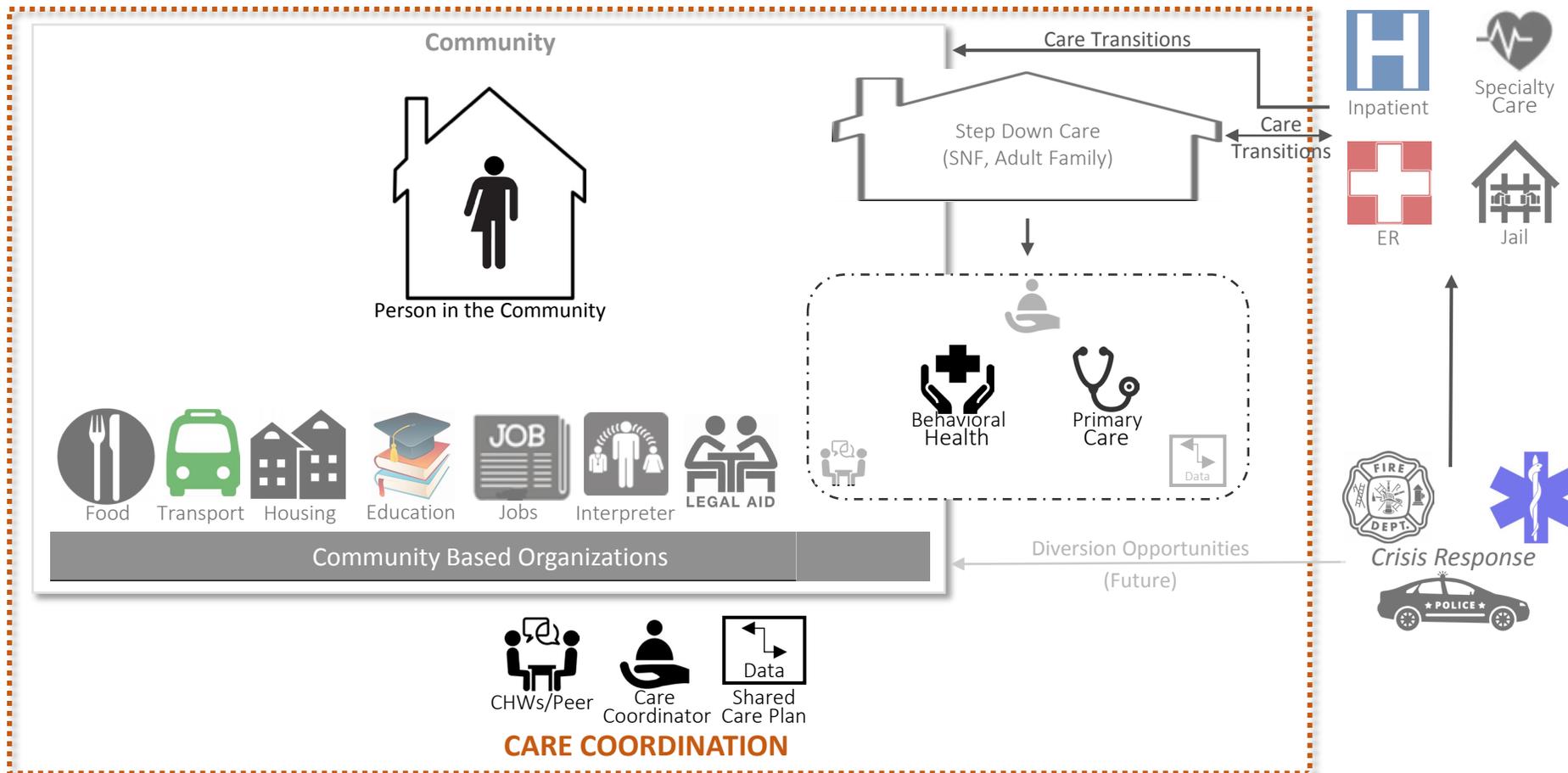


HealthierHere

A Person Centered Approach to System Transformation

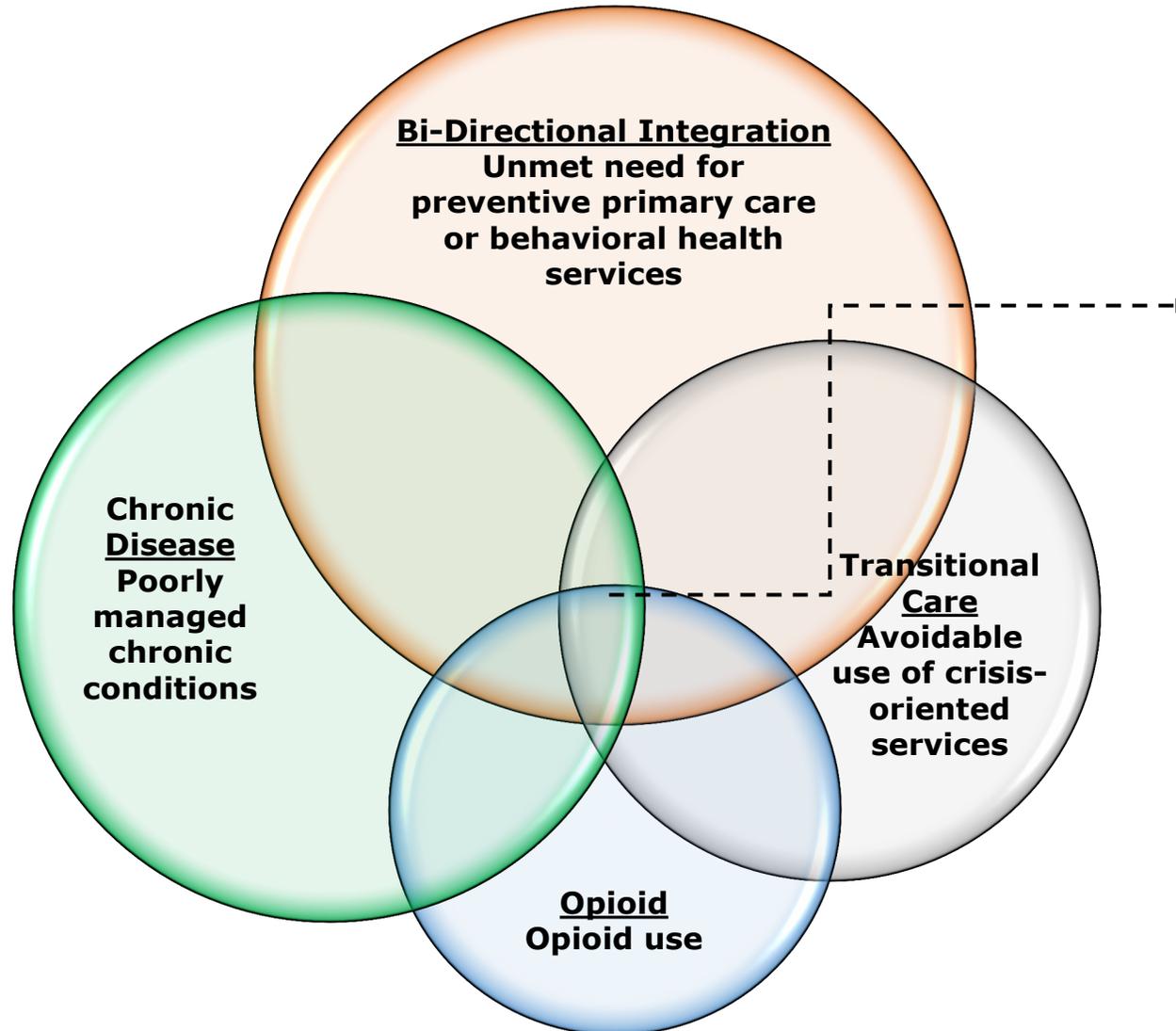
Prevention and management of chronic health and social concerns

Acute health & social concerns





Focus Populations and Projects



HOT & WARM SPOTS:

- Small populations with most complex health and social needs
- Disproportionately high amount of ED and hospital utilization (and cost)
- Heavily under-served by fragmented health & social service systems
- **Blend of performance and equity focus**

HIDDEN POPULATIONS:

- Populations under-utilizing traditional preventive health care services
- Populations under-represented in projects (women with reproductive health needs)
- Populations excluded from performance measures
- **Equity focus**



Current investment plan for “Population Health Management”

		DY1-2017		DY2-2018		DY3-2019		DY4-2020		DY5-2021		5-year total	
Project Costs	Project Management and Administration	15%	2.98	15%	5.86	15%	5.26	15%	4.43	15%	3.46	15%	22.00
	Project Engagement, Participation and Implementation	45%	8.94	35%	13.68	35%	12.28	25%	7.38	15%	3.46	31%	45.75
	Provider Performance and Quality Incentive Payments	20%	3.97	30%	11.72	30%	10.52	40%	11.81	50%	11.54	34%	49.58
		65%	12.92	65%	25.40	65%	22.80	65%	19.20	65%	15.01	65%	95.33
Domain 1	Financial Stability Through VBP	0%	0.00	0%	0.00	0%	0.00	4%	1.18	5%	1.15	2%	2.34
	Population Health Management	10%	1.99	8%	2.93	5%	1.75	3%	0.89	3%	0.69	6%	8.25
	Workforce	5%	0.99	5%	1.95	5%	1.75	3%	0.89	2%	0.46	4%	6.05
		15%	2.98	13%	4.89	10%	3.51	10%	2.95	10%	2.31	11%	16.64
ACH-defined	Social Equity and Wellness Fund	0%	0.00	5%	1.95	5%	1.75	10%	2.95	10%	2.31	6%	8.97
	Reserve (not to exceed \$XXX)	5%	0.99	3%	0.98	5%	1.75	0%	0.00	0%	0.00	3%	3.72
		5%	0.99	8%	2.93	10%	3.51	10%	2.95	10%	2.31	9%	12.69
		100%	19.87	100%	39.08	100%	35.08	100%	29.53	100%	23.09	100%	146.65

dollars in millions

TRUE

TRUE

TRUE

TRUE

TRUE



Small Group Discussion

- Where should we prioritize our investment? What HIE/HIT areas are most important to invest in?
- What are your criteria/principles that you want us to use as we make recommendations and determine how investments should be used?
- How should HH maximize the use of dollars for population health management? Does the current funding plan make sense?



HIE/HIT Assessment



HIT/HIE Assessment – Sources of information

- HIE/HIT Survey
- PMD Discussions
- State AIM and HIE/HIT meetings
- State ACH meetings
- 1:1 conversations



HIT/HIE Survey

Assessment Objectives

Understand current state of Health Information Exchange and Health Information Technology of organizations in King County. Make decisions locally cognizant of national and regional trends. Use HIE/HIT assessment data and recommendations to inform investment areas that will contribute to transformation.

Assessment Topics Covered

- | | |
|---|---|
| <ul style="list-style-type: none">• General organization information• Electronic Health Record (EHR)• Exchanging Health Information | <ul style="list-style-type: none">• Telehealth / Mobile Applications• Other Technologies• Population Health Management & Registries |
|---|---|

Survey

- Conducted in April 2018
- Completed by Chief Technology Officer (CTO), Chief Information Officer (CIO), Health Information Exchange (HIE) lead, or similar leadership role
- Included Provider/Clinical perspective on a subset of questions

Respondents

- Hospitals – 12 of 14
- FQHCs – 7 of 7
- BHAs / Other – 25 of 29





HIE/HIT Assessment – Findings & Themes



Key Findings from the HIE/HIT assessment

- Large variability in HIE/HIT capacity and use across and within sectors
 - Gap in behavioral health providers in HIE/HIT systems and capacity
 - Opportunity to help systems maximize/adopt population health approach
- Limited data partnerships and information systems that support clinical-community linkages
- Fragmented referral and coordination systems to address social determinant needs (e.g. housing, employment, food insecurity, childcare, etc...)

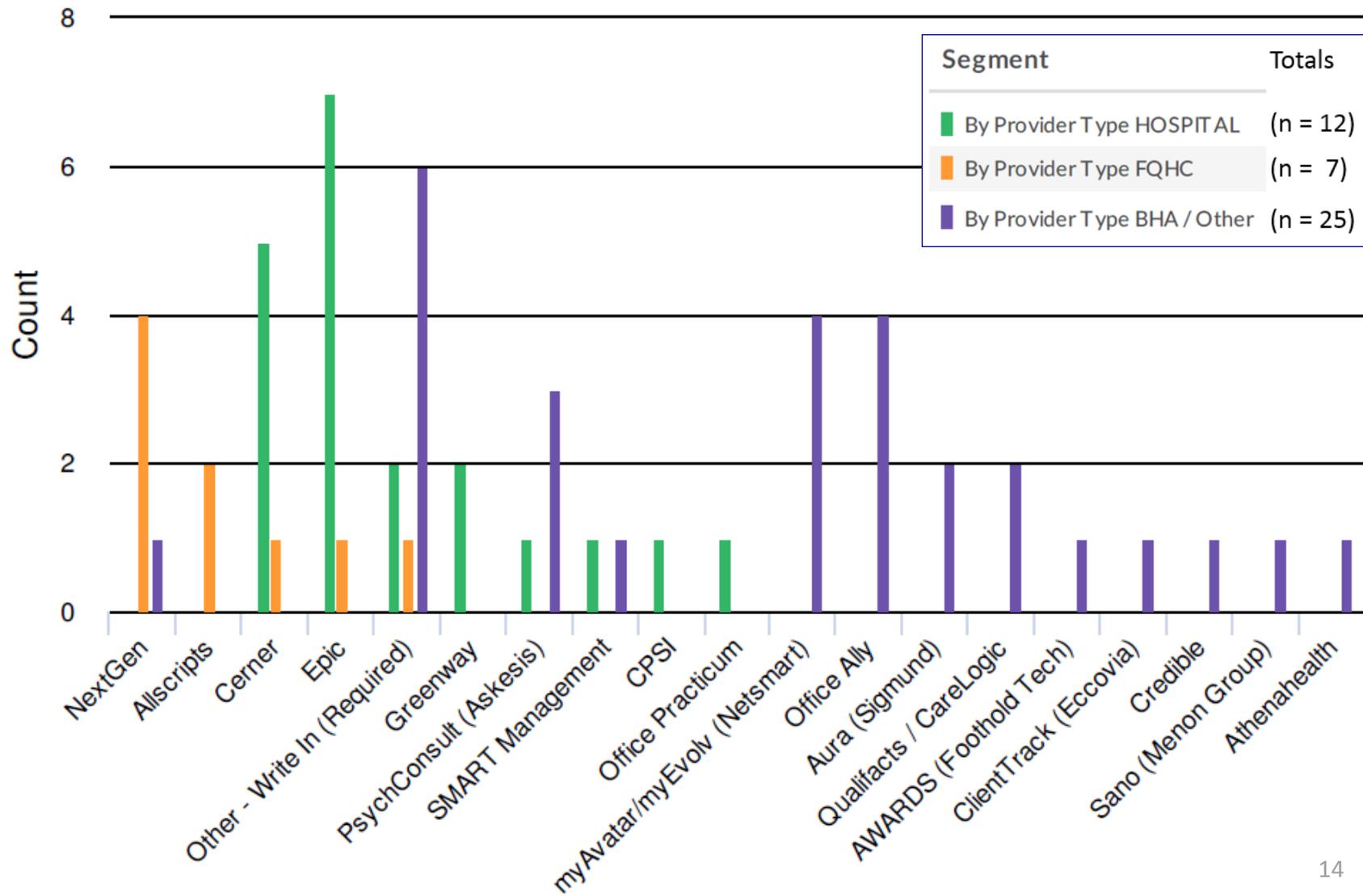


Large variability in HIE/HIT capacity and use
across and within sectors



Electronic Health Record Systems

Which EHR system(s) do you use? (Select all that apply.)





BH providers have greatest gap

- 75% of BHAs report using an electronic health record system
- Few BHAs (16%) have population health management systems or tools
- Low percentage of BHAs (24%) have registries and the barriers vary (i.e., training, costs, standardization)
- More than half of BHAs have no Prescription Monitoring Program (PMP) access and no current plans for its use

How might HH help?

- “Enable a single shared care plan for a patient across all caregivers for that patient”
- “Financial assistance”
- “Training on use of registries to track patient panels”
- “Support access to PMP data”



Variability in HIE/HIT Practice

In addition to the large variation in infrastructure capacity & use

- Lack of standardization in data collection, sharing, and use

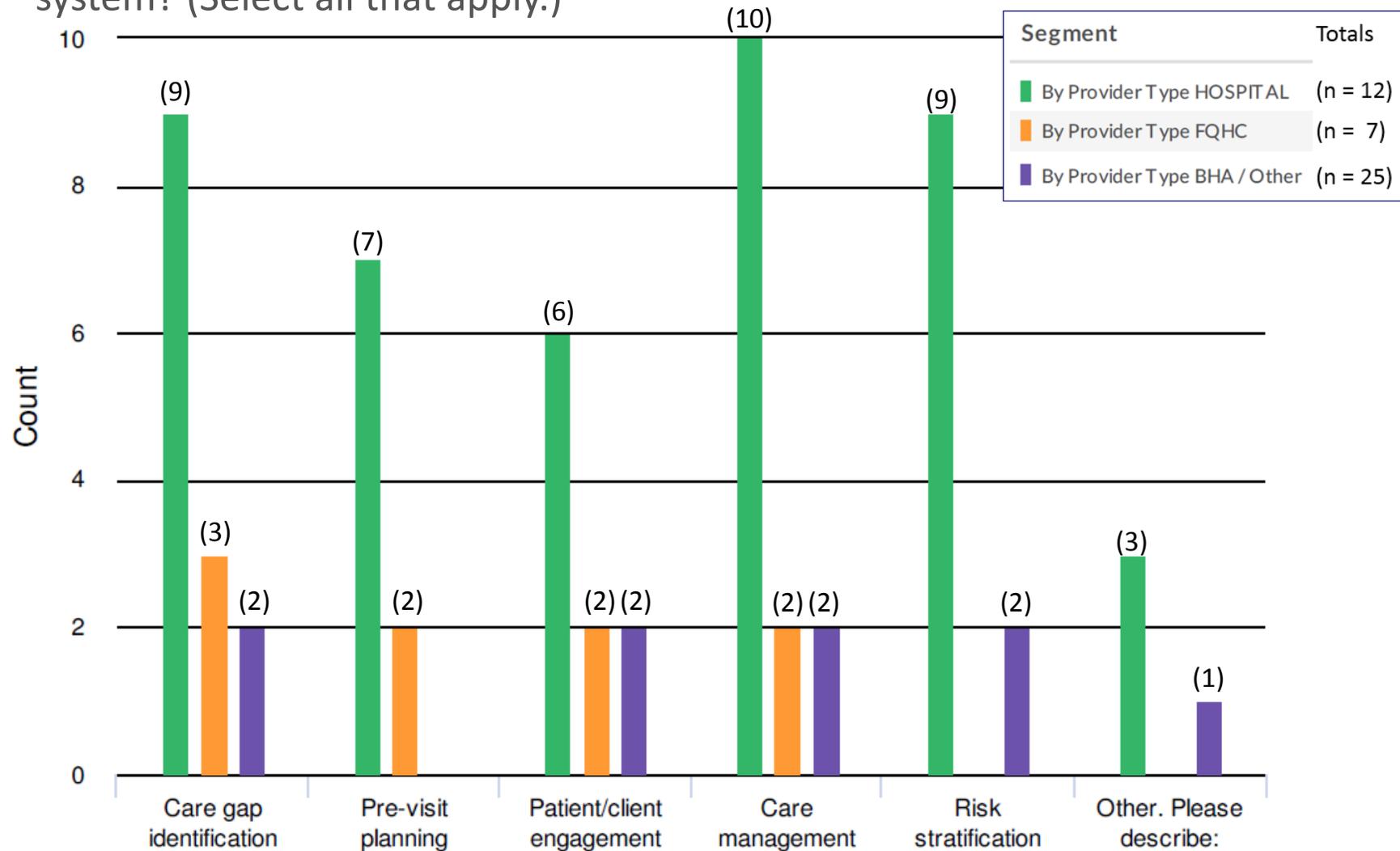
How might HH help?

- “Standardize data and care management requirements across MCOs”
- “Align data, reporting, and process across Medicaid (and Medicare)”
- “Standardize process among healthcare organizations for exchange of electronic records and other communications such as referrals”
- “Create standards for data exchange between community and medical services”



Population Health Management – Functions

What are the functions of your organization's Population Health Management system? (Select all that apply.)





Population Health Management (PHM)& Registries

- Varying levels of understanding of the tools available and best practices
- Most Hospitals (83%) and some FQHCs (43%) have PHM systems. Few BHAs (16%) have PHM systems
- Hospitals and FQHCs use their PHM systems to identify gaps in care, but only about half use their systems to monitor and track patient/client engagement
- Majority of respondents from Hospitals (75%) and FQHCs (86%) have patient registries and use registries to improve the quality of patient care
- Low percentage of BHAs (24%) have registries and the barriers vary (i.e., training, costs, standardization)



Opportunity for Population Health Management (PHM)

- PHM includes collecting and analyzing data on segments of your patient population and managing specific diseases within that population
- PHM requires ***an integrated infrastructure*** of people, process and technology to support:



How might HH help?

- “Would be helpful to have an aligned registry for who is homeless or who is on Medicaid”
- “Funding and technical assistance”
- “Sharing of best practices”

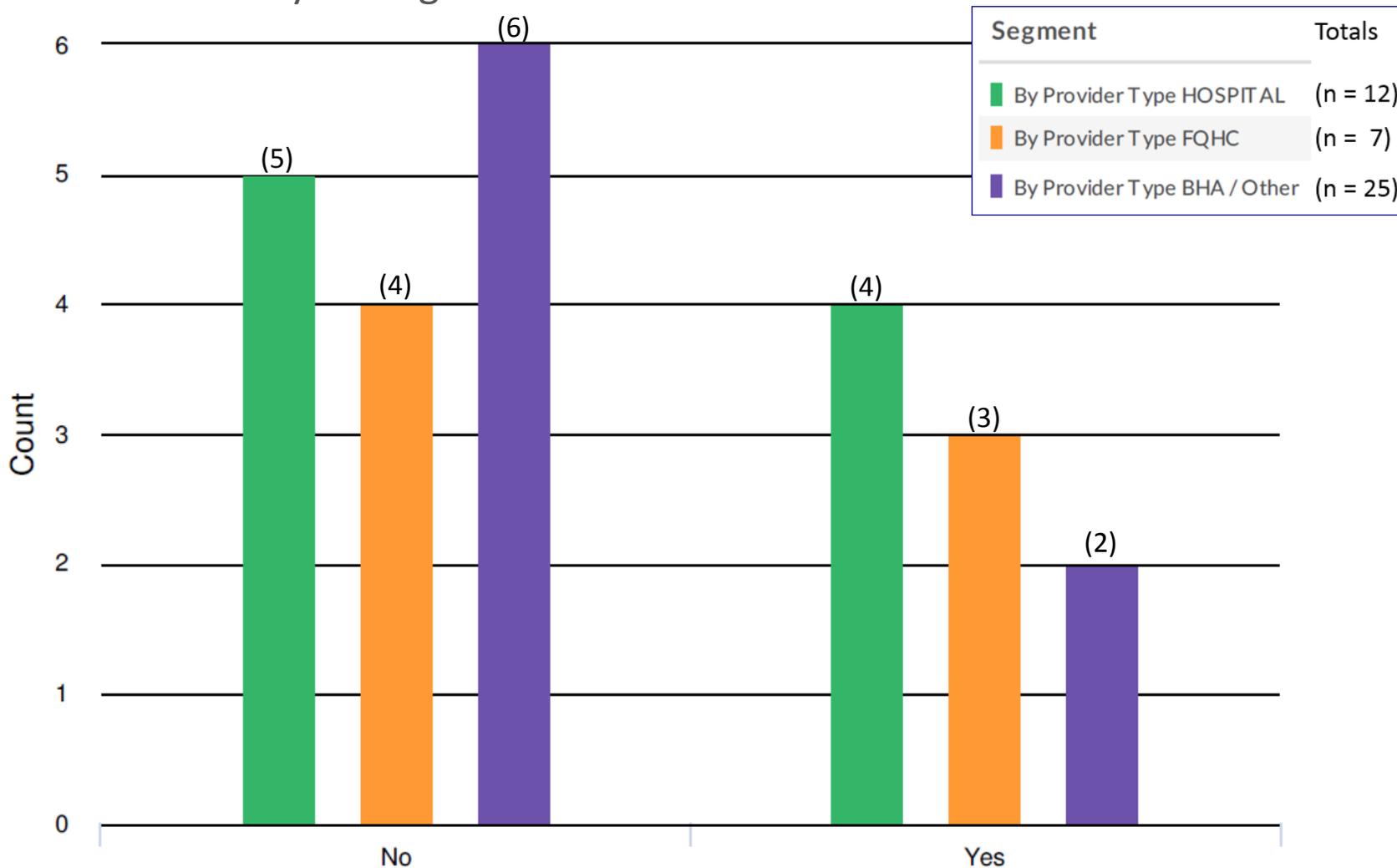


Limited data partnerships and information systems that support clinical-community linkages



Exchanging Health Information – External Access

Are there any community based organizations or social service agencies who have access to your organization's EHR?





Opportunity to support clinical-community linkages

- The majority of providers who responded do not share data through their EHR with community based organizations or social service agencies
- Over half of hospitals and BHAs reported exchanging some health information via paper or fax with community-based providers/social service agencies

How might HH help?

- “Real time integrated referral flow that captures social service needs...”
- “Working with community providers for better exchange of contact info, treatment capacity and care plans for patients in common”



Fragmented referral and coordination systems
to address social determinant needs



Fragmented referral and coordination systems

- There are several referral systems that exist for various focus populations in the region, the majority not linked to EHRs
- No technology platform in place that supports data sharing and coordination activities across community based organizations and social service agencies

How might HH help?

- “Enable a single shared care plan for a patient across all caregivers for that patient”
- “Financial assistance”



HIE/HIT Investment Guiding Principles

Meeting the needs of users at the point of care.

Focus on a handful of solutions that address King County needs and project portfolio in as meaningful a way as possible.

Leveraging existing data infrastructure and roles where possible is highly desired.

Prioritize areas of historical underinvestment, e.g., behavioral health agency and social service organization needs.

Aligns with other ACH HIE/HIT investments



Small Group Discussion

- Where should we prioritize our investment? What HIE/HIT areas are most important to invest in?
- What are your criteria/principles that you want us to use as we make recommendations and determine how investments should be used?
- How should HH maximize the use of dollars for population health management? Does the current funding plan make sense?

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Integrated Whole Person Care in Community Behavioral Health Centers

Goal

Immediate: Increase access to primary care services and improve screening rates for selected chronic conditions among individuals enrolled in behavioral health services.

Long-term: Integrate primary care services into community behavioral health centers in King County.

Focus Populations

Medicaid members with mental health and substance use disorders (SUDs), including opioid use disorders (OUDs) who meet a minimum of 3 of the following criteria:

- Prescribed antipsychotic medication
- Prescribed four or more medications
- Diagnosed with one of the following chronic conditions: asthma, chronic obstructive pulmonary disease (COPD), diabetes, cardiovascular disease (CVD)
- Low health literacy
- Limited English proficiency
- Limited engagement with primary care (no primary care visit in the last six months)
- Homeless or housing instability
- Limited community supports (e.g. ineligible for other programs such as Health Homes)

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [Bree Collaborative Behavioral Health Integration](#) model and the [AIMS Center Collaborative Care Model](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Conduct holistic screenings in the behavioral health setting, or confirm that they have been completed by primary care partner organization, with a focus on asthma, COPD, diabetes, and CVD. Screenings could include:
 - BMI screening for all or an identified subset of individuals served by the organization
 - Blood pressure screening, for all or an identified subset of individuals served by the organization
 - Tobacco use screening, for all or an identified subset of individuals served by the organization
 - Diabetes screening for all individuals using antipsychotic medication

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a PCP, social worker, or other appropriate provider.
- Provide best practice, culturally appropriate interventions to help individuals manage chronic conditions within community behavioral health centers and/or integrated care settings.
- Provide individuals with greater need with ongoing support and treatment via a co-located, integrated, or partner primary care organization.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- The care team will refer individuals to community resources, including chronic disease self-management programs, as appropriate.
- A community support specialist or a member of the integrated health care team will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual’s needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual’s treatment and progress.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Integrated Whole Person Care in Community Behavioral Health Centers project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
Antidepressant Medication Management	*Effective Acute Phase Treatment – People 18 and older diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication during the entire 12-week acute treatment phase. *Effective Continuation Phase Treatment – People 18 and older diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication for at least six months.
Child and Adolescents’ Access to Primary Care Practitioners	The percentage of members 12 months - 19 years of age who had a visit with a primary care provider. Report four separate rates: 12-24 months of age; 25 months - 6 years of age; 7-11 years of age; 12-19 years of age.
Comprehensive Diabetes Care: Hemoglobin A1c Testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year.
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement period, or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.
Comprehensive Diabetes Care: Medical Attention for Nephropathy	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement year or the year prior.
Follow-up after Emergency Department Visit for Alcohol or other Drug Dependence	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Emergency Department Visit for Mental Health	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner, reported separately for follow-up within 7 and 30 days of discharge.
Medication Management for People with Asthma (5 – 64 Years)	The percentage of members 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Potential Reporting Metrics

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there may be a potential delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify potential additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value-based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

Metric	Definition
Diabetes Screening for People with behavioral health conditions who are Using Antipsychotic Medication	People age 18 to 64 with mental health or substance use disorders, who were using an antipsychotic medication who had a glucose test or HbA1c test during the measurement year.
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 0018
Smoking Cessation	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: 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 a tobacco user 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
Body Mass Index (BMI)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Percentage of patients aged 18 years and older with a documented BMI and follow-up plan when appropriate

References/Guidelines

AIMS Center Collaborative Care Model

<https://aims.uw.edu/collaborative-care>

The Bree Collaborative Behavioral Health Integration Report and Recommendations

<http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf>

EPR-3 Guidelines on Asthma (NHLBI)

<https://www.nhlbi.nih.gov/files/docs/guidelines/asthgdln.pdf>

Global Initiative for Chronic Obstructive Lung Disease

<https://goldcopd.org/wp-content/uploads/2018/02/WMS-GOLD-2018-Feb-Final-to-print-v2.pdf>

Standards of Medical Care in Diabetes (American Diabetes Association)

<https://professional.diabetes.org/content-page/standards-medical-care-diabetes>

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Integrated Whole Person Care in Primary Care Settings

Goal

Immediate: Improve identification of behavioral health needs and access to behavioral health services (both mental health and substance use treatment) for individuals being served in primary care settings.

Long-term: Integrate behavioral health services into primary care practices in King County. Expand links to specialty behavioral health, including psychiatry.

Focus Populations

Medicaid members within traditional and non-traditional primary care settings who are at risk for or have a diagnosis of depression and/or substance use disorder (SUD), including opioid use disorder (OUD).

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [Bree Collaborative Behavioral Health Integration](#) model and the [AIMS Center Collaborative Care Model](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Conduct standardized screenings in the primary care setting, with a focus on depression and SUD, including OUD.
- Stratify individuals by risk and severity of disease.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a behavioral health provider, social worker, or other appropriate provider.
- Provide Medication Assisted Treatment (MAT) when needed.
- Provide best practice, culturally appropriate mental health and/or substance use disorder treatment interventions within primary and/or integrated care settings.
- Provide individuals with greater need with ongoing support and treatment via a co-located, integrated, or partner primary care organization.
- Provide linkage to specialty behavioral health, including psychiatry, when needed.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- A community support specialist or a member of the integrated health care team will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with behavioral health care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for behavioral health care providers/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual's needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Integrated Whole Person Care in Primary Care Settings project will agree to help HealthierHere improve the following set of metrics.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Metric	Definition
Antidepressant Medication Management	*Effective Acute Phase Treatment – People 18 and older diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication during the entire 12-week acute treatment phase. *Effective Continuation Phase Treatment – People 18 and older diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication for at least six months.
Follow-up after Emergency Department Visit for Alcohol or other Drug Dependence	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Emergency Department Visit for Mental Health	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner, reported separately for follow-up within 7 and 30 days of discharge.
Mental health Treatment Penetration (Broad Version)	The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for three age groups: 6-17 years, 18-64 years, and 65 years and older.
Substance Use Disorder Treatment Penetration	The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting for three age groups: 12-17 years, 18-64 years, and 65 years and older.

Potential Reporting Metrics

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there may be a potential delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify potential additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value-based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

Metric	Definition
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	People age 13 and older with a new episode of substance use disorder who initiated treatment through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, or medication assisted treatment (MAT) within 14 days of the index episode.
Screening for Clinical Depression and Follow-up	People 18 and older with an outpatient visit who were screened for clinical depression using a standardized depression tool, and if positive, with follow-up plan within 30 days.

References/Guidelines

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

AIMS Center Collaborative Care Model
<https://aims.uw.edu/collaborative-care>

The Bree Collaborative Behavioral Health Integration Report and Recommendations
<http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf>

Evidence-based Screening Tools for Adults and Adolescents (NIH National Institute on Drug Abuse)
<https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults>

Medication-Assisted Treatment (SAMHSA)
<https://www.samhsa.gov/medication-assisted-treatment>

Screening, Brief Intervention, and Referral to Treatment (SAMHSA-HRSA)
<https://www.integration.samhsa.gov/clinical-practice/sbirt>

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Transitions of Care from Jail

Goal

Immediate: Implement an integrated whole person model of care that ensures safe and successful transitions from jails back into community settings.

Long-term: Reduce avoidable emergency department (ED) visits and hospital readmissions, as well as readmissions to jail. Expand community-based support services for high-risk individuals leaving jails, including those individuals who experience homelessness.

Focus Populations

Medicaid members returning to the community from jail who have complex health and behavioral health conditions that necessitate care coordination and/or disease management.

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [APIC model](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and the services that are needed, share integrated care plans and other Continuity of Care Documents as appropriate and allowed by law with primary care providers, social service providers (such as supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Offer in reach services before reentry to identify and plan for necessary medical, behavioral health, justice system, social services, and community supports, including

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

assistance with health coverage, ensuring Medicaid eligible individuals are enrolled since coverage is suspended while they are incarcerated.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a behavioral health specialist, social worker, or other appropriate provider.
- Develop a plan for the treatment and services required to address the individual's needs, the identification of community and correctional programs for post-release services, and coordination of the transition plan to ensure implementation and avoidance of gaps in care with community-based services.
- Establish relationships with community-based physical and behavioral health providers and community partners who address the social determinants of health.
- Accommodate in reach services and provide a "warm hand off" for those individuals requiring additional help.
 - The individual will be introduced to a community support specialist (e.g. a care coordinator, community health worker, or peer support specialist with lived experience in the correctional system and/or behavioral health recovery) before reentry to establish trust.
 - Assign individuals at high risk for complications to a care manager.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate transition/reentry plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Share individuals' transition/reentry plan with their community support specialist and primary care provider (PCP)/community behavioral health provider to facilitate implementation and avoid gaps in care with community-based services.
- Ensure first appointment with PCP and/or Community Behavioral Health with prescribing capability is scheduled prior to reentry. This appointment should take place as soon as possible, ideally within one week of release.

Provide Self-Management support:

- All focus population individuals should receive self-management support by a member of the integrated health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit. When applicable, provide individuals with a 7-day supply of needed medications and a prescription for a 30-day supply, along with a medication plan and instructions on medication management upon reentry. As appropriate and allowed, the medication plan should be shared with the individual's community support specialist so that they can provide continuity and make sure the medication plan is shared with the PCP and care team on the receiving end and followed.
- Upon reentry, the assigned community support specialist will meet an individual and accompany them to his/her first appointment to establish a relationship with a partnering medical or behavioral health provider.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

- After reentry, the community support specialist conducts in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual’s self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can “teach back” expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual’s needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual’s treatment and progress.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Jail Transitions project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
Follow-up after Emergency Department Visit for Alcohol or other Drug Dependence	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Emergency Department Visit for Mental Health	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner, reported separately for follow-up within 7 and 30 days of discharge.
Percent Homeless (narrow definition)	The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes “homeless with housing” living arrangement code within the DSHS database ACES, reported for three age groups: 0-17, 18-64, and 65 and older.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Potential Reporting Metrics

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there may be a delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

Metric	Definition
30 Day Psychiatric Inpatient Readmissions	For members 18 years of age and older, the number of acute inpatient psychiatric stays that were followed by an acute readmission for a psychiatric diagnosis within 30 days.
Mental health Treatment Penetration (Broad Version)	The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for three age groups: 6-17 years, 18-64 years, and 65 years and older.
Substance Use Disorder Treatment Penetration	The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting for three age groups: 12-17 years, 18-64 years, and 65 years and older.

References/Guidelines

A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model, <http://www.prainc.com/wpcontent/uploads/2015/10/best-practice-approach-community-re-entry-inmates-co-occurring-disorders.pdf>

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Psychiatric Care Transitions from Hospital Settings

Goal

Immediate: Implement an integrated whole person model of care that ensures safe and successful transitions from psychiatric hospitals back into community settings, such as home or skilled nursing facilities.

Long-term: Reduce preventable emergency department (ED) visits and hospital readmissions due to behavioral health disorders. Ensure continuity of care.

Focus Populations

Medicaid members who live with serious mental illness and/or substance use disorder discharged from inpatient psychiatric settings or ED holds who meet a minimum of 3 of the following criteria:

- Two or more chronic conditions
- Active mental health issue and/or substance use disorder
- Four or more prescribed medications
- Two or more hospitalizations and/or four ED visits in the past 12 months
- Low health literacy
- Limited English proficiency
- Limited engagement with primary care (no primary care visit in the last six months)
- Limited engagement and/or disengaged from behavioral health care
- Homeless or housing instability
- Limited community supports, ineligible for other programs such as Health Homes

Alternatively, a clinical provider's determination of high risk for readmission is acceptable without regard to the above criteria.

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [Peer Bridger Program](#) and [Transition Support Program \(TSP\)](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, substance use, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Hospital staff will screen individuals before discharge to identify those at high risk for readmission based on the criteria above.
- Increase the completion of [POLST forms](#) and other advance care planning documents at your organization.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include PCP, behavioral health provider, and community support specialists.
- Assist individuals in obtaining a PCP and/or a behavioral health provider (if they don't have one) prior to discharge.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Notify individual, caregivers, and community partners of planned discharge at least 48 hours in advance.
- Refer individual to community support specialist (e.g. peer bridgers, peer support specialists), as appropriate.
 - Community support specialists serving this focus population should:
 - Receive training in trauma-informed care, crisis intervention, and motivational interviewing
 - Work collaboratively with clinical teams towards the goal of utilizing the same community support specialist to work with individuals both in the hospital and post-discharge.
 - Have access to a fund for basic services and essential needs such as bus passes, cell phones, clothing, food, engagement activities, etc.
 - Have a caseload of 8 – 14 patients.
 - Collaborate with hospital discharge planners during the discharge process.
 - Sit in on care team meetings while the individual is still in the hospital.
 - Sit in on intake sessions with case managers and psychiatrists, as able and if the individual is willing.
 - Aim for ongoing engagement/reengagement in behavioral health treatment by the individual.
 - Meet the patient where they are and share their own successful recovery stories to offer hope

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate transition and treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- High-risk individuals, caregivers, and community support specialists must be notified of planned discharge no later than 48 hours in advance to avoid adverse events upon discharge.
- Transition and treatment plans should include the following information:
 - Assigned community behavioral health specialist and PCP that includes post-hospitalization discharge notes
 - An updated and reconciled medication list
 - Next steps, including follow up appointments with specialist, as needed
- Aftercare appointments must be scheduled in coordination with the community support specialist.
- Ensure that the plan is available to all team members serving the individual's needs.
- Community support specialists will meet with individuals and their family caregivers before hospital discharge to develop individually tailored transition plans that:
 - Are based upon an assessment of needed community services and supports.
 - Emphasize productive interactions between the care team and the individual.
 - Include a reconciled medication list, follow-up appointment, and patient self-education (written at an appropriate health literacy level and in the individual's language).
- The individual must have an adequate supply of their medications upon discharge.

Provide Self-Management Support:

- All focus population individuals should receive self-management support by a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- After discharge, the community support specialist will conduct in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure patient can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Transitional Care project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
Follow-up after Emergency Department Visit for Alcohol or other Drug Dependence	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Emergency Department Visit for Mental Health	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner, reported separately for follow-up within 7 and 30 days of discharge.
Percent Homeless (narrow definition)	The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes "homeless with housing" living arrangement code within the DSHS database ACES, reported for three age groups: 0-17, 18-64, and 65 and older.

Potential Reporting Metrics

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there may be a delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

Metric	Definition
30 Day Psychiatric Inpatient Readmissions	For members 18 years of age and older, the number of acute inpatient psychiatric stays that were followed by an acute readmission for a psychiatric diagnosis within 30 days.
Mental health Treatment Penetration (Broad Version)	The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for three age groups: 6-17 years, 18-64 years, and 65 years and older.
Substance Use Disorder Treatment Penetration	The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting for three age groups: 12-17 years, 18-64 years, and 65 years and older.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

References/Guidelines

Viggiano, T., Pincus, H. A., & Crystal, S. (2012). "Care transition interventions in mental health." *Current Opinion in Psychiatry*, 25(6), 551-558.

https://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf

"King County Peer Bridger Program – Supporting Successful Transitions,"

https://ncc.expoplanner.com/files/15/SessionFilesHandouts/10_Jerome_1.pdf

"Program Helps Individuals Stay out of Hospitals, On to Stability," *Sound Mental Health*.

<https://www.sound.health/program-helps-individuals-stay-out-of-hospitals-on-to-stability/>

"What is the Peer Bridger Program?" <https://riinternational.com/our-services/washington/peer-bridger-program/>

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Transitions of Care: Hospital Discharges for High-risk Medicaid Individuals

Goal

Immediate: Implement an integrated whole person model of care that ensures safe and successful transitions from the hospital back into community settings, such as home or skilled nursing facilities.

Long-term: Reduce avoidable emergency department (ED) visits and hospital readmissions. Ensure continuity of care and redirect resources available to focus on long-term prevention and promotion rather than short-term crisis response.

Focus Populations

Medicaid members transitioning from inpatient hospital stays for chronic or acute conditions, including older adults and people with disabilities who meet a minimum of 3 of the following criteria:

- Age 50 or older
- Two or more chronic conditions
- Four or more prescribed medications
- Two or more hospitalizations and/or four ED visits in the past 12 months
- Active mental health issue and/or substance use disorder
- Low health literacy
- Limited English proficiency
- Limited engagement with primary care (no primary care visit in the last six months)
- Homeless or housing instability
- Limited community supports, ineligible for other programs such as Health Homes

Alternatively, a clinical provider's determination of high risk for readmission is acceptable without regard to the above criteria.

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based on the [Coleman model](#), implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and the services that are needed, share transition plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (such as supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Hospital staff will screen individuals before discharge to identify those at high-risk for readmission based on the criteria above.
- Increase the completion of [POLST forms](#) and other advanced care planning documents at your organization.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a PCP, behavioral health provider, care coordinator, social worker, community support specialist, or other appropriate provider.
- Individuals meeting the appropriate criteria will be assigned to a community support specialist (providing care coordination/transition coaching and capable of making home visits. Matching criteria for the assignment of a community support specialist will include language and cultural competency.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate transition plans that support patient engagement with the care team. Transition plans should be based upon an assessment of needed community services and supports and include referral and linkage to culturally appropriate services. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all providers serving the individual's needs.

Provide Self-Management support:

- All focus population individuals should receive self-management support by a member of the integrated health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- A community support specialist or a member of the integrated health care team will conduct in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
 - h. Increase self-management skills
 - i. Ensure personal goals are congruent with individual's self-efficacy
 - j. Improve continuity of care with PCP/specialist follow-up
 - k. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - l. Practice advocacy by identifying key questions for PCPs/specialists

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

- m. Educate on health system navigation
- n. Ensure individual can “teach back” expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including community support specialists.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual’s needs (e.g. transportation, food, shelter).
- For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual’s treatment and progress.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Hospital Transitions project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
All Cause Readmission Rate	Among Medicaid beneficiaries age 18-64 years old, the percent of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days
All Cause Emergency Department Visits per 1000 Member Months	The rate of Medicaid beneficiary visits to emergency department per 1000 member months, including visits related to mental health and substance use disorder, reported for three age groups: 10-17 years, 18-64 years, and 65 years and older.
Follow-up after Emergency Department Visit for Alcohol or other Drug Dependence	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Emergency Department Visit for Mental Health	The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, reported separately for follow-up within 7 and 30 days after discharge.
Follow-up after Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner, reported separately for follow-up within 7 and 30 days of discharge.
Inpatient Hospital Utilization	For members 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.
Percent Homeless (narrow definition)	The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes “homeless with housing” living arrangement code within the DSHS database ACES, reported for three age groups: 0-17, 18-64, and 65 and older.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Potential Reporting Metrics

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there may be a delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

Metric	Definition
30 Day Psychiatric Inpatient Readmissions	For members 18 years of age and older, the number of acute inpatient psychiatric stays that were followed by an acute readmission for a psychiatric diagnosis within 30 days.
Mental health Treatment Penetration (Broad Version)	The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for three age groups: 6-17 years, 18-64 years, and 65 years and older.
Substance Use Disorder Treatment Penetration	The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting for three age groups: 12-17 years, 18-64 years, and 65 years and older.

References/Guidelines

The Care Transitions Program

<https://caretransitions.org/>

Roberts, Shauna R, Jane Crigler, Cristina Ramirez, Deborah Sisco, and Gerald L. Early, “Working with Socially and Medically Complex Patients: When Care Transitions Are Circular, Overlapping, and Continual Rather than Linear and Finite,” *Journal for Healthcare Quality*, Vol. 37, No. 4, July/August 2015

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Prevention of Opioid-related Overdoses

Project Goal

Immediate:

Reduce opioid overdose deaths by providing at-risk individuals, and those who frequently interact with them, with take-home naloxone kits and supporting education and awareness around overdose prevention.

Long-term: Reduce deaths, non-fatal overdoses, onset of opioid use disorder (OUD), and harm to King County residents from prescription and non-prescription opioids through promotion of safer use strategies and harm reduction.

Focus Populations

Medicaid members who are at risk for prescription and non-prescription opioid abuse or who have a history of opioid-related overdoses as well as the individuals and service providers who are likely to encounter them.

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers, behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Screen for OUD and individuals at risk of overdose in medical and behavioral health settings as part of a robust person-centered care approach.
 - Organizations should use a recognized screening tool and have a standard protocol for

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

screening.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification.
- Establish protocols for referring individuals with OUD to the appropriate modality of medication-assisted treatment (MAT) -- opioid treatment programs or office-based opioid treatment.
- Utilize motivational interviewing to encourage individuals to participate in treatment, as appropriate.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide overdose education to individuals seen or at risk for opioid overdose.
- Provide all individuals seen or at risk for opioid overdose with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals who are ready to begin recovery to a community support specialist with common lived experience (e.g. a recovery coach or peer support specialist) who can assist individuals to regain control over their lives and their own recovery process. A community support specialist or a member of the integrated health care team will conduct in-person visits and follow-up by phone and/or telehealth options in service of the following goals:
 - o. Increase self-management skills
 - p. Ensure personal goals are congruent with individual's self-efficacy
 - q. Improve continuity of care with primary care follow-up
 - r. Ensure medication management and reconciliation with primary care or other providers including pharmacists
 - s. Practice advocacy by identifying key questions for primary care providers/specialists
 - t. Educate on health system navigation
 - u. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- Provide take-home naloxone kits to individuals seen for opioid overdose.
- Encourage individuals with OUD entering MAT to get a naloxone kit or prescription.
- Identify community partners, social service organizations, and other organizations who come into contact with individuals at risk of opioid overdose and partner with those organizations and provide them with training and access to naloxone kits.
- Encourage partners to safely distribute naloxone kits to prevent overdose deaths due to OUD.
- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual’s needs (e.g. transportation, food, shelter).
- For applicable individuals, the community support specialist will communicate with primary care provider and/or specialist(s) regarding the individual’s treatment and progress. In such cases, the community support specialist will follow-up after referrals to determine whether resources are accessed and needs are met.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Opioid Prevention project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
Patients Prescribed High-Dose Chronic Opioid Therapy	Percent of Medicaid beneficiaries prescribed chronic opioid therapy according to the following thresholds: 1.) Doses >50 mg morphine equivalent dosage (MED) in a quarter; 2.) Doses >90 mg MED in a quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.
Patients with Concurrent Sedatives Prescriptions	Among Medicaid beneficiaries receiving chronic opioid therapy ≥60 days, the percent that had ≥60 days of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.
Substance Use Disorder Treatment Penetration (Opioid)	The percent of Medicaid beneficiaries with an identified opioid use disorder treatment need who received medication assisted treatment (MAT) or medication-only treatment for opioid use disorder in the measurement year.

References/Guidelines

Harm Reduction Coalition’s Guide to Developing & Managing Overdose Prevention & Take-Home Naloxone Projects

<http://harmreduction.org/issues/overdose-prevention/tools-best-practices/manuals-best-practice/>

King County Heroin and Prescription Opiate Addiction Task Force, Final Report and Recommendations. September 15, 2016.

<https://www.kingcounty.gov/~media/depts/community-human-services/behavioral-health/documents/herointf/Final-Heroin-Opiate-Addiction-Task-Force-Report.ashx?la=en>

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Expanding Access to Opioid Treatment

Project Goal

Immediate:

Increase screening for opioid use disorder (OUD) and improve access and accessibility to appropriate and sustainable treatment including both modalities of medication-assisted treatment (MAT), office-based opioid treatment (OBOT) and opioid treatment programs (OTP).

Long-term: Reduce deaths, non-fatal overdoses, onset of OUD, and harm to King County residents from prescription and non-prescription opioids.

Focus Populations

Medicaid members with or suspected of having OUD (i.e. presenting with signs/symptoms of OUD in emergency departments, needle exchanges, primary care settings, behavioral health centers, etc.). Individuals may not yet be identified as having OUD but through system engagement can be screened, diagnosed, provided with a pathway to treatment.

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Implementing organizations will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and the services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers, behavioral health providers, social service providers (e.g. supportive housing providers), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Screen for OUD in medical and behavioral health settings as part of a robust person-centered care approach.
- Utilize motivational interviewing to encourage individuals to participate in treatment, as

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

appropriate.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification (members could include a nurse care manager, recovery coach, peer support specialist, or other appropriate provider.)
- Link individuals with OUD to a primary care medical home with an integrated care team.
- Increase low-barrier access points for treatment induction and access to MAT through onsite providers and/or new partnerships with treatment providers.
 - [Expand access to buprenorphine](#) in primary care and behavioral health settings by increasing the number of waived prescribers (physicians, nurse practitioners, physician assistants) and the number of new prescriptions originating in office-based settings.
 - Expand access to OTP providers (e.g. methadone treatment) by increasing the number of referrals to OTP for individuals who are most appropriate for that treatment modality.
- Refer individual to community support specialist (e.g. recovery coach, peer support specialist), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide all individuals with OUD with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals who are ready to begin recovery to a community support specialist with common lived experience (e.g. a recovery coach or peer support specialist) who can and assist individuals to regain control over their lives and their own recovery process. A community support specialist or a member of the integrated health care team will conduct in-person visits and follow-up by phone and/or telehealth options in service of the following goals:
 - v. Increase self-management skills
 - w. Ensure personal goals are congruent with individual's self-efficacy
 - x. Improve continuity of care with primary care follow-up
 - y. Ensure medication management and reconciliation with primary care or other providers including pharmacists
 - z. Practice advocacy by identifying key questions for primary care providers/specialists
 - aa. Educate on health system navigation
 - bb. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g. transportation, food, shelter).

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

- The integrated care team will work with the individual and community support specialists to support selected activities. For applicable individuals, the community support specialist will communicate with primary care provider and/or specialist(s) regarding the individual’s treatment and progress. In such cases, the community support specialist will follow-up after referrals to determine whether resources are accessed and needs are met.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Opioid Treatment project will agree to help HealthierHere with the following set of metrics.

Metric	Definition
Patients Prescribed High-Dose Chronic Opioid Therapy	Percent of Medicaid beneficiaries prescribed chronic opioid therapy according to the following thresholds: 1.) Doses >50 mg morphine equivalent dosage (MED) in a quarter; 2.) Doses >90 mg MED in a quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.
Patients with Concurrent Sedatives Prescriptions	Among Medicaid beneficiaries receiving chronic opioid therapy ≥60 days, the percent that had ≥60 days of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.
Substance Use Disorder Treatment Penetration (Opioid)	The percent of Medicaid beneficiaries with an identified opioid use disorder treatment need who received medication assisted treatment (MAT) or medication-only treatment for opioid use disorder in the measurement year.

References/Guidelines

Bree Collaborative Opioid Use Disorder Treatment Report and Recommendations.

<http://www.breecollaborative.org/wp-content/uploads/OUO-Treatment-Final-2017.pdf>

King County Heroin and Prescription Opiate Addiction Task Force, Final Report and Recommendations. September 15, 2016.

<https://www.kingcounty.gov/~media/depts/community-human-services/behavioral-health/documents/herointf/Final-Heroin-Opiate-Addiction-Task-Force-Report.ashx?la=en>

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Opioid Prescribing Practices

Project Goal

Immediate: Increase the number of medical and dental providers trained on opiate prescribing practices such as [Interagency Guideline on Prescribing Opioids for Pain](#) and [Dental Guideline on Prescribing Opioids for Acute Pain Management](#)

Long-term: Reduce deaths, non-fatal overdoses, onset of opioid use disorder (OUD), and harm to King County residents from prescription opioids, while expanding use of non-opioid pain management.

Focus Populations

Medicaid members age 18 and older who are receiving a new opioid prescription and emergency departments (ED), primary care practices, and dental practices serving a high volume of Medicaid members.

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based on the [Washington State Medical Association](#) and [Washington State Hospital Association's Opioid Pain Management clinical guidance](#), implementing partners will utilize the following key strategies.

Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Promote the use of the [Prescription Monitoring Program](#) (PMP) and its linkage into electronic health record systems to increase the number of providers regularly using the PMP.
- Distribute the Washington State Medical Association/Washington State Hospital Association/Health Care Authority opioid-prescribing variance reports with prescribers. Use of these variance reports allows prescribers to evaluate their prescribing practices relative to others in the state and to update and improve their practice.

Assess Whole Person Care Needs:

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere’s recommended assessments which have yet to be determined.
- Support adoption of non-opioid pain management strategies where appropriate.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual’s needs and risk stratification.
- Improve practice management of patients on chronic opioid therapy by adopting best practices such as the [Six Building Blocks](#).
 - Make [Six Building Blocks](#) experts and practice coaches available for individual consultation and practice-level assistance.
- Improve opioid prescribing practices in EDs.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Link to Community Resources:

- Promote [safe storage and disposal](#) of opioids and other medication, making those resources available and accessible to individuals who may have unused prescription opioids.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual’s needs (e.g. transportation, food, shelter).
- The integrated care team will work with the individual and community support specialists to support selected activities. For applicable individuals, the community support specialist will communicate with primary care provider and/or specialist(s) regarding the individual’s treatment and progress. In such cases, the community support specialist will follow-up after referrals to determine whether resources are accessed and needs are met.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Opioid Prescribing Practices project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
Patients Prescribed High-Dose Chronic Opioid Therapy	Percent of Medicaid beneficiaries prescribed chronic opioid therapy according to the following thresholds: 1.) Doses >50 mg morphine equivalent dosage (MED) in a quarter; 2.) Doses >90 mg MED in a quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.
Patients with Concurrent Sedatives Prescriptions	Among Medicaid beneficiaries receiving chronic opioid therapy ≥60 days, the percent that had ≥60 days of sedative hypnotics, benzodiazepines, carisoprodol, and/or barbiturates in the same calendar quarter. Bree Collaborative specifies for quarterly counts; all qualifying observations for a given quarter will count towards the overall, annual estimate required for DSRIP performance measurement.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Additional Reporting Metrics

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there is a delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

New Opioid Patients Transitioning to Chronic Opioids	Numerator: Number of patients who are prescribed >60 days supply of opioids in the current calendar quarter with at least one opioid prescription in the previous quarter, and no opioid prescription in the prior quarter. Denominator: Number of patients with at least one opioid prescription in the previous quarter who have no opioids prescribed in the prior quarter. Report as incidence per 1,000 population, age and sex adjusted.
--	--

References/Guidelines

CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016.

<https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

King County Secure Medicine Return Program. <https://kingcountysecuremedicinereturn.org/>

King County Heroin and Prescription Opiate Addiction Task Force, Final Report and Recommendations. September 15, 2016.

<https://www.kingcounty.gov/~media/depts/community-human-services/behavioral-health/documents/herointf/Final-Heroin-Opiate-Addiction-Task-Force-Report.ashx?la=en>

Parchman, Von Korff, Baldwin, Stephens, Ike, Crompton, Hsu, and Wagner. “Primary Care Clinic Re-Design for Prescription Opioid Management,” JABFM January–February 2017 Vol. 30 No. 1. https://www.improvingopioidcare.org/wp-content/uploads/2018/02/JABFM-article_2017.pdf

Washington State Hospital Association, Opioid-Pain Management.

<http://wsha.wpengine.com/quality-safety/projects/opioid-pain-management/>

Washington State Agency Medical Directors Group’s Interagency Guideline on Prescribing Opioids for Pain

<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>

Washington State Agency Medical Directors Group’s Dental Guideline on Prescribing Opioids for Acute Pain Management

http://www.agencymeddirectors.wa.gov/Files/20171026FINALDentalOpioidRecommendations_Web.pdf

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Chronic Disease Management: Asthma and COPD

Goal

Immediate: Identify individuals with asthma and chronic obstructive pulmonary disease (COPD), stratify risk level, and improve care coordination for highest risk individuals. Increase home-based services to manage the conditions.

Long-term: Decrease rates of asthma- and COPD-related complications in those with the diseases. Empower individuals to achieve successful self-management practices. Sustain home-based services to manage the conditions and reduce avoidable asthma- and COPD-related emergency department (ED) visits and hospital admissions.

Focus Population

Medicaid members age 5 and older with uncontrolled asthma or COPD, defined as having one or more ED visit or hospitalization for the condition(s) in the past 12 months.

Key Project Elements

The following interventions are strongly recommended for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [Chronic Care Model](#), NHLBI & NAEPP recommendations, and Global Initiatives for Asthma & COPD recommendations, implementing providers will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Ensure that registry is in place to allow for identification of target population, and establish a process for adding appropriate individuals to registry (e.g individuals who have asthma and/or COPD without a corresponding ICD-10 code on the problem list).
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, substance use, behavioral health, oral health, and the social determinants of health. Partners will determine their standard

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.

- Identify individuals with asthma and COPD, and assess and monitor their severity levels using spirometry.
- Control conditions with appropriate treatment (e.g. medication, pulmonary rehabilitation, etc.).
- Make referrals to asthma specialists for individuals with uncontrolled asthma and/or individuals in need of Step 4 or higher treatment.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a social worker, community support specialist, or other appropriate provider.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.
- For individuals with asthma, create an Asthma Action Plan and support individuals in self-monitoring of asthma symptoms.

Provide Self-Management Support:

- Provide all individuals with asthma or COPD should with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- A community support specialist should assess the home environment and work with individuals on remediation (e.g. allergen and irritant exposure control).
- Refer individuals at highest risk for complications from asthma and/or COPD to a community support specialist (e.g. community health worker, peer educator, or health coach) who will conduct in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services and/or chronic disease self-management programs.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual's needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and a community support specialist to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Chronic Disease Management – Asthma and COPD project will be held accountable to the following set of metrics.

Metric	Definition
Medication Management for People with Asthma (5 – 64 Years)	The percentage of members 5-64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period.

Potential Reporting Metrics

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there may be a potential delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify potential additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

Metric	Definition
Medical Assistance with Smoking and Tobacco Use Cessation	<p>Advising Smokers and Tobacco Users to Quit:</p> <ul style="list-style-type: none"> Adults 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year. <p>Discussing Cessation Medications:</p> <ul style="list-style-type: none"> Adults 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. <p>Discussing Cessation Strategies:</p> <ul style="list-style-type: none"> Adults 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.
Use of Spirometry Testing in the Assessment & Diagnosis of COPD (SPR)	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
Use of appropriate spirometry testing to confirm asthma diagnosis in children and adults	Percent of asthma and COPD diagnoses confirmed with spirometry testing.
Percentage of individuals with asthma and/or COPD who received an annual influenza vaccine	Percentage of individuals aged 6 months or older with a diagnosis of asthma or COPD who received an influenza immunization OR who reported previous receipt of an influenza immunization.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Percentage of eligible individuals with COPD who received a pneumococcal vaccine	Percentage of individuals 65 years of age and older with a diagnosis of asthma or COPD who have ever received a pneumococcal vaccine.
--	---

References/Guidelines

The Chronic Care Model

<http://www.improvingchroniccare.org/>

NHLBI Asthma Care Quick Reference

https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf

Global Initiative for Asthma Pocket Guide for Asthma Management and Prevention

<https://ginasthma.org/2018-pocket-guide-for-asthma-management-and-prevention/>

Global Initiative for Chronic Obstructive Lung Disease Pocket Guide to COPD Diagnosis, Management, and Prevention

<https://goldcopd.org/wp-content/uploads/2018/02/WMS-GOLD-2018-Feb-Final-to-print-v2.pdf>

Global Initiative for Chronic Obstructive Lung Disease Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease Report

https://goldcopd.org/wp-content/uploads/2017/11/GOLD-2018-v6.0-FINAL-revised-20-Nov_WMS.pdf

NAEPP Guidelines Implementation Panel Report

https://www.nhlbi.nih.gov/files/docs/guidelines/gip_rpt.pdf

NHLBI & NAEPP Guidelines for the Diagnosis and Management of Asthma Report

<https://www.nhlbi.nih.gov/files/docs/guidelines/asthgdln.pdf>

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Chronic Disease Management: Cardiovascular Disease

Goal

Immediate: Identify individuals with cardiovascular disease (CVD), stratify risk level, and improve care coordination for highest risk individuals.

Long-term: Decrease rates of CVD-related complications in those with the disease. Improve blood pressure control. Improve hyperlipidemia. Empower individuals with CVD to implement successful self-management practices.

Focus Population

Medicaid members age 18 and older with an ICD-10 code on the problem list diagnosing CVD. Individuals with CVD are considered at high risk for complications if they are not currently taking aspirin or a statin, have uncontrolled blood pressure $\geq 140/90$, and/or are smokers.

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g. Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [Chronic Care Model](#) and the [Million Hearts 2022](#) treatment protocols, implementing providers will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Ensure that a registry is in place to allow for identification of focus population, and establish a process for adding appropriate individuals to registry (e.g. individuals who have CVD without a corresponding ICD-10 code on the problem list).
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

- Identify and risk stratify individuals with diabetes.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a registered dietician, social worker, or other appropriate provider.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Ensure each member of the focus population has a planned CVD visit in which their CVD risk factors are assessed. This assessment should also include behavioral health, oral health, and social determinants of health. Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide all individuals with CVD with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals at highest risk for complications from CVD to a community support specialist (e.g. community health worker, peer educator, or health coach) who will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
 - a. Increase self-management skills
 - b. Ensure personal goals are congruent with individual's self-efficacy
 - c. Improve continuity of care with primary care follow-up
 - d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
 - e. Practice advocacy by identifying key questions for PCPs/specialists
 - f. Educate on health system navigation
 - g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services and/or chronic disease self-management programs.
- To address the social determinants of health, the integrated care team will connect the individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and a community support specialist to support selected activities. In such cases, the community support specialist will communicate with primary care providers and/or specialist(s) regarding the individual's treatment and progress.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Chronic Disease Management – Cardiovascular Disease project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
Statin Therapy for Patients with Cardiovascular Disease (SPC) (Prescribed)	Percentage of males 21-75 years of age and females 40-75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria: (1) Received statin therapy: Members who were dispensed at least one high or moderate-intensity statin medication.

Potential Reporting Metrics

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there may be a potential delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify potential additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

Metric	Definition
Aspirin When Appropriate	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet Percentage of patients aged 18 years and older with IVD with documented use of aspirin or other antithrombotic
Blood Pressure Control	Hypertension (HTN): Controlling High Blood Pressure Percentage of patients aged 18 through 85 years who had a diagnosis of HTN and whose blood pressure was adequately controlled (
Smoking Cessation	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: <ul style="list-style-type: none"> - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months - Percentage of patients aged 18 years and older who were for screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention - 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
Cardiac Rehab	<u>Cardiac Rehabilitation Patient Referral from an Outpatient Setting:</u> Percentage of eligible patients evaluated in an outpatient setting who are referred to an outpatient cardiac rehabilitation/secondary prevention program <u>Cardiac Rehabilitation Patient Referral from an Inpatient Setting:</u> Percentage of eligible patients admitted to a hospital who are referred to an early outpatient cardiac rehabilitation/secondary prevention program
Body Mass Index (BMI)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Percentage of patients aged 18 years and older with a documented BMI and follow-up plan when appropriate

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

References/Guidelines

The Chronic Care Model

<http://www.improvingchroniccare.org/>

Million Hearts 2022 Protocols

<https://millionhearts.hhs.gov/tools-protocols/protocols.html>

Practice Transformation for Physicians and Health Care Teams

<https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams>

[Self-Management Resource Center](https://www.selfmanagementresource.com/)

<https://www.selfmanagementresource.com/>

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Clinical Summary

Chronic Disease Management: Diabetes

Goal

Immediate: Identify individuals with diabetes, stratify risk level, and improve care coordination for highest risk individuals.

Long-term: Decrease rates of diabetes-related complications in those with the disease. Empower individuals with diabetes to implement successful self-management practices.

Focus Population

Medicaid members age 18 and older with an ICD-10 code on the problem list diagnosing type 1 or type 2 diabetes. Individuals with diabetes are considered at high risk for complications with one or more of the following: HbA1c >9%, blood pressure \geq 140/90, history of cardiovascular disease, one or more emergency department visits in past 12 months related to diabetes, and history of smoking/tobacco use.

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based upon the [Chronic Care Model](#) and the [American Diabetes Association Standards of Medical Care in Diabetes](#) recommendations, implementing providers will utilize the following key strategies. Specific criteria used for assessments and stratification will be determined by HealthierHere and implementing partners through Quality Improvement Learning Collaboratives.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and services that are needed, share integrated care plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers, behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.
- Ensure that registry is in place to allow for identification of target population, and establish a process to for adding appropriate individuals to registry (e.g. individuals who have diabetes without a corresponding ICD-10 code on the problem list).
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Identify and risk stratify individuals with type 1 or type 2 diabetes.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a registered dietician, social worker, or other appropriate provider.
- Assign individuals at high risk for complications to a member of the team who can provide care coordination.
- Ensure each member of the focus population has a planned diabetes visit in which their glycemic control, cardiovascular risk factors, and end-organ damage are assessed. This assessment should also include behavioral health, oral health, and social determinants of health.
- Refer individual to community support specialist (e.g. community health worker, patient navigator), as appropriate.

Develop Integrated Care Planning:

- Create individually tailored, culturally relevant treatment plans that support patient engagement with the care team. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all team members serving the individual's needs.

Provide Self-Management Support:

- Provide all individuals with diabetes with self-management support from a member of the health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- Refer individuals at highest risk for complications from diabetes to a community support specialist (e.g., community health worker, peer educator, or health coach) who will conduct in-person meeting(s) and follow-up by phone and/or telehealth options in service of the following goals:
 - h. Increase self-management skills
 - i. Ensure personal goals are congruent with individual's self-efficacy
 - j. Improve continuity of care with primary care follow-up
 - k. Ensure medication management and reconciliation with primary care or other providers including pharmacists
 - l. Practice advocacy by identifying key questions for primary care providers/specialists
 - m. Educate on health system navigation
 - n. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including culturally and linguistically appropriate services and/or chronic disease self-management programs.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies and community based organizations depending on the individual's needs (e.g. transportation, food, shelter). For applicable individuals, the integrated care team will work with the individual and a community support specialist to support selected activities. In such cases, the community support specialist will communicate with primary care providers and/or specialist(s) regarding the individual's treatment and progress.

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Chronic Disease Management – Diabetes project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
Comprehensive Diabetes Care: Hemoglobin A1c Testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year.
Comprehensive Diabetes Care: Medical Attention for Nephropathy	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy during the measurement period.
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement period, or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

Potential Reporting Metrics

While the required metrics are needed to ensure that the Medicaid Transformation Project is successful, there may be a potential delay in reporting, which could inadvertently prevent HealthierHere and its implementing partners from knowing when transformation is on track and/or when course corrections are needed. HealthierHere has engaged stakeholders and subject matter experts to identify potential additional metrics that are not claims based, which can be easily collected using electronic health records, and are currently collected for other reasons, such as value based care incentive payments.

The following metrics are not intended as requirements. Rather, they are intended to guide partners in thinking about their quality improvement next steps. Key metrics to be monitored on a system level will be determined at a future date.

Metric	Definition
Blood pressure control	Hypertension (HTN): Controlling High Blood Pressure Percentage of patients aged 18 through 85 years who had a diagnosis of HTN and whose blood pressure was adequately controlled (
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (CDC ³)	Percentage of Medicaid members 18-75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c testing and results >9.0%.
Body Mass Index (BMI)	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Percentage of patients aged 18 years and older with a documented BMI and follow-up plan when appropriate

Note: Summaries included in this report are current as of July 10, 2018. Revisions to the summaries may have been made after this date

References/Guidelines

American Diabetes Association Standards of Medical Care in Diabetes – 2018 Abridged for Primary Care

Providers

<http://clinical.diabetesjournals.org/content/early/2017/12/07/cd17-0119>

The Chronic Care Model

<http://www.improvingchroniccare.org/>

Diabetes Self-Management Program

<https://www.selfmanagementresource.com/programs/small-group/diabetes-self-management/>

Practice Transformation for Physicians and Health Care Teams

<https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams>

[Self-Management Resource Center](https://www.selfmanagementresource.com/)

<https://www.selfmanagementresource.com/>

PROJECT-SPECIFIC AGREEMENT

This Project-Specific Agreement (this “PSA”) is made as of _____, 2018 (the “Effective Date”), by and between King County Accountable Community of Health LLC, located at 1000 Second Avenue Suite 1730, Seattle, Washington 98104 (“HealthierHere”) and the participant listed on the signature page hereof (the “Participant”), and is a “Project-Specific Agreement” as described in the Master Services Agreement, also referred to as the “Standard Partnership Agreement,” entered into by and between HealthierHere and the Participant (the “MSA”). Any capitalized terms used but not defined in this PSA will have the meaning given to those terms in the MSA. This PSA is hereby incorporated into and made a part of, and is subject to, the MSA.

1. Provision of Funding. Subject to the terms and conditions of this PSA and the MSA, the Participant will be entitled to payment of Medicaid transformation funds from the Financial Executor in accordance with the provisions of one or more addenda to this PSA (each, an “Addendum” and collectively, the “Addenda”). The initial Addendum is attached. Each additional Addendum must be agreed to by the parties in writing and will be incorporated into this PSA by reference. In the event of any conflict between the MSA or this PSA and any Addendum, the MSA or this PSA will control unless the Addendum expressly refers to the parties’ intent to alter the terms of the MSA or this PSA with respect to that Addendum.

2. Term. This PSA will commence as of the Effective Date and will remain in effect until December 31, 2021, unless earlier terminated in accordance with Section 3.

3. Termination. This PSA may be terminated as follows:

(a) This PSA may be terminated at any time by mutual written agreement of the parties.

(b) Either party may, upon written notice provided to the other party, terminate this PSA if the other party commits a material breach of its obligations under this PSA. However, if the breach is capable of being cured within thirty (30) days, then this right may not be exercised unless the breaching party has been given written notice of the breach and has failed to cure such breach within thirty (30) days of receiving notice of such breach. This cure period will be reduced if a shorter period is required by HCA or any other applicable governmental authority.

(c) This PSA will terminate automatically upon termination of the MSA.

4. Compliance with MSA. This PSA will be subject to, and in performing its obligations under this PSA the Participant will comply in all respects with, the terms and conditions of the MSA.

5. Miscellaneous

(a) Entire Agreement. This PSA, together with the MSA, constitutes the entire agreement and supersedes all prior agreements and understandings, both written and oral, among the parties to this PSA with respect to the subject matter of this PSA. This PSA may not be amended except in a written instrument executed by the parties.

(b) Counterparts. This PSA may be simultaneously executed in counterparts, all of which will constitute one and the same instrument and each of which will be, and will be deemed to be, an original. The delivery of an executed signature page of this PSA by portable document (.pdf) format will have the same effect as the delivery of a manually executed counterpart hereof.

IN WITNESS WHEREOF, the parties have caused this PSA to be executed by their duly authorized representatives.

King County Accountable Community of Health LLC

By: _____
Name: _____
Title: _____

[Print Name of Participant]

By: _____
Name: _____
Title: _____



Consolidated Financial Statements

For the Year Ended December 31, 2017

Table of Contents

	Page
Independent Auditor's Report	1 - 2
Consolidated Financial Statements:	
Consolidated Statement of Financial Position	3
Consolidated Statement of Activities	4
Consolidated Statement of Cash Flows	5
Notes to Consolidated Financial Statements	6 - 24
Supplementary Information:	
Consolidating Statement of Financial Position	25
Consolidating Statement of Activities	26

Independent Auditor's Report

**To the Board of Trustees
Seattle Foundation
Seattle, Washington**

We have audited the accompanying consolidated financial statements of Seattle Foundation (the Foundation), which comprise the consolidated statement of financial position as of December 31, 2017, and the related consolidated statements of activities and cash flows for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.



T: 425-454-4919
T: 800-504-8747
F: 425-454-4620

10900 NE 4th St
Suite 1400
Bellevue WA
98004

clarknuber.com

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Foundation as of December 31, 2017, and the results of its activities and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Summarized Comparative Information

We have previously audited the Foundation's 2016 consolidated financial statements, and we expressed an unmodified opinion on those audited financial statements in our report dated May 15, 2017. In our opinion, the summarized comparative information presented herein as of and for the year ended December 31, 2016, is consistent, in all material respects, with the audited consolidated financial statements from which it has been derived.

Report on Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating statement of financial position and the consolidating statement of activities are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Clark Nuber PS

Certified Public Accountants
June 22, 2018

SEATTLE FOUNDATION
Consolidated Statement of Financial Position
December 31, 2017
(With Comparative Totals for 2016)
(In Thousands)

	2017	2016
Assets:		
Cash and cash equivalents	\$ 15,221	\$ 6,742
Accounts and other receivables	357	379
Pledges receivable and other assets, net	1,232	2,523
Bequests receivable	183	2,797
Beneficial interests held in trust	28,316	25,372
Investments	944,290	828,312
Real estate held for sale	2,928	2,178
Mission related investments	10,762	9,163
Fixed assets, net of accumulated depreciation	2,870	3,250
Total Assets	\$ 1,006,159	\$ 880,716
Liabilities and Net Assets		
Liabilities:		
Unconditional grants payable	\$ 5,183	\$ 2,936
Other liabilities	2,871	1,707
Funds held for others	51,547	48,404
Liability for life estate	469	536
Liability for charitable lead and remainder trusts	29,608	26,494
Liability for charitable gift annuities	2,473	2,723
Total Liabilities	92,151	82,800
Net Assets:		
Unrestricted-		
Community/area of interest	110,925	93,925
Donor advised	439,639	374,041
Designated	249,366	220,041
Supporting organizations	46,305	53,575
Administrative	7,829	7,926
Total unrestricted	854,064	749,508
Temporarily restricted	47,260	37,234
Permanently restricted - perpetual trusts	12,684	11,174
Total Net Assets	914,008	797,916
Total Liabilities and Net Assets	\$ 1,006,159	\$ 880,716

See accompanying notes.

SEATTLE FOUNDATION
Consolidated Statement of Activities
For the Year Ended December 31, 2017
(With Comparative Totals for 2016)
(In Thousands)

	Unrestricted	Temporarily Restricted	Permanently Restricted	2017 Total	2016 Total
Revenues and Support:					
Contributions and agency funds-					
Community/area of interest	\$ 13,060	\$ 16,083	\$ -	\$ 29,143	\$ 3,940
Donor advised	68,996			68,996	96,821
Designated	1,637	498		2,135	1,680
Supporting organizations	4,537			4,537	1,534
Agency	1,388			1,388	810
Administrative	686			686	446
GiveBIG	12,634			12,634	16,354
	<u>102,938</u>	<u>16,581</u>		<u>119,519</u>	<u>121,585</u>
Less agency	(1,388)			(1,388)	(810)
Less GiveBIG	(12,634)			(12,634)	(16,354)
	<u>88,916</u>	<u>16,581</u>		<u>105,497</u>	<u>104,421</u>
Total contributions					
Dividend and interest income	14,634			14,634	12,428
Gains on investments, net	103,642	11		103,653	39,332
Change in value of charitable gift annuities and trusts	(184)	4,358	1,510	5,684	2,629
Other income	1,445			1,445	923
Net assets released from restriction	10,924	(10,924)			
	<u>219,377</u>	<u>10,026</u>	<u>1,510</u>	<u>230,913</u>	<u>159,733</u>
Expenses:					
Grants-					
Community/area of interest	15,328			15,328	7,788
Donor advised	67,734			67,734	57,832
Designated	9,464			9,464	8,898
Supporting organizations	2,320			2,320	7,330
Agency	5,579			5,579	4,565
	<u>100,425</u>			<u>100,425</u>	<u>86,413</u>
Less agency	(5,579)			(5,579)	(4,565)
	<u>94,846</u>			<u>94,846</u>	<u>81,848</u>
Total grants expense					
Investment management and trustee fees	5,261			5,261	4,198
Support expenses	14,714			14,714	10,653
	<u>114,821</u>			<u>114,821</u>	<u>96,699</u>
Total Expenses					
Change in Net Assets	104,556	10,026	1,510	116,092	63,034
Net assets, beginning of year	749,508	37,234	11,174	797,916	734,882
Net Assets, End of Year	\$ 854,064	\$ 47,260	\$ 12,684	\$ 914,008	\$ 797,916

See accompanying notes.

SEATTLE FOUNDATION
Consolidated Statement of Cash Flows
For the Year Ended December 31, 2017
(With Comparative Totals for 2016)
(In Thousands)

	2017	2016
Cash Flows From Operating Activities:		
Change in net assets	\$ 116,092	\$ 63,034
Adjustments to reconcile change in net assets to net cash provided by operating activities-		
Noncash items included in change in net assets:		
Depreciation	501	348
Change in present value adjustment of pledges receivable		(57)
Net gain on investments	(103,653)	(39,332)
Loss on disposal of assets	69	9
Noncash contributions of real estate held for sale	(750)	
Net gain on charitable gift annuities and trusts	(5,604)	(5,801)
Noncash change in value of beneficial interest assets	(2,944)	833
Noncash change in liability for annuities and trusts	2,864	2,339
Change in operating accounts:		
Accounts receivable and other assets	22	(132)
Pledges receivable	1,291	1,180
Bequests receivable	2,614	(1,804)
Mission related investments	(1,599)	(1,514)
Funds held for others	3,143	(613)
Unconditional grants payable	2,247	630
Other liabilities	1,097	826
	15,390	19,946
Cash Flows From Investing Activities:		
Purchase of fixed assets	(190)	(2,630)
Purchase of investments	(492,904)	(390,495)
Proceeds from sale of investments	486,183	373,126
	(6,911)	(19,999)
Net Change in Cash and Cash Equivalents	8,479	(53)
Cash and cash equivalents, beginning of year	6,742	6,795
Cash and Cash Equivalents, End of Year	\$ 15,221	\$ 6,742
Supplementary Information:		
Fixed asset purchases included in accounts payable	\$ -	\$ 149
Noncash contributions of real estate held for sale	\$ 750	\$ -

See accompanying notes.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 1 - Description of Seattle Foundation

Seattle Foundation was established in 1946 as a public charity and is incorporated under the laws of the State of Washington. Seattle Foundation's mission is to ignite powerful, rewarding philanthropy to make Greater Seattle a stronger, more vibrant community for all. It accomplishes this purpose through contributions from individuals, corporations and nonprofit agencies that support a wide range of organizations that promote educational, cultural, health, social and civic development. Seattle Foundation is authorized to accept gifts, bequests, contributions and grants of property in a variety of asset forms including cash, stock, real estate and other assets to carry out its organizational purpose. The Foundation generally does not administer programs of its own; instead, it grants funds to a variety of charitable and nonprofit organizations to support their respective programs.

Our goal as a community foundation is to simplify giving and strengthen the impact of philanthropy for the more than 1,200 individuals, families, businesses and nonprofits we serve. We provide deep community insights, powerful civic leadership, effective philanthropic advising and judicious stewardship of assets in support of our mission. We use our donor funds to support a wide range of community interests including those expressed through our Healthy Community Framework, making grants to nonprofit organizations to support their programs. In pursuit of its mission, Seattle Foundation is guided by the central principles of equity and opportunity and developed the Center for Community Partnerships (the Center) to focus directly on efforts to achieve greater racial and economic equity. Understanding that social problems are products of networks of cause and effect at a policy level, the Center focuses on advancing systems change as the most effective way to advance our mission of creating a stronger, more vibrant community for all.

Supporting Organizations - The consolidated financial statements include the activities of seven supporting organizations for which Seattle Foundation performs accounting and administrative functions as well as appointing a majority of voting members to the Board of Directors for each organization. Each governing board may establish its own investment policy and grant guidelines. As the supporting organizations are effectively under Seattle Foundation's control and Seattle Foundation has an economic interest, their financial activities and balances are consolidated with Seattle Foundation for financial reporting purposes. The supporting organizations make grants to outside organizations.

In addition to the seven existing supporting organizations, during the year ended December 31, 2017, the following supporting organizations were dissolved, and their remaining net assets were contributed to Seattle Foundation: Dabney Point Fund; Dillion Family Foundation; Walker Family Foundation; and The Luino and Margaret Dell'Ossso Family Foundation.

Fund Types - Seattle Foundation has approximately 1,200 funds, organized over a variety of fund types. While the fund attributes may have one or more of the following: specified area of interest, annual spending limitation, temporary or permanent restriction, or may be associated with a donor who recommends grant distributions, all are subject to a legal variance power. Under this power, Seattle Foundation, in its sole discretion, shall have the right to withhold, withdraw, or demand the immediate return of any funds if, in Seattle Foundation's reasonable judgment, the provider is not in compliance with the reporting obligations or cannot use the funds for the intended purpose. The fund types are as follows:

Community - Funds for which donors have neither imposed any restrictions nor reserved any rights to make recommendations regarding distributions. Distributions from these funds are made at the discretion of the Board based on identified community needs, including the Healthy Community Framework elements of Health & Wellness, Basic Needs, Arts & Culture, Education, Environment, Global Giving, and Economic Opportunity.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 1 - Continued

Area of Interest - Funds designated by donors who want to focus grants toward a specific field of interest or specific geographic area but who do not want to take an active role in grant making. This type of fund allows the donor to identify and support a charitable purpose such as strong and connected neighborhoods, or a category of interest such as arts or a geographic area in the State of Washington.

Donor Advised - Donor advised funds allow donors to recommend grant recipients, aligned with their values and interests, subject to the Foundation's due diligence and approval. Seattle Foundation holds almost 600 donor advised funds.

Designated - Funds designated by the donors for support of specific charitable organizations. A donor-advised fund allows donors to recommend grant making to any charitable organization, while a designated fund identifies a single organization that is supported through the donor's lifetime and beyond through the application of Seattle Foundation's spending policy, which determines the amount of the annual grant, and may be paid either annually or quarterly. If the beneficiary organization ceases to exist, loses its tax-exempt status or changes its mission, Seattle Foundation's variance power allows the monies to be re-directed to support an organization with a similar mission.

Administrative - Funds which are used to pay the operating costs of the Foundation.

Agency - Funds received under the terms of agreements with certain qualified not-for-profit organizations that specify themselves as the ultimate beneficiary for the funds. Even though these funds are classified as agency funds (funds held for others), Seattle Foundation maintains legal variance power over these assets.

King County Accountable Community of Health, LLC - During the year ended December 31, 2017, Seattle Foundation became the sole member of King County Accountable Community of Health, LLC, doing business as Healthier Here. The LLC revenues and expenses totaled \$6,010 and \$1,872, respectively, for the year ended December 31, 2017.

Trueblood Diversion Workgroup - During the year ended December 31, 2017, Seattle Foundation became the fiscal sponsor to oversee the management and disbursement of funds awarded as the result of a class action lawsuit. The funds will be distributed to various local mental healthcare organizations. Revenues and expenses for this program totaled \$9,956 and \$3,194, respectively, for the year ended December 31, 2017.

Note 2 - Summary of Significant Accounting Policies

Principles of Consolidation - The consolidated financial statements as of December 31, 2017, include the financial statements of Seattle Foundation, its supporting organizations, King County Accountable Community of Health, LLC, and the sponsored program (collectively, the Foundation). Inter-organization transactions and balances have been eliminated in the consolidation.

Basis of Presentation - The consolidated financial statements of Seattle Foundation have been prepared on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP).

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 2 - Continued

Cash and Cash Equivalents - Cash and cash equivalents consist of cash in bank accounts and highly liquid investments with maturities of three months or less at date of acquisition. Cash and cash equivalents on deposit with brokers or in investment pools are considered to be investments.

Pledges Receivable - Pledges receivable (unconditional promises to give) are stated at the amount management expects to receive. Management provides an allowance for probable uncollectible pledges through a charge to contribution revenue and a credit to the allowance account based on its assessment of each pledge. Pledges that are deemed uncollectible are written off through a charge to the allowance and a credit to pledges receivable. Pledges are recognized as revenues in the period the pledge is received. Pledges receivable over periods more than one year are recorded at present value. Amortization of discounts is included in contribution revenue.

Bequests Receivable - Bequests are recorded as contribution revenue when Seattle Foundation is notified of its beneficiary status, the bequest becomes irrevocable, and Seattle Foundation's interest can be estimated. If the value of Seattle Foundation's interest cannot be estimated, contribution revenue is recognized when distributions are received.

Charitable Trusts and Charitable Gift Annuities - Seattle Foundation has an irrevocable interest in a number of charitable trusts and charitable gift annuities whose maturities are based on the life expectancies of the income beneficiaries or on a specified period of time (Note 5).

Trusts and annuities for which Seattle Foundation is the trustee and a beneficiary are recorded at the fair value of the trust assets, which are included in investments on the consolidated statement of financial position. A corresponding liability for the net present value of future amounts to be paid to other trust beneficiaries is reported as a liability for charitable lead and remainder trusts, and liability for charitable gift annuities on the consolidated statement of financial position.

Trusts for which Seattle Foundation is not the trustee but in which Seattle Foundation has a beneficial interest are recorded at the net present value of expected future payments to be received as beneficial interests held in trust on the consolidated statement of financial position.

Investments - Investments in debt securities and equity securities with readily determinable market values are recorded at fair value. Investments in securities traded on organized securities exchanges are valued at the closing price on the last business day of the fiscal year; securities traded on the over-the-counter markets are valued at the last reported bid price. Real estate investments are recorded at fair value determined by periodic appraisals which are obtained as deemed necessary based upon economic conditions and management's discretion with the assistance of third-party investment managers. The fair value of other investments, principally investments in hedge funds and private equities, for which quoted market prices are not available, are determined by management with the assistance of third-party investment managers using methods it considers appropriate. Securities are generally held in custodial investment accounts administered by certain financial institutions.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 2 - Continued

Investments are made according to the Investment Objectives and Policies adopted by Seattle Foundation's and supporting organizations' Boards of Trustees. These guidelines provide for investment in equities, fixed income, and other securities with performance measured against appropriate benchmarks and indices. Outside parties are contracted by Seattle Foundation to provide investment consulting.

Investment securities, in general, are exposed to various risks, including interest rate, credit, and overall market volatility. Due to the level of risk associated with certain long-term investments, it is reasonably probable that changes in the values of these investments will occur in the near term and that such changes could materially affect the amounts reported in the consolidated statement of financial position.

Real Estate Held for Sale - Seattle Foundation receives gifts in the form of real estate. Seattle Foundation generally liquidates the real estate as soon as practical after transfer of title to Seattle Foundation.

Mission Related (Impact) Investments - Seattle Foundation has made loans, loan guaranties, and equity investments for program purposes. Loans receivable are generally due over a period of one to ten years. The loans are recorded net of a present value discount, and imputed interest is recognized over the term of the loans, calculated using the simple-interest method on the principal outstanding. Seattle Foundation has outstanding capital commitments for equity mission related investments totaling \$1.3 million at December 31, 2017. There were no outstanding capital commitments at December 31, 2016. Management has reviewed the collectability of the notes receivable and equity investments and has determined an allowance for impairment is not necessary as of December 31, 2017 and 2016.

Fixed Assets Capitalization and Depreciation - Seattle Foundation capitalizes assets with a cost greater than \$5,000 and an estimated useful life of more than one year. Purchased fixed assets are recorded at cost and donated fixed assets are recorded at fair value on the date received. Software development costs incurred to create a website and intangibles consisting of rebranding costs are capitalized.

Depreciation and amortization are recorded on a straight-line basis over the estimated useful lives of the related assets or, for leasehold improvements, over the term of the lease as follows:

Technology, equipment and software	3 - 5 years
Leasehold improvements	10 years
Furniture and fixtures	3 - 10 years
Intangibles	5 - 10 years

Funds Held for Others - In accordance with U.S. GAAP, when a not-for-profit organization, such as a community foundation, accepts a contribution from a donor and agrees to transfer those assets, the return on investment of those assets, or both, to another entity that is specified by the donor, the community foundation must account for the transfer of such assets as if it is holding the funds as an agent of the donor. These funds, identified as agency funds, are included in Seattle Foundation's assets with an offsetting liability on the consolidated statement of financial position. The liability is valued at the fair value of the agency funds, estimated by Seattle Foundation. Activities related to the agency funds do not affect the change in net assets of Seattle Foundation.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 2 - Continued

Net Assets - Seattle Foundation presents its net assets, revenues, gains, and losses based on the existence or absence of donor-imposed restrictions. Accordingly, the net assets of Seattle Foundation and changes therein are classified and reported as follows:

Unrestricted Net Assets - Net assets on which there are no donor-imposed restrictions for use or on which donor-imposed restrictions have expired.

Temporarily Restricted Net Assets - Net assets subject to donor-imposed restrictions that will be met either by actions of Seattle Foundation or the passage of time. Items that affect this net asset category are gifts for which a time restriction has not been met, and income that is not yet available for use as designated by the donor. Temporarily restricted net assets include charitable remainder trusts, charitable lead trusts, pledges, and bequests which will be collected in a future year, and the net assets of the LLC and sponsored program.

Permanently Restricted Net Assets - Net assets subject to donor-imposed restrictions to be maintained permanently by Seattle Foundation. Permanently restricted net assets consist of perpetual trusts.

Revenues are reported as increases in unrestricted net assets unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets unless their use is restricted by explicit donor stipulation or by law. When a restriction expires, (that is, when a stipulated time restriction ends or purpose restriction is accomplished), temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statement of activities as net assets released from restriction.

Seattle Foundation's corporate bylaws and contribution documents grant Seattle Foundation "variance power" that in effect gives Seattle Foundation control over all grant disbursements. Consequently, all contributions are classified as unrestricted if they are available to Seattle Foundation with no restriction as to when the funds are available for expenditure.

Revenue Recognition - Contributions are recognized as revenue when received or unconditionally promised. Unconditional promises to give that are expected to be collected in future years are recognized at fair value based on discounted cash flows. Contributions of assets other than cash are recorded at their estimated fair value on the date received. Contributed real estate is recorded at appraised or estimated fair value on the date received.

Grants - Community, area of interest, agency and designated grants are approved by the Board of Trustees of Seattle Foundation in accordance with Seattle Foundation's bylaws and operating guidelines. The Board has delegated authority to certain Foundation senior staff members to approve donor advised fund grant recommendations consistent with Seattle Foundation's charitable purposes and policies. Grants are approved by the Board of Trustees of Seattle Foundation or supporting organizations under their respective bylaws and guidelines. Unconditional grants and distributions are recorded in the consolidated financial statements when approved and communicated to the grantee. Grants approved by the Board of Trustees that are payable upon the performance of specified conditions by the grantee are not reflected in grants payable in the consolidated financial statements until those conditions are satisfied.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 2 - Continued

In-Kind Contributions - Each year, volunteers give their time and expertise to Seattle Foundation in a wide variety of areas including grants, audit, investment, finance and other activities. These contributions, despite their considerable value to the mission of Seattle Foundation, are not reflected in the consolidated financial statements.

Concentration of Credit Risk - Investments in cash, mutual funds, and investments held in banks generally exceeded the available federally insured amounts.

Approximately 14% of contributions was from one donor for the year ended December 31, 2016, there were no contribution concentrations for the year ended December 31, 2017. Approximately 100% and 87% of pledges receivable were from four donors at December 31, 2017 and 2016, respectively.

Use of Estimates - The preparation of consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Functional Expense Allocation - Expenses which apply to more than one functional category have been allocated among program and support expenses based on the time spent on these functions by specific employees as estimated by management. Indirect expenses such as facilities costs, information technology and general office supplies are allocated based on the overall number of staff in various functional categories used by functional departments. Certain marketing material costs are allocated based on the percentage of the publication devoted to each functional area. All other costs are charged directly to the appropriate functional category.

Income Taxes - Seattle Foundation and its supporting organizations qualify as tax-exempt organizations and are not subject to federal or state income taxes, except on unrelated business income, under Section 501(c)(3) of the Internal Revenue Code. In addition, Seattle Foundation and its supporting organizations qualify for the charitable contribution deduction under Section 170(b)(a)(A) of the Internal Revenue Code and have been classified as organizations that are not private foundations as defined in Section 509(a) of the Code. Seattle Foundation is subject to federal income tax only on "unrelated business taxable income" as defined in Section 512 of the Code. Unrelated business income tax, if any, is immaterial and no tax provision has been made in the accompanying consolidated financial statements. King County Accountable Community of Health, LLC (Note 1) is wholly owned by Seattle Foundation and is a disregarded entity for tax purposes.

New Accounting Pronouncements - During the year ended December 31, 2017, Seattle Foundation implemented ASU 2015-07, *Fair Value Measurement (Topic 820): Disclosures for Investments in Certain Entities that Calculate Net Asset Value per Share (or its Equivalent)*, which removes the requirement that investments for which fair value is measured using the net asset value (NAV) per share, or its equivalent, be categorized in the fair value hierarchy (Note 3). The change was implemented retrospectively for all periods presented.

Comparative Amounts for 2016 - The consolidated financial statements include certain prior-year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with U.S. GAAP. Accordingly, such information should be read in conjunction with Seattle Foundation's consolidated financial statements for the year ended December 31, 2016, from which the summarized information was derived.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 2 - Continued

Subsequent Events - Seattle Foundation has evaluated subsequent events through June 22, 2018, the date on which the consolidated financial statements were available to be issued.

Note 3 - Investments and Fair Value Measurements

Fair Value Measurements - U.S. GAAP establishes a framework for measuring fair value and requires certain disclosures. To increase consistency and comparability in fair value measurements, fair value is required to be determined based on the exchange price that would be received for an asset or paid to transfer a liability (exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants.

U.S. GAAP utilizes a three-level valuation hierarchy based on observable and unobservable inputs. Observable inputs consist of data obtained from independent sources. Unobservable inputs reflect market assumptions. These two types of inputs are used to create the fair value hierarchy, giving preference to observable inputs.

Financial assets and liabilities classified as Level 1 have fair values based on unadjusted quoted market prices for identical instruments in active markets. Financial assets and liabilities classified as Level 2 have fair values based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in inactive markets, and model-derived valuations whose inputs are observable. Financial assets and liabilities classified as Level 3 have fair values based on value drivers that are unobservable.

While this requirement applies to all financial assets recorded on a recurring basis, it primarily applies to the securities held in Seattle Foundation's investment portfolio and certain liabilities.

Valuation Techniques - Valuation techniques utilized to determine fair value are consistently applied. Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2017 and 2016.

Cash and Money Market Funds - Includes cash held in investment pools and is reflected at cost plus accrued interest, which represents fair value.

Marketable Equity and Fixed Income Securities - Valued at the closing price reported on the active market in which the securities are traded.

Real Return Funds - Valued at net asset value (NAV), which represents Seattle Foundation's proportionate share of the net assets of the investment as reported by the underlying investment managers or general partners.

Real Estate and Other Assets - Valued based on estimates of similar assets and are generally illiquid.

Beneficial Interests Held in Trust - Valued at Seattle Foundation's proportionate share of the underlying assets held by the trusts.

Funds Held for Others - Valued at each fund's proportionate share of Seattle Foundation's investment portfolio, which is valued as described above.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements
For the Year Ended December 31, 2017
(In Thousands)

Note 3 - Continued

Fair values of Seattle Foundation's investments and liabilities measured on a recurring basis are as follows at December 31, 2017:

	In Thousands			
	Level 1	Level 2	Level 3	Total
Investments at Fair Value:				
Cash and money market funds	\$ 75,672	\$ 1,779	\$ -	\$ 77,451
Domestic equities	278,498			278,498
International equities	75,131			75,131
Domestic fixed income	112,624	3,820		116,444
International fixed income	2,624	301		2,925
Real estate funds	2,959			2,959
Real return funds	6,997			6,997
Real estate notes receivable			193	193
Real estate			451	451
Other assets			816	816
	554,505	5,900	1,460	561,865
Beneficial interests held in trust			28,316	28,316
Total Investments in the Fair Value Hierarchy	\$ 554,505	\$ 5,900	\$ 29,776	590,181
Investments measured at NAV				382,425
Total Investments at Fair Value				\$ 972,606
Liabilities at Fair Value:				
Funds held for others	\$ -	\$ -	\$ 51,547	\$ 51,547
Total Liabilities at Fair Value	\$ -	\$ -	\$ 51,547	\$ 51,547

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements
For the Year Ended December 31, 2017
(In Thousands)

Note 3 - Continued

Fair values of Seattle Foundation's investments and liabilities measured on a recurring basis are as follows at December 31, 2016:

	In Thousands			
	Level 1	Level 2	Level 3	Total
Investments at Fair Value:				
Cash and money market funds	\$ 53,413	\$ 1,324	\$ -	\$ 54,737
Domestic equities	252,106			252,106
International equities	54,014			54,014
Domestic fixed income	93,975	3,991		97,966
International fixed income	2,377			2,377
Real return funds	6,222			6,222
Real estate			412	412
Other assets			958	958
	<u>462,107</u>	<u>5,315</u>	<u>1,370</u>	<u>468,792</u>
Beneficial interests held in trust			<u>25,372</u>	<u>25,372</u>
Total Investments in the Fair Value Hierarchy	<u>\$ 462,107</u>	<u>\$ 5,315</u>	<u>\$ 26,742</u>	494,164
Investments measured at NAV				<u>359,520</u>
Total Investments at Fair Value				<u>\$ 853,684</u>
Liabilities at Fair Value:				
Funds held for others	\$ -	\$ -	\$ 48,404	\$ 48,404
Total Liabilities at Fair Value	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 48,404</u>	<u>\$ 48,404</u>

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements
For the Year Ended December 31, 2017
(In Thousands)

Note 3 - Continued

A reconciliation of the beginning and ending balances, by each major category of assets, for fair value measurements made using significant unobservable inputs (Level 3) is as follows for the years ended December 31:

	In Thousands			
	Investments	Beneficial Interests Held in Trust	Total 2017 Assets at Fair Value	Total 2016 Assets at Fair Value
Beginning balance	\$ 1,370	\$ 25,372	\$ 26,742	\$ 27,632
Total gains-				
Realized and unrealized	57	3,299	3,356	(645)
Interest and dividends, net of fees				48
Purchases and receipts	149		149	
Sales and distributions	(116)	(355)	(471)	(293)
Ending Balance	\$ 1,460	\$ 28,316	\$ 29,776	\$ 26,742

A reconciliation of the beginning and ending balances, by each major category of liability, for fair value measurements made using significant unobservable inputs (Level 3) is as follows for the years ended December 31:

	In Thousands	
	2017 Funds Held for Others	2016 Funds Held for Others
Beginning balance	\$ (48,404)	\$ (49,017)
Total gains-		
Realized and unrealized	(7,176)	(2,960)
Interest and dividends, net of fees	(776)	(187)
Purchases and receipts	(1,416)	(1,331)
Sales and distributions	6,225	5,091
Ending Balance	\$ (51,547)	\$ (48,404)

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements
For the Year Ended December 31, 2017
(In Thousands)

Note 3 - Continued

The table below summarizes significant terms of the agreements with certain investment companies. There are no significant redemption restrictions or unfunded commitments on other types of investments. After year end, two commitments totaling \$14.6 million were approved.

Asset Class	Fair Value (in thousands)	Remaining Life	Unfunded Commitments (in thousands)	Redemption Terms	Redemption Restrictions
Hedged Strategies	\$85,891	No limit.	None	Redemption terms are quarterly with notification periods ranging from 45 to 90 days.	Lockup provisions range from none to 24 months.
Private Equity	\$36,552	Ranging from 1 to 11 years.	\$4,692	Closed end funds not eligible for redemption.	Not redeemable.
Real Estate (Closed End Funds)	\$15,565	Closed end funds range from 1 to 11 years.	\$18,347	Closed end funds not eligible for redemption.	Not redeemable.
Real Return Funds	\$27,897	Ranging from 6 to 12 years.	\$8,792	Closed end funds not eligible for redemption.	Not redeemable.
Domestic Equity	\$67,376	No limit.	None	No restrictions.	Lockup provision for 42 months.
International Equity	\$105,098	No limit.	None	No restrictions.	None
Other Global Equities	\$43,590	No limit.	None	Redemption terms are quarterly with notification periods ranging from 60 to 180 days.	Lockup provisions range from none to 3 months.
Other Assets	\$456	No limit.	None	Closely held interests not eligible for redemption.	Not redeemable.
Total	\$382,425		\$31,831		

Hedged Strategies and International Equity - Managers in this category strictly utilize long/short equity strategies in pursuit of investment returns. Investments may be made directly to the managers' funds or to a fund of funds vehicle.

Private Equity - Includes closed end fund of funds that make direct investments in venture capital and buy-out managers. The funds have a predetermined lifespan and redemptions during the life of the fund are not allowed.

Real Estate (Closed End Funds) and Other Global Equities - Closed end funds have predetermined lifespans and redemptions during the life of the funds are not allowed.

Real Return Funds - Includes investments in commingled trusts that, in turn, provide exposure to Treasury Inflation Protected Securities (TIPS), commodities, natural resources and other inflation hedging strategies.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 3 - Continued

Domestic Equity - Includes a fund that invests in public equity markets and follows a value-driven strategy.

Other Assets - Includes closely held stock, life insurance annuities, real estate, and life insurance cash values.

Seattle Foundation has various sources of liquidity at its disposal, including cash, cash equivalents, marketable debt securities and marketable equity securities. Had it been necessary to generate liquid funds to meet short-term needs on December 31, 2017, management estimates that it could have liquidated approximately \$707 million.

Note 4 - Pledges Receivable

Pledges receivable are expected to be received as follows at December 31:

	In Thousands	
	2017	2016
Due within one year	\$ 520	\$ 1,774
Due within two to five years	717	754
	1,237	2,528
Less discount to present value	(5)	(5)
Pledges Receivable, Net	\$ 1,232	\$ 2,523

Note 5 - Charitable Trusts and Charitable Gift Annuities

Charitable trusts and charitable gift annuities are recorded as follows:

Charitable Gift Annuities - Under its Charitable Gift Annuity (CGA) program, Seattle Foundation receives contributions from donors pursuant to written agreements that stipulate periodic payments will be made to specified beneficiaries. Upon the death of the beneficiaries, the related periodic payments cease and the related remaining funds, decreased by payments to other beneficiaries if stipulated, become available for use by Seattle Foundation.

The present value of the periodic payments is actuarially determined at year end based on mortality and discount rate assumptions that meet or exceed those set forth under Washington state law as applicable to issues of charitable gift annuities. It is expected that the investment earnings and a portion of the original contributions will be distributed; however, if for some reason principal is depleted, Seattle Foundation is responsible to continue the periodic payments.

Upon receipt of a CGA contribution, Seattle Foundation records the fair value of the assets received and the net present value of the actuarially determined liability. The portion of the actuarially determined residuum payable to Seattle Foundation is recorded as a contribution.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 5 - Continued

Investment income and changes in the estimated liability are recognized in the consolidated statement of activities. As of December 31, 2017, Seattle Foundation had 43 active CGAs. Underlying investments were valued at \$3,380 and \$3,723 at December 31, 2017 and 2016, respectively. The corresponding liability for payments to other beneficiaries was determined to be \$2,473 and \$2,724 at December 31, 2017 and 2016, respectively. Seattle Foundation maintains assets equal to reserves on outstanding agreements and a surplus of 10 percent of such reserves, under Washington state law.

Charitable Remainder Trusts - Under Seattle Foundation's Charitable Remainder Trust (CRT) program, a donor establishes and funds a trust with specified distributions to be made to the donor and/or other beneficiaries over the trust's term. Seattle Foundation will receive the amounts remaining in a CRT at the end of the trust's stated term.

Charitable Lead Trusts - Under Seattle Foundation's Charitable Lead Trust (CLT) program, a donor establishes and funds a trust with specified distributions to be made to Seattle Foundation. At the termination of the trust, the amount remaining in the CLT reverts to the donor and/or other beneficiaries.

Upon formation of an irrevocable CRT or CLT when Seattle Foundation is the trustee, the fair value of the assets received is recorded as an investment, and the net present value of Seattle Foundation's actuarially determined charitable interest is recorded as contribution revenue. The difference is recorded as a liability. Subsequently, changes in the fair value of the assets and changes in the estimated liability are recognized in the consolidated statement of activities. Included in investments are CRTs and CLTs with a fair value of \$50,088 and \$45,244, at December 31, 2017 and 2016, respectively. The corresponding liability totaled \$29,608 and \$26,494 at December 31, 2017 and 2016, respectively.

When Seattle Foundation has irrevocable rights to a CRT or CLT, but Seattle Foundation is not the trustee and does not hold the assets, Seattle Foundation's interest in the trust assets and specified future distributions is recorded as a beneficial interest held in trust, using actuarial assumptions. The change in value of Seattle Foundation's beneficial interest during the year is recorded as a component of change in value of charitable gift annuities and trusts. At December 31, 2017, beneficial interests in CRTs and CLTs totaled \$10,092 and \$4,372, respectively. At December 31, 2016, beneficial interests in CRTs and CLTs totaled \$8,735 and \$4,429, respectively.

Perpetual Trusts - Seattle Foundation is a named income beneficiary on various perpetual trusts for which Seattle Foundation does not serve as trustee. Under these arrangements, Seattle Foundation is to receive all income earned on its share of the underlying assets held in perpetuity. Contribution revenue and the related asset are recognized at fair value in the period in which Seattle Foundation receives notice that the trust agreement conveys an unconditional, irrevocable right to receive benefits. Subsequent changes in the value of the underlying assets have been recorded in the accompanying consolidated statement of activities as a component of change in value of charitable gift annuities and trusts. At December 31, 2017 and 2016, beneficial interests in perpetual trusts totaled \$13,852 and \$12,208, respectively. Included in these amounts is a perpetual trust held for others which totaled \$1,168 and \$1,034 at December 31, 2017 and 2016, respectively.

The assets held in charitable gift annuities and charitable trusts, for which Seattle Foundation is the trustee, are recorded at fair value using the same valuation method as Seattle Foundation's investments. Beneficial interest held in trusts, for which Seattle Foundation is not the trustee, is based on estimates provided by third party trustees.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 6 - Fixed Assets

Fixed assets consist of the following at December 31:

	In Thousands	
	2017	2016
Technology, equipment and software	\$ 1,987	\$ 1,928
Leasehold improvements	1,990	1,978
Furniture and fixtures	816	830
Intangible assets	196	196
	4,989	4,932
Less accumulated depreciation	(2,119)	(1,682)
Fixed Assets, Net	\$ 2,870	\$ 3,250

Depreciation expense totaled \$501 and \$348 for the years ended December 31, 2017 and 2016, respectively.

Note 7 - Unconditional Grants Payable

Unconditional grants payable are scheduled to be disbursed as follows at December 31:

	In Thousands	
	2017	2016
Due within one year	\$ 3,691	\$ 1,389
Due within two to five years	1,251	1,494
Thereafter	241	53
Total Unconditional Grants Payable	\$ 5,183	\$ 2,936

The discount for present value was immaterial at December 31, 2017 and 2016.

Note 8 - GiveBIG

Seattle Foundation's annual GiveBIG campaign, which began in 2011, is an online giving event designed to raise money for nonprofit organizations in Greater Seattle. Select contributions are increased by \$2,500 as part of the Dollar for Change provided by both Seattle Foundation and GiveBIG sponsors.

GiveBIG contributions are made online to over 1,600 nonprofit organizations representing a broad range of issues. Donors contribute through a secure third-party service provider, and the contributions are forwarded directly to the nonprofit organizations. Seattle Foundation does not collect personal or payment information from any GiveBIG donor. In order for the nonprofit organizations to receive maximum benefit, no fees are charged by Seattle Foundation.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 8 - Continued

Contributions and other information related to GiveBIG consist of the following for the years ended December 31:

	In Thousands	
	2017	2016
Online contributions	\$ 12,634	\$ 16,354
Dollars for change	452	
Stretch pool		1,000
Total GiveBIG Contributions	\$ 13,086	\$ 17,354
Number of donors	33,348	42,569
Number of gifts	82,076	89,097
Number of nonprofit recipient organizations	1,662	1,641

Note 9 - Temporarily Restricted Net Assets

Temporarily restricted net assets are restricted for future periods or for specific programs. They consist of the following at December 31:

	In Thousands	
	2017	2016
Charitable remainder and lead trusts	\$ 34,944	\$ 31,913
Pledges receivable	1,232	2,524
Bequests receivable	183	2,797
Fiscal sponsorship and LLC	10,901	
Total Temporarily Restricted Net Assets	\$ 47,260	\$ 37,234

Note 10 - Endowments

Seattle Foundation's endowments consist of funds established for a variety of purposes. Its endowments include both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments (quasi-endowments). Net assets associated with endowment funds, including quasi-endowments, are classified and reported based on the existence or absence of donor-imposed restrictions. However, because of Seattle Foundation's variance power as described in Notes 1 and 2, all endowments are classified as unrestricted.

Interpretation of Relevant Law - The Board has interpreted the Washington State Prudent Management of Institutional Funds Act (PMIFA) as making it advisable for Seattle Foundation to track the fair value of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements
For the Year Ended December 31, 2017
(In Thousands)

Note 10 - Continued

Seattle Foundation's organizing documents set forth the power to modify any restrictions or conditions on distributions from funds if, in Seattle Foundation's judgment, such restriction or condition becomes unnecessary, incapable of fulfillment, or inconsistent with the charitable needs of the area being served. Because of this variance power, Seattle Foundation classifies as unrestricted net assets (a) the original value of gifts donated to the permanent endowment, and (b) the original value of subsequent gifts to the permanent endowment.

Endowment net assets consist of the following at December 31:

	In Thousands	
	2017	2016
Donor-restricted endowment funds	\$ 133,922	\$ 118,216
Board designated quasi-endowment funds	226,522	201,194
Endowment Net Assets	\$ 360,444	\$ 319,410

Changes to endowment net assets are as follows for the years ended December 31:

	In Thousands	
	2017	2016
Endowment net assets, beginning of year	\$ 319,410	\$ 301,321
Endowment investment return-		
Interest and dividends, net of fees	5,999	5,266
Total net gains	47,972	18,217
Total investment returns	53,971	23,483
Contributions	6,518	13,540
Net transfer from endowments	(19,455)	(18,934)
Endowment Net Assets, End of Year	\$ 360,444	\$ 319,410

Funds With Deficiencies - From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the total amount of the gifts made to the endowment by the donor. Deficiencies of this nature that are reported in unrestricted net assets were \$102 and \$214 at December 31, 2017 and 2016, respectively. These deficiencies resulted from unfavorable market fluctuations in prior years.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 10 - Continued

Return Objectives and Risk Parameters - Seattle Foundation has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that Seattle Foundation has been instructed to hold in perpetuity or for donor-specified periods and board-designated funds. Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce results that, over time, will provide a real rate of return equal to the spending rate while assuming a reasonable level of investment risk. Seattle Foundation expects its endowment funds, over time, to provide an average real rate of return of approximately 4.5 percent annually. While actual returns may vary, the targeted nominal rate of return is approximately 7 percent.

Strategies Employed for Achieving Objectives - To satisfy its long-term rate-of-return objectives, the Foundation relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). Seattle Foundation targets a diversified asset allocation that places a greater emphasis on equity-based investments to achieve its long-term return objectives within prudent risk constraints.

Spending Policy and How the Investment Objectives Relate to Spending Policy - Seattle Foundation has a general policy of appropriating for distribution each year 4.5 percent of its endowment fund's average fair value over the prior 12 quarters through the calendar year end preceding the fiscal year in which the distribution is planned. In establishing this policy, Seattle Foundation considered the long-term expected return on its endowment. Over the long term, Seattle Foundation expects the spending policy to allow its endowment to grow at a rate equal to inflation. This follows Seattle Foundation's objective to maintain the purchasing power of the endowment assets held in perpetuity.

Note 11 - Support Expenses

The detail of support expenses is as follows for the years ended December 31:

	In Thousands	
	2017	2016
Administrative fund	\$ 7,520	\$ 7,819
Program and support services for other funds	6,495	2,834
Change in allowance for loss from uncollectible amounts	699	
Total Support Expenses	\$ 14,714	\$ 10,653

Fundraising expenses were immaterial for the years ended December 31, 2017 and 2016.

Note 12 - Retirement Plans

Seattle Foundation maintains a defined contribution retirement plan that complies with Code Section 403(b). All regular employees are eligible to participate in the retirement plan immediately upon commencing employment. Although employee contributions can be made to the plan immediately, an employee is not eligible to receive matching contributions from Seattle Foundation until completion of the orientation period, which is currently 90 days.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements For the Year Ended December 31, 2017 (In Thousands)

Note 12 - Continued

Seattle Foundation matches employee contributions based on years of service as follows:

<u>Years of Service</u>	<u>Matching Percentage</u>
0 - 4 years	5.0%
5 - 9 years	7.5%
10 or more	10.0%

Total matching expense was \$258 and \$256 for the years ended December 31, 2017 and 2016, respectively. All contributions under the plan vest with employees when contributions are made.

Seattle Foundation also maintained a nonqualified deferred compensation plan covered under Section 457(b) of the Internal Revenue Code. Only employees specifically designated by the Board of Trustees are eligible. The maximum salary deferral under the 457(b) plan was \$18 (plus a catch-up provision of \$6 for eligible participants) for the years ended December 31, 2017 and 2016, respectively. There were no matching provisions. The nonqualified deferred compensation plan was administered by Seattle Foundation. There was one participant in the 457(b) plan during the year ended December 31, 2016. There were no participants in the 457(b) plan at December 31, 2017. Assets of the 457(b) plan totaled \$86 and \$91 as of December 31, 2017 and 2016, respectively. Assets in the plan are held by Seattle Foundation on a nontrust basis and are subject to the claims of its creditors.

Note 13 - Commitments

Revolving Line of Credit - Seattle Foundation entered into a line of credit agreement on November 10, 2014, which provides for borrowings of up to \$10 million and bears interest equal to the LIBOR rate plus 0.90%; however, in no event can the interest rate charged exceed the highest rate permitted by applicable state or federal law or be less than 0.90% per annum. The covenants require Seattle Foundation to maintain collateral of at least \$50 million in assets at an account established with the creditor. The credit agreement also contains various other customary restrictive covenants. Seattle Foundation has complied with all covenants and there was no outstanding balance owed on the line at December 31, 2017 or December 31, 2016.

Leases - Operations of Seattle Foundation are conducted in leased office space in Seattle, Washington. The prior lease for office space expired in November 2016. In March 2016, Seattle Foundation leased space in Westlake Tower to accommodate growth and expand meeting space available to support community convenings and outreach. The new lease commenced in November 2016 and expires in February 2027. Seattle Foundation may extend the initial term of the new lease for two successive periods of five years. Both leases include escalating base rent plus a proportionate share of the actual operating costs of the building as specified in the lease agreements. Rent expense was \$851 and \$419 for the years ended December 31, 2017 and 2016, respectively.

SEATTLE FOUNDATION

Notes to Consolidated Financial Statements
For the Year Ended December 31, 2017
(In Thousands)

Note 13 - Continued

Seattle Foundation also leases copier equipment. Future minimum lease payments under all noncancelable leases for existing office space and equipment are:

For the Year Ending December 31,	In Thousands		
	Office Space	Equipment Leases	Total
2018	\$ 728	\$ 9	\$ 737
2019	746	9	755
2020	763	4	767
2021	781		781
2022	799		799
Thereafter	3,519		3,519
Total Future Lease Payments	\$ 7,336	\$ 22	\$ 7,358

The new office in Westlake Tower also includes office space for community partners, aligned with Seattle Foundation's mission, to sublease. As of December 31, 2017, Seattle Foundation had sublease agreements with Global Washington, Seattle International Foundation and SkillUp Washington. The subleases have terms that extend through 2021 with total annual sublease payments ranging from \$160 to \$179.

SUPPLEMENTARY INFORMATION

SEATTLE FOUNDATION

**Consolidating Statement of Financial Position
December 31, 2017
(In Thousands)**

	Seattle Foundation	Supporting Organizations	Eliminations	Consolidated Total
Assets:				
Cash and cash equivalents	\$ 15,016	\$ 205	\$ -	\$ 15,221
Accounts and other receivables	85	272		357
Pledges receivable and other assets, net	1,232			1,232
Bequests receivable	183			183
Beneficial interests held in trust	28,316			28,316
Investments	902,943	41,347		944,290
Real estate held for sale		2,928		2,928
Mission related investments	8,262	2,500		10,762
Fixed assets, net of accumulated depreciation	2,870			2,870
Total Assets	\$ 958,907	\$ 47,252	\$ -	\$ 1,006,159
Liabilities and Net Assets				
Liabilities:				
Unconditional grants payable	\$ 5,068	\$ 115	\$ -	\$ 5,183
Other liabilities	2,738	133		2,871
Funds held for others	51,547			51,547
Liability for life estate	-	469		469
Liability for charitable lead and remainder trusts	29,608			29,608
Liability for charitable gift annuities	2,473			2,473
Total Liabilities	91,434	717		92,151
Net Assets:				
Unrestricted-				
Community/area of interest	110,925			110,925
Donor advised	439,639			439,639
Designated	249,366			249,366
Supporting organizations		46,305		46,305
Administrative	7,829			7,829
Total unrestricted	807,759	46,305		854,064
Temporarily restricted	47,030	230		47,260
Permanently restricted - Perpetual trusts	12,684			12,684
Total Net Assets	867,473	46,535		914,008
Total Liabilities and Net Assets	\$ 958,907	\$ 47,252	\$ -	\$ 1,006,159

See independent auditor's report.

SEATTLE FOUNDATION

**Consolidating Statement of Activities
For the Year Ended December 31, 2017
(In Thousands)**

	Seattle Foundation	Supporting Organizations	Eliminations	Consolidated Total
Unrestricted				
Revenues and Support:				
Contributions and agency funds	\$ 111,772	\$ 4,540	\$ (13,374)	\$ 102,938
Less agency and GiveBIG	(14,022)			(14,022)
Total contributions	97,750	4,540	(13,374)	88,916
Dividend and interest income	13,832	802		14,634
Gains on investments, net	97,836	5,806		103,642
Change in value of charitable gift annuities and trusts	(184)			(184)
Other income	1,246	1,667	(1,468)	1,445
Transfers within	779	(779)		
Net assets released from restriction	10,807	117		10,924
Total Revenues and Support	222,066	12,153	(14,842)	219,377
Expenses:				
Grants	92,526	15,694	(13,374)	94,846
Investment management and trustee fees	4,739	522		5,261
Support expenses	12,975	3,207	(1,468)	14,714
Total Expenses	110,240	19,423	(14,842)	114,821
Change in Unrestricted Net Assets	111,826	(7,270)		104,556
Temporarily Restricted				
Revenues and Support:				
Contributions	16,234	347		16,581
Gain on investments	11			11
Change in value of charitable gift annuities and trusts	4,358			4,358
Net assets released from restriction and transfers	(10,807)	(117)		(10,924)
Change in Temporarily Restricted Net Assets	9,796	230		10,026
Permanently Restricted				
Revenues and Support:				
Change in value of charitable gift annuities and trusts	1,510			1,510
Change in Permanently Restricted Net Assets	1,510			1,510
Total Change in Net Assets	123,132	(7,040)		116,092
Net assets, beginning of year	744,341	53,575		797,916
Net Assets, End of Year	\$ 867,473	\$ 46,535	\$ -	\$ 914,008

See independent auditor's report.