



North Sound Accountable Community of Health

Healthier Washington Medicaid Transformation

Semi-Annual Report

Reporting Period: January 1, 2018 – June 30, 2018

July 31, 2018

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Introduction

NORTH SOUND ACH INITIATIVE PORTFOLIO

Moving from eight Project Areas to four Initiatives

The North Sound ACH elected to pursue strategies in all eight project areas in the Medicaid Transformation toolkit. As our ACH moved toward implementing these strategies, it became clear there was a significant amount of overlap, both in the populations of focus and in the partners, who would be implementing strategies. As a result, the North Sound ACH has folded the strategies from its eight project areas into the following four initiatives: Care Coordination, Care Transformation, Care Integration, and Capacity Building. These initiatives will be referenced throughout this Semi-Annual Report. Please see the following Figures 1-3, as well as Attachment A, for a full description of these initiatives and how regional Medicaid Transformation strategies fit into them.

Figure 1. North Sound ACH Medicaid Transformation Initiatives

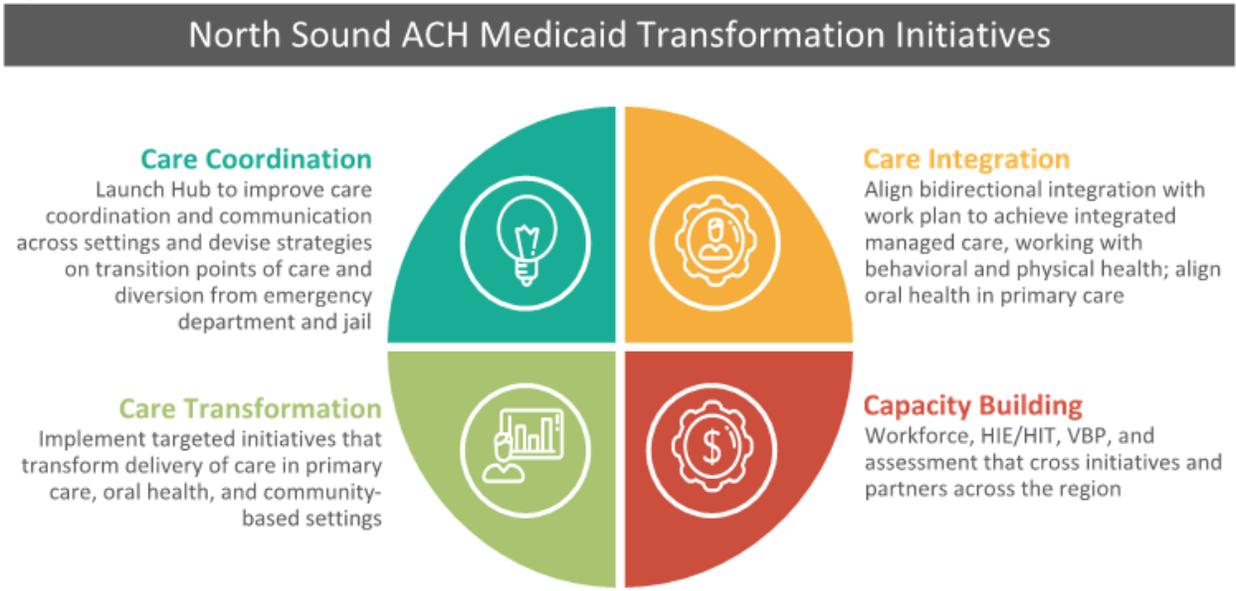


Figure 2. North Sound ACH Medicaid Transformation Initiatives and Project Plan Strategies

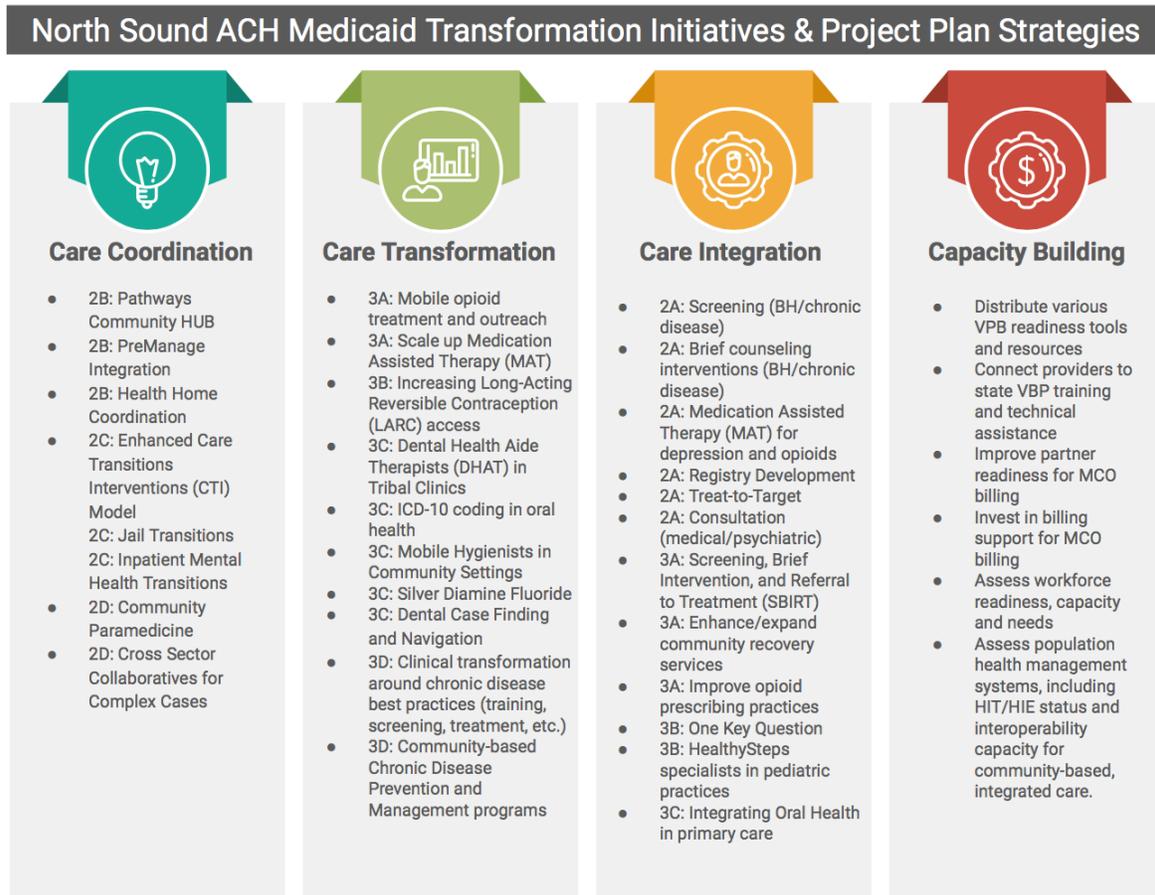
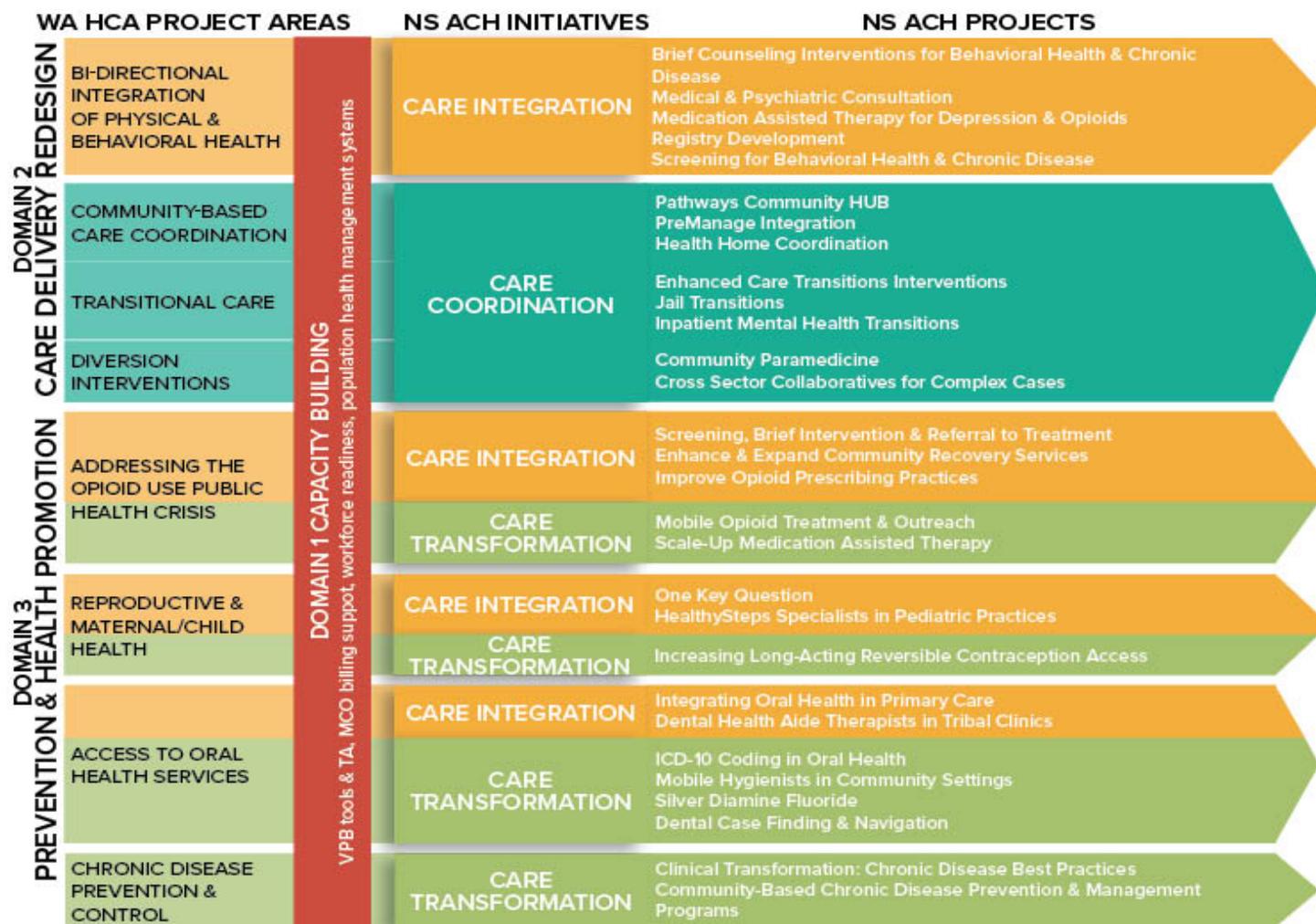


Figure 3. Detailed Description of Initiatives and the 8 Project Areas

A more detailed description of these initiatives, including their relationship to the eight toolkit project areas and initiative objectives, is included in Attachment A.



Foundational Concept: Targeted Universalism

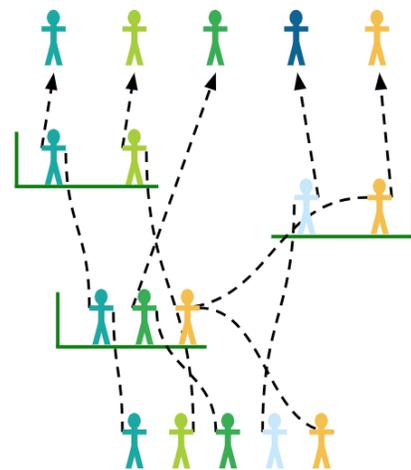
The North Sound ACH has adopted targeted universalism as an operational and communication framework to ensure health equity is strongly featured throughout the lifespan of project planning and implementation. Using targeted universalism, one sets out universal goals for all, identifies obstacles faced by specific groups, and tailors strategies to address the barriers in those specific situations. It is a strategy that allows universal project goals that improve health for an entire population to target approaches to address disparities within groups.

Figure 4. Brief Description of Targeted Universalism

Targeted Universalism

Setting universal goals that can be achieved through targeted approaches:

- Step 1- Define a universal goal: Articulate a particular goal based upon a robust understanding and analysis of the problem at hand.
- Step 2- Measure overall population: Assess difference of general population from universal goal.
- Step 3- Measure population segments: Assess particular geographies and population segments divergence from goal.
- Step 4- Understand group based factors: Assess barriers to achieving the goal for each group/geography.
- Step 5- Implement targeted strategies: Craft targeted processes to each group to reach universal goal.



Targeted Universalism, Haas Institute, University of California Berkeley (2018). John A. Powell, Post-Racialism or Targeted Universalism, 86 *Denn. U. L. Rev.* 785 (2008). Slide from Ben Duncan, Chief Diversity and Equity Officer Multnomah County. Bridging Leadership and Equity: Purpose driven work for Accountable Communities of Health (2017).

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.

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

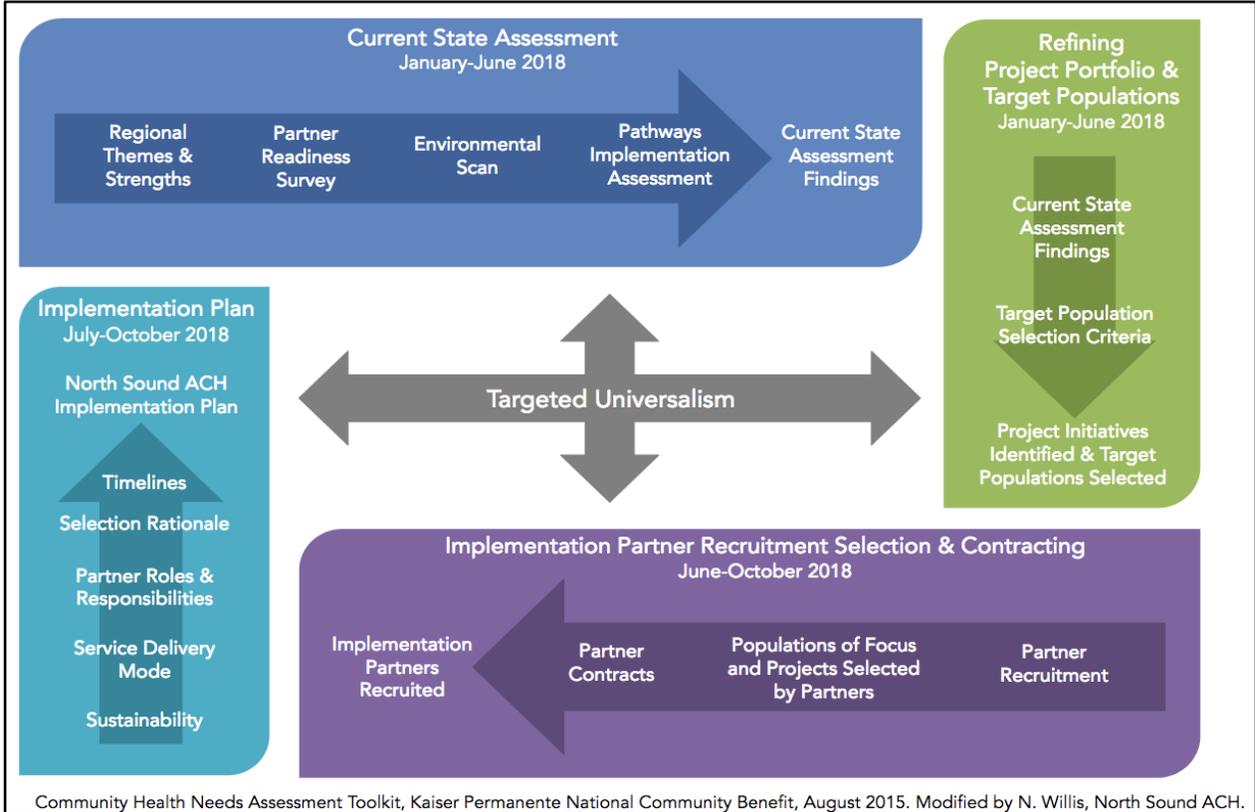
- 3. Describe assessment activities and processes that have occurred, including discussion(s) with partnering providers and other parties from which the ACH requested input. Highlight key findings, as well as critical gaps and mitigation strategies, by topic area for the project portfolio and/or by project.**

ACH Response: See the following response.

Background

The North Sound ACH designed Current State Assessment (CSA) activities and processes to ensure that information gathered would inform the implementation plan development process (Figure 5).

Figure 5: North Sound ACH 2018 Planning Process



North Sound ACH staff utilized best-practice resources in the assessment design process from the National Association of County and City Health Officials, Community Commons, and the Kaiser Permanente National Community Board. The following framework was developed to assist in coordinating the various data and information collection activities:

- Use quantitative and qualitative assessment methods to identify current state themes for the project portfolio.
- Assess potential partnering provider’s interest, readiness, and needs in Medicaid Transformation efforts.
- Identify regional health needs and assets based upon data and existing assessments.
- Refine project portfolio and initiatives and target populations.
- Inform the identification of populations of focus for initiative strategies.
- Apply targeted universalism framework throughout the process (please see page 8 for a brief description of targeted universalism).

North Sound ACH staff developed four assessment activities to ensure success in achieving the assessment goals (Table 1). In addition to utilizing the best available assessment guidance, North Sound ACH staff collaborated with the other ACHs and the Health Care Authority’s AIM Team to identify assessment resources and activities. Working across ACHs brought great value and collaboration to our CSA.

Table 1: North Sound ACH 2018 CSA Activities and Processes

Activity	Process & Methodology
<p>1. Environmental Scan</p>	<p>The environmental scan is similar to a literature review. For the purpose of the CSA, staff focused on more than 25 local and state reports, assessments, and plans that were identified as relevant to transformation work in the North Sound. This scan will be incorporated into our online research/resource library and will be updated on an ongoing basis as new and relevant research and reports are identified.</p>
<p>2. Partner Readiness Survey</p>	<p>We have pulled this into its own table to summarize the results of the Partner Readiness Survey (see Table 3) in order to avoid repetition of the same response for each initiative. The partner readiness survey was a required component of the North Sound ACH’s Call for Partners application. The survey included open and closed-ended questions related to:</p> <ul style="list-style-type: none"> • Initiatives that the organization commits to working on • Identification of which North Sound ACH target populations the organization is currently working with • Current capacity of key workforce designated to the initiative • Types of services currently provided to individuals eligible for or enrolled in Medicaid • Current capacity to implement change <p>Over 70 potential partnering providers completed the questionnaire, and 32 of those providers completed a supplemental application for care coordinating agencies (CCAs).</p>
<p>3. Pathways Implementation Assessment (specifically called out in the Care Coordination Initiative)</p>	<p>Because of an expedited timeline to implement the North Sound Community HUB, the North Sound ACH has undertaken a comprehensive Pathways implementation assessment. After consulting with Pathways HUB model creator Dr. Sarah Redding, the North Sound ACH focused on identifying assets that would support the start of a HUB in the region. These criteria include:</p> <ul style="list-style-type: none"> • There is baseline data available to illustrate a need for better care coordination for the HUB’s target population. • Payers have expressed interest in this population and would consider paying for Pathways outcomes. • CCAs in the community or region have the capacity to serve this population. • The HUB and CCAs have staff who can provide culturally and linguistically proficient services to the targeted population.
<p>4. Regional Themes & Strengths</p>	<p>Borrowed from the National Association of County and City Health Officials’ guidance on community-driven strategic planning process, the regional themes and strengths activity is a collection of multiple partner engagement activities in which qualitative information is collected through key informant interviews, regional convenings, community forums, and work sessions. Over 350+ regional partners participated in the information collection process.</p>

As the North Sound ACH attests to completing CSA activities, we recognize the need for assessment work to continue as partnering providers are selected and the collaborative process of creating a regional implementation plan begins. Ongoing assessment work will continue in July 2018, including partnering provider readiness assessment of the following:

- Gaps in best practices
- Specific HIT/HIE capacity and expected needs
- Availability of culturally and linguistically proficient services for target populations
- Gaps in health equity knowledge and skills

Current State Assessment Key Findings

As highlighted in Table 2, CSA activities and processes were separated into four areas: Environmental Scan, Partner Readiness Survey, Pathways Implementation Assessment (detailed in the Care Coordination Initiative only), and Regional Themes & Strengths. Key findings for each assessment activity are described using the framework of the four North Sound ACH Initiatives (Figures 1-3).

Table 2: CSA Key Findings by Initiatives

Key Findings for Care Coordination Initiative (Project Areas 2B, 2C, 2D)
<p>1. Environmental Scan</p> <p>Health assessments & improvement plan: Alignment of ACH initiatives with community health improvement efforts led by local county health departments, hospital/health system, and community action agencies throughout the region.</p> <ul style="list-style-type: none"> • Identification of gaps in services for housing, food access, veteran services, and child care throughout the region. • Regional support and prioritization to address health care access, immunizations, prenatal care, upstream/prevention care, mental health, adverse childhood experiences, abuse, housing, homelessness, care coordination, bi-directional integration, substance abuse, and the opioid crisis. • Awareness and collaboration to support individuals who are high system utilizers, including how substance abuse and mental illness exacerbate the issue. • Desire across region and sector to address the underlying mental health and alcohol and drug use contributions to high utilization. <p>Workforce: The North Sound ACH is launching a North Sound Community HUB and it relies on Community Health Workers (CHWs) in its model. An occupational profile of CHWs identified the need to include standardized CHW education and credentialing statewide and identified a lack of cohesion and "collective voice" among CHW workforce. The profile illustrated that CHWs are well known among community-based organizations, but as a workforce they experience low engagement with employers and have minimal structures in place for professional growth (e.g., training opportunities)</p> <p>Transportation: North Sound Transportation Alliance (NSTA) facilitates and leads community conversations aimed at developing better ways for people to travel within the region, which is critical specifically to San Juan County, dependent on the ferry system. NSTA's Focus on Ferries workshop identified objectives and solutions for ferry service in the region. North Sound ACH staff participated in the workshop and found overlap with North Sound ACH strategies to address social determinants of health in initiative planning</p>

Key Findings for Care Coordination Initiative (Project Areas 2B, 2C, 2D)

and implementation. NSTA's Health & Transportation Workshop identified health-related transportation services and gaps in health-related transportation services, prioritized needs based on community needs, and identified solutions.

Transformation capacity: 72% (52) of partners have internal practice transformation/quality improvement (QI)/population health management team

Care coordination capacity: 87% (27) of partners provide in-home or community-based services and 53% (16) employ, contract, or are in the process of hiring CHWs

2. Partner Readiness Survey: Please see Table 3 on Page 20

3. Pathways Implementation Assessment

A. Implementation Assessment Part One: Examine Best Practice

The North Sound ACH consulted with Pathways HUB model founder Dr. Sarah Redding and reviewed the base of evidence for the Pathways model. Dr. Redding outlined key elements for HUB best practice and the North Sound ACH determined that each of these readiness assets exist in the region:

- Baseline data exist for the targeted population.
- Payers have expressed interest in this population and would consider paying for Pathways outcomes.
- CCAs in the community or region have the capacity to serve this population.
- The HUB and CCAs have staff who can provide culturally and linguistically proficient services to the targeted population.

The North Sound ACH examined additional elements that would lead to successful HUB implementation, focusing on the preferred scope for population served in year 1 and the ability to address Medicaid Transformation Project measures. The North Sound ACH concluded that:

- The HUB's first year should begin with an initial size of 250-500 clients.
- The initial population of focus must have diagnoses that will move the metrics in area 2B of the Medicaid Transformation Project.
- The HUB must meet with payers and validate their support of the HUB's population of focus.

B. Implementation Assessment Activity Two: Identification of Populations of Focus

The North Sound ACH spent Q1 of 2018 doing qualitative validation that the population of focus identified in area 2B of the Project Plan would be appropriate for care coordination services via the Pathways HUB model. This mostly included Medicaid claims data, which identified indicators associated with the need for care coordination—such as medication management, readmission, and social determinants of health (e.g. lack of housing or employment)—and showed disparities across self-identified demographic groups, geographic regions, or co-occurring diagnoses. The existence of these disparities demonstrates insufficient system capacity to serve specific patient populations and a need to address them through culturally appropriate, community-based, and patient-centered care coordination. Data sources reviewed to make these initial assessments included:

- Measure Decomposition Data, RDA/DSHS, released July 7, 2017.

Key Findings for Care Coordination Initiative (Project Areas 2B, 2C, 2D)

- ACH Profiles Future, DSHS/RDA, released April 11, 2017.
- Measure Decomposition Data, RDA/DSHS, released July 7, 2017

This initial review of populations with unmet needs and/ or disparities in health outcomes that could be improved with additional care coordination services resulted in a high-level identification of the North Sound HUB target population. The next step identified was to run further statistical analysis of populations identified in the Project Plan, and then to validate our findings with regional partners and care coordination agencies.

C. Implementation Assessment Activity Three: Identifying Care Coordination Agencies and Key Partners for HUB Launch

Successful implementation of the North Sound ACH Community HUB requires knowing the strengths, level of interest, and barriers to engagement of necessary HUB partners. The North Sound ACH's HUB staff dedicated significant time to understand community support of the Pathways HUB model.

Additional opportunities for implementation assessment and their outcomes were:

- Two Pathways informational sessions: Held in June 2018, these open invitation calls allowed community members, partners, and interested CCA applicants to address the HUB Director with their Pathways or CCA questions and concerns.
- A meeting of community-based organizations that included a presentation on Pathways and gathered information and questions from participants
- Two HUB Core Team meetings: Held in June 2018, these meetings convened representatives from each of North Sound's five counties. Topics discussed included the timeline for development of a North Sound Community HUB, approach for effective community and partner engagement in the HUB, examination of the HUB and CCA relationship, review of the Care Coordination Systems software, discussion of North Sound ACH's target population selection and what considerations the HUB must apply to our five CCA criteria elements. Needs identified included better communication about financial aspects of HUB, sustaining momentum and energy beyond the initial CCA selection, and having clear next steps for potential partners.

Additionally, the success of the HUB requires building a network of capable and committed referral partners and CCAs. The HUB will convene key stakeholders to collaborate on bodies of work including strategic design, funding timelines, operational barriers and quality improvement efforts. A list of HUB convening bodies is shown in Table 10 on page 92.

4. Regional Themes & Strengths

- Care coordination
 - There is a greater awareness of and support for designing care coordination that accounts for social determinants of health
- Communication & engagement
 - There is a need for more effort and clearer messaging about health systems transformation
 - There is an opportunity for the ACH to help "translate" messages to the community
- Populations
 - Focus on beneficiaries with behavioral health needs, comorbid physical and behavioral health needs, substance abuse disorder, adverse childhood experiences (ACEs), high-

Key Findings for Care Coordination Initiative (Project Areas 2B, 2C, 2D)

- risk pregnancies, children and families, and high utilizers
- Need to focus on populations experiencing health disparities such as homeless and transitional youth (ages 16 to 21)
- Many populations have needs that cut across program areas
- Access
 - Need to address specific challenges of rural communities, including geography
 - Transportation can be a barrier to access
- Care coordination
 - Need to partner with local public health
 - Use and invest in resources such as local care coordinators and existing relationships
 - Need to address concerns about how HUB will coordinate with CCAs and CHWs
 - Need to better coordinate services across partners, including state-level agencies with local organizations
 - Need specific coordination for people experiencing homelessness
 - 211 is a vital resource for connecting people with health systems and other care services
 - Community organizations are critical in care coordination
 - Need for pediatric care coordination
- Sustainability
 - Need to build on existing collaborations and momentum

5. Regional Asset Inventory

Regional community-based organizations (CBOs) exist throughout the North Sound, and these partners will be critical for successful project implementation. The North Sound ACH has identified the following regional assets by organization type and focus area, including:

- 32 Behavioral Health Assets
- 9 Educational Assets
- 33 Food/Nutrition Assets
- 30 Transportation Assets
- 25 Social Service Assets

Key Findings for Care Transformation Initiative (Project Areas 3A, 3B, 3C, 3D)

1. Environmental Scan

Health Assessments & Improvement Plans:

- Alignment of ACH initiatives with community health improvement efforts lead by local county health departments, hospital/health systems, and community action agencies throughout region.
- Gaps in services for housing, food access, veteran services, and child care throughout the region.
- Regional support and prioritization to address health care access, immunizations, prenatal care, upstream/prevention care, mental health, adverse childhood experiences, abuse, housing, homelessness, care coordination, bi-directional integration, substance abuse, and opioid crisis.
- Awareness and collaboration in supporting individuals who are high system utilizers, including how substance abuse and mental illness exacerbate the issue.

Key Findings for Care Transformation Initiative (Project Areas 3A, 3B, 3C, 3D)

- Desire across region and sector to address the underlying mental health and alcohol and drug use contributions to high utilization.

Workforce:

- Strong workforce research capabilities from the University of Washington's Center for Health Workforce Studies and the Rural Health Research Center where the North Sound ACH can learn more about workforce needs.
- Dental providers statewide identified workforce and training as barriers to care, especially for individuals with Medicaid health coverage and those living in rural areas. Dental providers suggested working with ACHs to reduce barriers to care.

Opioid Response:

- The North Sound Behavioral Health Organization Opioid Reduction Plan and the 2017 Washington State Opioid Response Plan are widely endorsed, and strategies are being implemented locally.
- The Washington State Opioid Response Plan provides annual updates on activities related to the strategies for each of the four priority goals. To date, the following activities have been listed as complete: 1) Offer pregnant and parenting women overdose education and take-home naloxone training. 2) Allocate SAMHSA block grant or other funding to scale up and sustain naloxone distribution at syringe exchange programs. 3) Ensure that Medicaid contracts require naloxone with no prior authorization. 4) Increase PMP reporting frequency by pharmacies from weekly to daily to reduce the lag between opioid dispensing and viewing the prescription in the PMP from 10 to 4 business days. 5) Develop measures using PMP data to monitor prescribing trends.
- The North Sound Behavioral Health Organization Opioid Reduction Plan has identified four goals to reducing opioid usage in the North Sound: 1) Prevent opioid use and misuse, 2) Link individuals with OUD to treatment and support services, 3) Intervene in opioid overdoses to prevent death, 4) Use data and information to detect opioid use and misuse, monitor morbidity and mortality, and evaluate interventions.

2. **Partner Readiness Survey:** Please see Table 3 on page 20.

3. Pathways Implementation Assessment

See findings in Care Coordination section.

4. Regional Themes & Strengths

- Integration
 - Bi-directional integration is happening rapidly, but the systems are fragile
 - Perception that medication-assisted treatment (MAT) is not available for opioid treatment
- Social determinants of health
 - People with SUD and behavioral health conditions should be priority populations
 - Need for more social services available to people with SUD
 - Transportation is largest social factor that is a barrier to treatment
 - Coordinated entry for homeless individuals could be a benefit across the region

Key Findings for Care Transformation Initiative (Project Areas 3A, 3B, 3C, 3D)

- Communication & engagement
 - There is an opportunity for the ACH to help translate messages to the community
 - Engage stakeholders across all organizational levels, from leadership to frontline staff
- Populations
 - Focus on beneficiaries with behavioral health needs, comorbid physical and behavioral health needs, SUD, ACEs, high-risk pregnancies, children and families, and high utilizers
 - Need to focus on individuals experiencing health disparities such as homeless and transitional youth (ages 16 to 21)
 - Shortage of behavioral health providers that accept Medicaid
- Access
 - High need for oral health and SUD services, particularly in rural communities
 - Telehealth in behavioral health is working well
 - Need to increase number of behavioral health providers accepting Medicaid
- Care coordination
 - Opportunity to leverage the ACH's relationship with the behavioral health organization (BHO)
 - Need to communicate health outcomes and cost-savings to payers
 - Use and invest in resources such as local care coordinators and existing relationships
 - Need to better coordinate services across partners, including state-level agencies with local organizations
 - Need specific coordination for people experiencing homelessness
- Sustainability
 - Need to build on existing collaborations and momentum
 - Identify ways to capture savings and invest in sustainable solutions
 - Build evaluation into program plans
 - Start small and find ways to expand
- Other
 - Funding is critical to access and quality of care
 - Manage expectations with early and frequent communication
 - Be focused on the work and action oriented
- Regional CBOs exist throughout the North Sound, and these community care providers will be critical for successful project implementation. To date, the North Sound ACH has identified the following regional assets by organization type and focus area, including the following:
 - 32 Behavioral Health Assets
 - 9 Educational Assets
 - 33 Food/Nutrition Assets
 - 30 Transportation Assets
 - 25 Social Service Assets

Key Findings for Care Integration Initiative (Project Area 2A)

1. Environmental Scan

Health Assessments & Improvement Plans:

Key Findings for Care Integration Initiative (Project Area 2A)

- North Sound ACH initiatives align with established regional improvement priorities that include health care access, immunizations, prenatal care, upstream/prevention care, mental health, adverse childhood experiences, abuse, housing, homelessness, care coordination, bi-directional integration, substance abuse, and the opioid crisis
 - Awareness and collaboration in supporting individuals that are high system utilizers, including how substance abuse and mental illness exacerbate the issue
 - Desire across region and sector to address the underlying mental health/alcohol and drug use contributions to high utilization
2. **Partner Readiness Survey:** Please See Table 3 on Page 20.
3. **Pathways Implementation Assessment**
- See findings in Care Coordination section.
4. **Regional Themes & Strengths**
- Integration
 - Bi-directional integration is happening rapidly, along with moving to full integration for managed care, putting stressors on an already fragile system
 - Perception that MAT is not available for opioid treatment
 - Communication & engagement
 - Opportunity to communicate challenges in tribal communities and opportunities to learn from tribal integration successes
 - Engage stakeholders across all organizational levels, from leadership to frontline staff
 - Populations
 - Primary focus should be on beneficiaries with behavioral health needs, comorbid physical and behavioral health needs, SUD, and high utilizers
 - Need to focus on individuals experiencing health disparities such as homeless and transitional youth (ages 16 to 21)
 - Shortage of behavioral health providers that accept Medicaid
 - Access
 - High need for oral health and SUD services, particularly in rural communities
 - Telehealth in behavioral health is working well
 - Need to increase number of behavioral health providers accepting Medicaid
 - Care coordination
 - Perception from counties that the ACH is perhaps crowding their ability to sustain revenue
 - Opportunity to leverage the ACH's relationship with the BHO
 - Need to communicate health outcomes and cost-savings to payers
 - Use and invest in resources such as local care coordinators and existing relationships
 - Need to better coordinate services across partners, including state-level agencies with local organizations
 - Need specific coordination for people experiencing homelessness
 - Sustainability
 - Need to build on existing collaborations and momentum
 - Identify ways to capture savings and invest in sustainable solutions
 - Build evaluation into program plans

Key Findings for Care Integration Initiative (Project Area 2A)

- Start small and find ways to expand
- Role of MCOs in sustainability is not clearly understood and must be explored in collaboration with the MCOs
- Other
 - Funding is critical to access and quality of care
 - Manage expectations with early and frequent communication
 - Be focused on the work and action oriented

Key Findings for Capacity Building Initiative (Domain 1)

1. Environmental Scan

Health Assessments & Improvement Plans:

- There is alignment of ACH initiatives with community health improvement efforts led by local county health departments, hospital/health systems, and community action agencies throughout the region.

Workforce:

- Strong workforce research capabilities from the University of Washington's UW Center for Health Workforce Studies and the Rural Health Research Center
- Dental providers statewide identified workforce and training as barriers to care, especially for individuals with Medicaid health coverage and those living in rural areas. They suggested working with ACHs to reduce barriers to care; 42% of primary care providers reported receiving training in how to screen for oral health needs
- An occupational profile of CHWs identified the need to include standardized CHW education and credentialing statewide
- Lack of cohesion and "collective voice" among CHW workforce; CHWs are well known among CBOs, but as a workforce they experience low engagement with employers and have minimal structures in place for professional growth (training opportunities, etc.)

Opioid Response:

The North Sound Behavioral Health Organization Opioid Reduction Plan and the 2017 Washington State Opioid Response Plan are widely endorsed, and strategies are being implemented locally.

2. **Partner Readiness Survey:** Please see Table 3 on page 20.

3. Pathways Implementation Assessment

- See findings in Care Coordination section of Table 2.

4. Regional Themes & Strengths

- Workforce: Rather than duplicating work that has already been completed, in collaboration with other ACH directors and teams, the North Sound ACH is partnering with UW and the Association of WA Public Hospital Districts to summarize what is known to date about workforce challenges statewide and pull forth recommendations from various taskforces and commissions to see how many recommendations have been actualized since publication of those reports. This summary will be complete by fall 2018.

Key Findings for Capacity Building Initiative (Domain 1)

- Population Health: As part of our Call for Partners in May 2018, we asked several questions aimed at gauging partner readiness for transformation, including HIE/HIT capacity and current state. What we found is similar to other regions: there is no consistent platform being used across the region and limited interoperability inhibits the ability to share needed information across systems (sometimes within one’s own organization), which creates challenges for effective care coordination.
- VBP: The North Sound region’s clinical partners have participated in HCA’s partner surveys on uptake of VBP arrangements, and in the process have identified barriers to further implementation. North Sound is considering requiring completion of the HCA surveys as an element of participating in North Sound ACH earnings.

Table 3: Summary from Partner Readiness Questions

Key Findings from Partner Readiness Survey Questions

Regional representation of counties served by partner organizations:

- Island 25/34%
- San Juan 24/32%
- Skagit 32/43%
- Snohomish 42/57%
- Whatcom 34/46%

Partner workforce size:

- 28% with 1-25 employees
- 24% with 26-99 employees
- 41% with 100-999 employees
- 7% with 1,000 or more employees

Total # of staff committed to participate in project area trainings for all partners:

- 277 Bi-directional integration of Physical and Behavioral Health
- 258 Community-Based Care Coordination
- 194 Care Coordination During Care Transition
- 190 Diversion Interventions
- 201 Addressing the Opioid Crisis
- 110 Reproductive/ Maternal Child Health
- 60 Access to Oral Health Services
- 168 Chronic Disease Prevention and Management

Population health management capacity:

- 70% (52) of partners track Medicaid enrollment status
- 26% (19) report to WA’s immunization registry
- 16% (12) enter data into/use WA’s prescription monitoring program
- 43% (32) have an EHR which all charts are electronic; no paper charts

Key Findings from Partner Readiness Survey Questions

Transformation capacity:

- 72% (52) of partners have internal practice transformation/QI/population health management team

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 information collected from the CSA has informed project portfolio refinement, future partner engagement strategies, selection criteria for target populations and populations of focus, and implementation plan requirements. Data collected through our partner readiness survey will inform key areas of the implementation plan requirements.

The most valuable information collected throughout the CSA that has shaped project planning came from listening to partners. The CSA's regional themes and strengths activity collected information from over 350 partners, who shaped the following:

- Affirmed the importance of moving from eight project areas to four project portfolio initiatives, and greatly informed the organizing of the four initiatives
- Proposed ways to align target populations and identified challenges to alignment
- Informed the development of selection criteria for target populations for initiatives and populations of focus for strategies within initiatives
- Identified the importance of involving partners in the final selection of initiative strategy
- Acknowledged the need and readiness to address gaps in health equity knowledge and work together to identify solutions

For the North Sound Community HUB, the following changes were made from the 2017 Project Plan based on partner assessments completed in 2018:

- Population of focus was narrowed. The pilot population will be individuals who are experiencing co-occurring behavioral health and physical health conditions. Specifically, the pilot population will be individuals with a mental health condition and SUD. They must also be experiencing either one chronic condition or be of childbearing age. The North Sound ACH is continuing to run additional statistical analysis on various demographic or geographic segmentation scenarios to further narrow the pilot population prior to full implementation.
- Final pilot population was left open to refinement by initiative partners. In the Project Plan, we indicated that the pilot population would be determined prior to seeking CCA partners. After consultation with Pathways HUB experts and shared learning sessions with other ACHs, we modified this approach. Instead, we took the approach of allowing our final pilot population to be based on responses from interested CCAs. This approach was based on experiences of HUBs who have run into implementation barriers by seeking partners based on too narrow of a pilot population.
- Using a strengths-based approach to partner selection. With CCAs selected, the North Sound ACH can develop a more strengths-based approach to selection of HUB partners. To achieve this

framework, our partner applications were designed with more open-ended questions than the general ACH partner application. This allows HUB staff stronger insight into which agencies excel and could potentially mentor other CCAs on important aspects of HUB implementation.

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:

The North Sound ACH will leverage *all* regional assets to support the goals of reducing disparities and increasing health equity in the region. To date, cross-sector collaborations among partners from multiple fields/sectors and coalitions working with population groups experiencing health inequities have been identified as community assets that will directly support the health equity goals of the region. Further refinement of these assets will come from the partnering providers in the region. See table 4 on the next page for a summary of the assets that have a role in addressing health equity, in addition to our partnering providers, staff and Board leadership.

In addition to the community assets, the partner readiness activity of the CSA identified that nearly 90% of potential partnering providers are currently serving populations who are at risk and/or experiencing health outcome disparities and disparities in access and utilization of health services.

Table 4: Organizational Assets that Support Work Toward Health Equity

Assets in North Sound ACH Region That Have a Role in Addressing Health Equity	
<i>Organization/Entity</i>	<i>Focus</i>
Latino Advisory Council	Advocacy and empowerment for Latino populations
Communities of Color Coalition	Coalition for racial justice
Familias Unidas	Advocacy for Latino populations
Children’s Wellness Coalition	Child and family wellness
Behavioral Health Coalition	Advocacy for individuals with behavioral health needs
NAACP	Advocacy for African Americans and other communities of color
Comunidad a Comunidad (Community to Community)	Social justice focus on migrant worker rights
Coalition to End Homelessness	Individuals experiencing homelessness
Immunization Coalition	Cross-sector coalition for immunization education and access
NAMI (National Alliance for Mental Illness)	Mental health advocates
Snohomish County Transportation Coalition	Transportation
Generations Forward	Child and family wellness
North Sound Transportation Alliance	Transportation in the North Sound
Population Health Trust	Cross-sector coalition to advance community health
Coalition to End Homelessness	Cross-sector coalition to end homelessness
The Interlocal Leadership Council	Cross-sector coalition for health care integration
NW Washington Indian Health Board	Collaboration of five tribes in the North Sound to improve health and access

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:

The North Sound ACH has taken steps to ensure that gaps in health equity knowledge and skills are assessed and addressed by:

- Identifying a multi-initiative target population for individuals experiencing access, care, and utilization disparities
- Utilizing targeted universalism as an operational and communication framework to ensure that health equity is featured strongly throughout the lifespan of project planning and implementation (please see page 8 for a description of targeted universalism)
- Launching a regional health equity coalition by supporting a community organization that will assess, plan, and convene other community partners interested in tangible strategies to address disparities across the region
- Participating in the planning of a statewide health equity summit that regional partners will be encouraged to attend
- Developing health equity measures for the regional implementation plan with support from experts from the Haas Institute at UC Berkeley
- Seeking partnering organizations that can augment learning and teaching about equity and racial and social justice; for example, education related to the strength and resilience of the region's tribes
- Hosting a learning session in fall 2017 on equity and racism for approximately 100 staff and regional workgroup members developing the Project Plan
- Hosting a learning session on the Native Transformation Project, carried out by Upper Skagit, Lummi, and Swinomish tribes
- Requiring the 70+ implementation partners that they commit to key agreements within the Call for Partners application (which will be included in their Participation Agreements when signed):
 - My organization will participate in shared learning around equity and disparities.*
 - My organization will participate in shared learning about the tribes of the North Sound region.*
 - My organization is committed to partner with upstream (social determinants of health) organizations and strategies to address underlying conditions that impact health and disparities.*

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 value-based payment. Place an “X” in the appropriate box.

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:

In the November 2017 Project Plan, the North Sound ACH described the approach to identifying Domain 1 strategies and preliminary strategies within each area. In 2018 to date, the North Sound ACH has continued the process of identifying Domain 1 strategies with partners and further refining identified strategies. Because these foundational health system capacity development strategies cut across all the project areas, much of the identification and strategy development process has overlapped with ongoing project planning.

Key activities that have helped the ACH progress in identifying and developing Domain 1 strategies, as shown in Table 5 which follows.

Table 5: Activities That Have Informed Domain 1 Strategies

Project Activities and Domain 1 Focus Area(s)	
Call for Partners and CSA process identification of Domain 1 needs through application, convenings, and partner assessments	All Domain 1 Areas
ACH directors weekly call to discuss cross-ACH strategies	All Domain 1 Areas
ACH directors monthly in-person meeting to discuss cross-ACH strategies on VBP, workforce, and population health alignment tools/reporting	All Domain 1 Areas
Engagement with physical and behavioral health systems to support integrated managed care transition and bi-directional integration	All Domain 1 Areas
CSA activities and convenings to identify existing health system capacity and needs	All Domain 1 Areas
BHO/ACH Interlocal Structure Activities to identify behavioral health agency (BHA) readiness to participate in VBP contracting and needed population health management strategies and workforce development to support those contracts	All Domain 1 Areas
North Sound Community Hub Start-up Activities Population Health Management support opportunities through CCS platform Workforce development for community health worker reimbursements through North Sound Community HUB Exploring VBP opportunities with MCOs to support HUB sustainability	All Domain 1 Areas
HCA convened meetings to discuss Domain 1 strategies across ACHs	All Domain 1 Areas
Participating with HCA and MVP action team regarding VBP statewide taskforce and relationship to ACH-specific activities	Financial Sustainability through VBP
Meetings with managed care organizations (MCOs) to discuss alignment with VBP strategies	Financial Sustainability through VBP

Project Activities and Domain 1 Focus Area(s)	
ACH data leads call with Collective Medical Technologies	Population Health Management Strategies
ACH directors' meeting with Collective Medical Technologies to discuss EDIE/PreManage and relationship to Pathways/CCS platform	Population Health Management Strategies
North Sound ACH Staff Participation in Clinical Data Repository Database Workgroup	Population Health Management Strategies
Meetings with regional practice transformation initiatives including P-TCPI PTN, PeaceHealth TCPI PTN, UW Medicine TCPI PTN, and the Healthier Washington Practice Transformation Support Hub for assessment of practice transformation activity in the region	Population Health Management Strategies
Workforce meetings and forums with community colleges and potential partnering providers to identify workforce gaps and opportunities for regional workforce development	Workforce Development
HCA/UW and Association of Washington Public Hospital Districts meetings to discuss workforce development strategies on statewide basis	Workforce Development
ACH Representative participates in the planning of a regional CHW Symposium, cohosted by PeaceHealth, North Sound ACH, and the Chuckanut Foundation; the symposium will be held in fall 2018 and convene local CHWs for shared learning and networking	Workforce Development

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:

In addition to the strategies described in the project plan, the North Sound ACH has participated in ongoing discussions with the University of Washington, the Association of Washington Public Hospital Districts, and other statewide partners about the opportunity to leverage resources and strategies to support statewide health care workforce development and population health management strategies. These discussions are ongoing and referenced above in Question 3. The region’s approaches have evolved as the HCA has refined its expectations of the ACHs and fostered regional and cross-sector discussions.

Across all clinical transformation strategies, partners will be required to describe in their individual implementation plans how they will be aligning their activities with VBP contracts with the goal of improving internal systems to prepare for further contracts that are outcomes-based. As these processes continue with the Call for Partners and the North Sound ACH Implementation Plan development continues, Domain 1 strategies will be further developed.

Although the CSA provided insights into Domain 1 capacity and needs (see CSA findings in Section 1), North Sound has not made significant changes to the Domain 1 activities listed in the Project Plan. Domain 1 investments are foundational across all of the initiatives, and readiness to take on VBP contracts is a core goal for clinical partners, who recognize the importance of Domain 1 assessment work to continue. As planned, North Sound will administer a Part 2 of the Partnering Providers Readiness Survey that will collect specific information on capacity and needs for financial sustainability through (VBP) and on workforce and systems for population health management.

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:

State agencies are critical partners for supporting health system capacity building, and the ACH has engaged in ongoing conversations to identify and develop resources with state partners and with other ACHs. ACHs worked collaboratively to develop a table of needed support resources from state partners in order to reach success. They are summarized in Table 6 which follows.

Table 6: ACH Response to Needs from State Partners		
Health System Capacity Building	Technical Assistance	Administrative
Strong partnerships with Washington Association of Public Hospital Districts	HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Approving general behavioral health integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program, and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings

Strong partnerships with Washington Hospital Association	Support from HCA for guidance on the ACHs' role in moving towards whole person care and value-based payment.	streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring.
Stronger collaboration between HCA and MCOs	ACH's would benefit from additional training to fully understand our role in supporting VBP contracts between HCA, MCOs, and provider organizations.	Streamline informational requests from our partners. will enhance continued assessment and planning.
ACH and HCA continued collaboration to find interoperability solutions	ACH also seeks greater clarity on the state's ongoing role in the Practice Transformation Support Hub, the P-TCPI Practice Transformation Network, and its vision for continuity after January 2019.	Regular communication and access to results from state-level health system capacity surveys such as the Value-based Payment survey, the Washington State Health Workforce Sentinel Network, and the Medicaid EHR Incentive Program
HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Clear timelines and transparency about the extent of continued support planned—and needed—for practice transformation resources and initiatives	Engagement of ACH staff and key partners in design and dissemination of these and other surveys will also limit redundancy and increase response rates to data collection processes.
In collaboration with stakeholders, identify solutions for provider shortages, increasing access and expanding the scope of practice for current providers and allowing for reimbursement on additional codes	Support from the state on VBP, specifically understanding how we can advance VBP to support project implementation and sustainability of health system transformation. This support can be facilitated through the MVP Action Team or other technical assistance from the state.	ACHs wants to ensure that information held in these data repositories (<i>All-Payers Claims Database and Clinical Data Repository</i>) is accurate, accessible, timely, and useful to our transformation work and to our partners.
Systems for Population Health Management support for: <ul style="list-style-type: none"> •Data governance •Interoperability •HIE •Disease registries •Telehealth •PreManage/EDIE •Centralized registries 	Training and TA for key workforce positions within required projects (e.g., CHWs, peer support specialists, care coordinators BH specialists)	MCO VBP and quality improvement requirements as well as VBP models to support CHWs, peers, and other positions not reimbursed by Medicaid
Stronger recruitment and tuition support at the state level for primary care,	Training and TA for common training needs: MAT, PMP, 6 Building Blocks, Transitional Care models, Trauma	Establishing a career path for rural nursing and workforce needs, from high school, through 4-year programs

behavioral health, nursing, and licensed social workers	Informed Practices, Cultural Sensitivity	
Support for Dental Health Aide Therapists and other dental professions that expand scope of practice will improve dental access	Increased capacity for practice transformation support directly to participating providers-i.e. practice transformation coaches, clinical subject matter expertise, change management expertise, workforce training and collaborative tools needed to work across ACH regions	Improved coordination with the Department of Health to ensure coordinated Opioid prevention efforts.
	Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) so they truly understand the types of VBP arrangements and rural multi-payer models and how it will impact them, and what steps they should take to be prepared.	Help bring more alignment to measures and incentives across payers. Reducing variability in how providers are rewarded for performance would allow providers to focus on the actual work of providing better care
	Resources tailored to behavioral health providers who are having to build capacity around quality improvement and measurement as they look ahead and adapt to a landscape where they are rewarded for quality, not quantity.	Advocate for increased Medicaid rates in Washington State. Providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation Projects.
	Best practices and strategies specific to billing/coding for healthcare providers that aligns payments with the intent behind bi-directional integration i.e. DOH's Practice Transformation Hub is coordinating with the UW AIMS Center to provide guidance around collaborative care codes.	Taking leadership role around regulations that are a barrier to MTP goals, specifically behavioral health information exchange (42 CFR, Part 2). These laws prevent some of the ideals of healthcare reform and health information exchange from happening.

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

ACH Response:

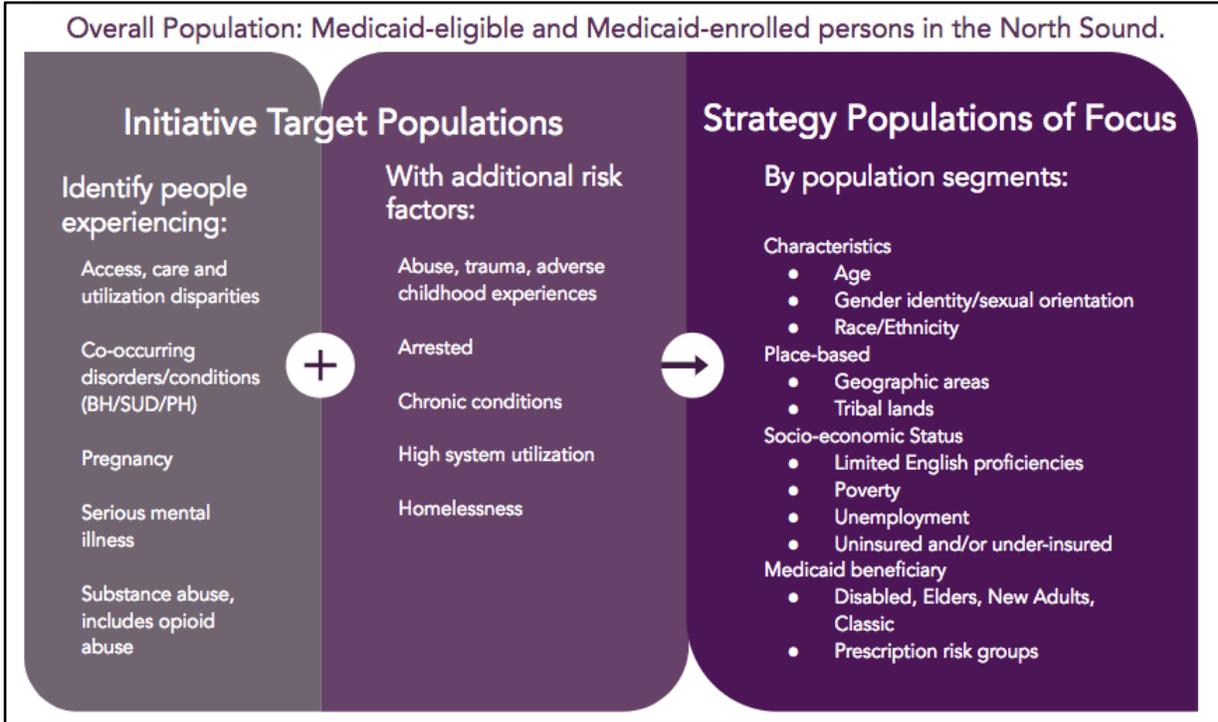
The detailed ACH responses to this question can be found in Table 6, starting on page 34, broken down by each of the eight project areas. A detailed description follows describing the overarching criteria used for all project areas.

Ongoing feedback during CSA activities identified strong support from partners to create shared target populations across project areas and initiatives, as well as the appropriateness to work with partnering providers in identifying populations of focus for specific projects and strategies. To successfully embed targeted universalism within our processes, the North Sound ACH will continue to work collaboratively with partnering providers to:

1. Define a universal goal: articulate universal goals in a regional implementation plan based upon a robust understanding and analysis of the problem at hand with partnering providers.
2. Measure overall population: assess difference of general population and overall Medicaid population from universal goal by completing a benchmarking analysis.
3. Measure population segments: assess the divergence of particular geographies and population segments from the universal goal by disaggregating data using the methodology of selecting populations of focus for targeted strategies.
4. Understand group-based factors: work with partnering providers to assess barriers to achieving the goal for each group/geography.
5. Implement targeted strategies: informed by data and best-practice research, craft targeted processes to each selected population of focus to reach universal goals.

We believe that by expanding implementation of the targeted universalism framework to include partnering providers, transformation efforts in the North Sound will reach populations with health disparities and increase the likelihood of success on performance metrics during the Medicaid Transformation Project period. As previously stated, the North Sound ACH has shifted from eight target populations to shared target populations among all three initiatives and has created criteria for selecting populations of focus for targeted strategies within each initiative. Figure 6 shows the three-step criteria process the North Sound ACH will implement with partners during implementation plan development activities.

Figure 6. Process to Further Refine Populations of Focus



Finalization of the populations of focus will occur in collaboration with partnering providers, but we have carried forward appropriate population segments within each initiative that were identified in the original eight target populations.

Expansion or Scaling of Transformation Strategies and Approaches

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.

ACH Response:

To avoid redundancy and duplication, the response to the question of how our region will approach Expansion or Scaling of Transformation Strategies and Approaches is summarized once here, rather than in Table 7, to avoid repetition of the same response in each Project Area.

The North Sound ACH will implement a monitoring and continuous improvement plan using the IHI’s MFI and Framework for Spread. This plan leverages infrastructure such as internal QI teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data. IHI best practices in planning for scale and spreading improvement will inform the selection of initial pilot sites for testing strategies, before spreading to other teams and sites across ACH partner organizations.

Methods for improvement will include embedded evaluation tools and continuous QI techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles and run charts to track project success

and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis to determine the success of evidence-based approaches.

As strategies are tested and improved through this model, the ACH staff, Data and Learning Collaborative, and initiative planning teams will identify opportunities to spread innovations across sites. Initial pilot sites will be identified based on partner readiness and capacity assessment, as well as any demonstrated experience with evidence-based approaches. Scaling activities across the region will rely on partner readiness and capacity to implement new or expanded strategies. Because ACH partners will be starting at different levels of capacity for implementing transformative strategies, learning collaboratives and cohorts will be used to support peer-based and cross-sector information sharing where possible.

Table 7: Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations

Project 2A: Bi-directional Integration of Physical and Behavioral Health
<p>1. Transformation Strategies and Approaches</p> <p>Description of Evidence-based Approaches</p> <p>The North Sound ACH intends to use the Collaborative Care model and Bree Collaborative model to facilitate the integration of physical and behavioral health services. There are five common elements across both models: creating a patient-centered care team, measuring symptoms and treating to target, using population-based care tools, practicing accountable care, and using evidence-based treatment. Behavioral and physical health settings of outpatient care will use these elements to transform the systems of care delivery and improve physical and behavioral health outcomes. During the 2018 planning year, the North Sound ACH will adapt the model elements to the North Sound ACH region’s diverse geographic and workforce resources and needs, implementing elements of integrated care models as appropriate to improve health outcomes and reduce health disparities across all community-based and geographic contexts.</p> <p>There is strong evidence that integrating behavioral health services into physical health care improves patient outcomes while reducing cost of care for depression and anxiety disorders, as well as improving the control of diabetes and hypertension. Integration of behavioral health in primary care through the Collaborative Care model for people with depression has reduced serious cardiovascular events compared to those receiving usual care years after treatment of depression, supporting the model’s long-term benefits. Integrated physical and behavioral health care has the potential to reach a broad population with diverse needs, expand access and reduce barriers to behavioral health services, and help mitigate the use of emergent or crisis care.</p> <p>Transformation Activities</p> <p><i>In the Physical Health Setting</i></p> <p>The physical health care practices involved maintain different levels of integration on a continuum, and the North Sound ACH will work with partners to identify and target strategies appropriate for their level of integration and specific contextual factors such as size, complexity, and rurality. The ACH will collaboratively support expansion of services to move providers toward full integration, recognizing that the diversity of environment, needs, and capacity will require different forms and extent of support.</p> <p>To help advance practices along the continuum of integration, individual practices will be evaluated based on several factors and grouped into cohorts supported by the University of Washington Advancing Integrated Mental Health Solutions (UW AIMS) Center and Healthier Washington Practice Transformation Support HUB training to enhance learning and transformation.</p> <p>Leadership from large physical health delivery systems across the North Sound counties have committed to explore implementation of the Collaborative Care model or Bree Collaborative approach in their physical health care clinic settings, including:</p>

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

- Screening for depression and alcohol and opiate use as an expected component of physical health care. Screening may be expanded for additional conditions as experience and capabilities grow, and may include anxiety, PTSD, ADHD, and other substances of abuse.
- Brief counseling interventions for identified behavioral health conditions by behavioral health counselors embedded in the physical health care practice.
- Medication-assisted therapies for depression and opiate abuse, which may expand as experience and capabilities grow. Primary care practice leaders are committed to developing Suboxone treatment for opiate addiction identified within their physical health care systems to ensure access to Suboxone treatment.
- Registry development to track patients with identified behavioral health conditions.
- Treat-to-target those with identified behavioral health conditions.
- Psychiatric consultation for physical health care providers, which in some practices may include direct patient consultation or telepsychiatry, depending on system capacity, geography, or other factors.
- Referral to specialty behavioral health services, including the need for improved referral mechanisms and information exchange with specialty behavioral health providers.

The North Sound ACH is considering partnerships with the UW AIMS Center, Healthier Washington Practice Transformation Support Hub, and The National Council of Behavioral Health to enhance existing efforts, expand the scope of integration, and reduce duplication of services. Further, the North Sound ACH is collaborating on bi-directional integration projects with North Sound regional leaders (e.g., the North Sound BHO, Compass Health, and PeaceHealth) to ensure that projects enhance and expand integration without duplicating efforts.

In the Behavioral Health Setting

Behavioral health providers will pursue integrated care by adapting the Collaborative Care model elements into the behavioral health setting. Nationally, fewer models and metrics are available for integration of physical care into behavioral health settings. The North Sound ACH has identified behavioral health providers exploring the move to integration by providing access to physical care in the behavioral health practice setting through on-site services or telehealth. The North Sound ACH seeks to expand this work by engaging leadership from behavioral health practices across the North Sound ACH region to implement the following methods:

- Screening for chronic health conditions in a clinic by a physical health provider
- Counseling interventions connected to health behaviors and the maintenance or improvement in chronic health conditions using the current workforce
- Physical health interventions including prescribing and tracking changes in chronic physical health conditions
- Registry development to track patients' physical and behavioral health improvement and to identify people who aren't improving
- Treat-to-target for behavioral health and physical conditions as allowable with evidence-based clinical tools
- Consultation with physical health providers on complex health situations
- Referral to specialty physical health providers for more complex physical health needs, specific conditions, or specialty screenings

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

Behavioral health providers in the North Sound ACH region have training and experience in providing evidence-based interventions. Using regular symptom measurement and population health tools, treating to target, and managing chronic physical disease are new components for many behavioral health providers that will require training, implementation support, and ongoing education.

Relationship to North Sound ACH Initiatives

The evidence-based approaches and strategies described above as part of the Bi-directional Integration of Physical and Behavioral Health Services project area (2A) will be integrated into multiple North Sound ACH initiatives, with the majority of 2A activities falling into the Care Integration and Capacity Building Initiatives.

In the Care Integration Initiative, strategies will focus on implementing innovative models or standards of care in a clinical setting, which will improve the quality, efficiency, and effectiveness of care processes, in addition to adopting evidence-based standards of integrated care. Clinical partners will be supported in their integration activities through training sessions in evidence-based models of integrated care, as well as ongoing practice coaching, learning collaboratives, population health management tools, and other clinical transformation supports.

The strategies above also fit into the Capacity Building Initiative, as they support partners in implementing transformation projects on population health management, workforce development, and adapting to new value-based contracts.

Please see pages 5-7 for a description of the North Sound ACH Initiatives.

2. Target Populations Described in Project Plan for 2A:

All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or SUD.

2018 Initiative Target Populations and Strategy Populations of Focus for 2A:

People experiencing:

- Access, care, and utilization disparities by population segments (characteristics, place-based, socioeconomic status, Medicaid beneficiary type).
- Co-occurring disorders/conditions (behavioral and physical health and SUD)
- Serious mental illness
- Substance abuse (includes opioid abuse)

With additional risk factors:

- Abuse, trauma, adverse childhood experiences
- Contact with the justice system
- High system utilization
- Homelessness

Target population segments:

- Characteristics: All age groups, other characteristics to be determined collaboratively with partnering providers prior to submission of October 2018 Implementation Plan
- Place-based: To be determined collaboratively with partnering providers

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

- Socioeconomic Status: To be determined collaboratively with partnering providers
- Medicaid beneficiary groups: To be determined collaboratively with partnering providers

NOTE: 2A'S P4P metric will be analyzed to determine disparities:

- All-Cause Emergency Department Visits, per 1,000 MM
- Antidepressant Medication Management Acute (12 weeks)
- Antidepressant Medication Management Continuation (6 months)
- Child and Adolescent Access to Primary Care
- Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Follow-up after Emergency Department Visit for AOD Dependence Within 7 Days
- Follow-up after Emergency Department Visit for AOD Dependence Within 30 Days
- Follow-up after Emergency Department Visit for Mental Illness Within 7 Days
- Follow-up after Emergency Department Visit for Mental Illness Within 30 Days
- Follow-up After Hospitalization for Mental Illness within 7 days
- Follow-up After Hospitalization for Mental Illness within 30 days
- Inpatient Hospital Utilization, per 1,000 Members
- Medication Management for People with Asthma Medication Compliance 75%
- Mental Health Treatment Penetration
- Plan All-Cause Readmission Rate (30 Days)
- SUD Treatment Penetration

3. Expansion or Scaling of Transformation Strategies and Approaches

Please see description on Page 32.

Project 2B: Care Coordination

1. Transformation Strategies and Approaches

Description of Evidence-based Approaches

The Pathways HUB model is an evidence-based community care coordination approach that uses 20 standardized care plans (Pathways) to address common areas of risk or barriers to health for individuals. The North Sound ACH recognizes that achieving whole-person health requires an approach that acknowledges and addresses the crucial impacts of social determinants of health. The North Sound Community HUB will coordinate client services between clinical and nonclinical providers. The North Sound Community HUB will identify and address risk factors at the level of the individual but can also affect population health by tracking care coordination services across agencies, providers, and funders, leading to improved outcomes and reduced costs.

Establishing a Community HUB in the North Sound ACH region will ensure that patients in the target populations receive robust and patient-centered care coordination from CHWs who can help them navigate resources. In the Pathways model, community-based care coordinators travel to clients' locations and work with them and their families to overcome social and economic barriers to managing their health. The North Sound ACH's Community HUB will connect Medicaid enrollees with

Project 2B: Care Coordination

coordinated, community-based services, thus improving outcomes and reducing costs. Pathways provides a blueprint for sustainable and scalable care coordination, which will help ensure that these improvements last. The Pathways model will provide the North Sound ACH and our partners with a formal structure for reducing duplication of care coordination services, achieving better health outcomes, and addressing the social determinants of health.

In the Pathways model, services are reimbursed by payers, thus providing sustainability beyond the funded Medicaid Transformation period. Throughout the planning process, the North Sound ACH has collaborated with MCOs and other partners to ensure that the design for the HUB has payer buy-in, and that the transformation built through Pathways lasts beyond the Medicaid Transformation Project. Additionally, the North Sound ACH sees opportunities to pursue other sources of funding to support the HUB (e.g., private insurance payers, foundations) as we scale the model after the initial pilot phase.

Transformation Activities:

1. Development of bi-directional referral process with Health Homes model of care coordination to ensure that the models are complementary, not competitive
2. Training of internal HUB staff on outcome-based payment methodology in practice in HUBs across the country
3. Discussions with Medicaid MCOs to develop reimbursement structures related to attainment of Pathways health or referral outcomes (via use of the outcome-based payment model above)
4. Training of CHW staff and supervisors at selected CCAs in the Pathways model, care coordination best practices, and use of the statewide data platform for Pathways HUBs (Care Coordination Systems)

Relationship to North Sound ACH Initiatives

The evidence-based approaches and strategies described above as part of the Care Coordination project area (2B) will be integrated into the North Sound ACH's Care Coordination Initiative. In this initiative, The North Sound ACH will use or enhance services in the community to promote care coordination across the continuum of health, ensuring that individuals with complex health needs are connected to the appropriate interventions and services needed to improve and manage their health. In addition, this initiative will develop links between care coordinators by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination practices, and promotes accountable outcome monitoring for beneficiaries being served.

Strategies within the initiative will be designed and implemented to meet the needs of the region's identified high-risk, high-needs target populations.

Strategies in this initiative come from the following project areas:

- Community-Based Care Coordination (2B)
- Transitional Care (2C)
- Diversion Interventions (2D)

Please see pages 5-7 for a full description of the North Sound ACH Initiatives.

Project 2B: Care Coordination

Workforce Development through the North Sound Community HUB: Additionally, components of strategies in this project area (2C) fit into the North Sound ACH's Capacity Building Initiative. There is a robust workforce of CHWs and care coordinators based in the community service organizations and FQHCs across the North Sound region, including the following:

- Health Home Care Coordination Organizations (CCOs) that provide care coordination services to high-risk Medicaid Enrollees. MCO and CCO partners may be able to support cross-training of Health Home care coordinators to also serve as HUB community-based care coordinators.
- CHWs who are employed throughout the region at CBOs and at FQHCs.
- Other CBO staff who serve in CHW-like roles but have not yet completed CHW training. Capacity building through training opportunities is an essential component for individuals and organizations that play a key care coordination role but are not currently reimbursed for that work. In the Pathways HUB model, CHWs serve as care coordinators, and the North Sound ACH intends to leverage this existing workforce capacity to engage the target populations and expand the workforce, especially in communities experiencing disparities, where CHWs with lived experience play a critical role as community liaisons.

The regional transition from traditional models of care coordination to an outcome-based model of care coordination presents significant challenges and opportunities for the community-based care workforce.

- Anticipated challenge: Successfully incorporating an outcome-based model for care coordination requires a shift in how services are provided to individuals, business structures for tracking outcomes, and integration of a reporting platform that will capture progress toward those outcomes. In addition, organizations will need to develop sustainable models to support care coordinators after revenue is based on outcomes. Although similar to models such as Health Homes, the Pathways model will only reimburse for care coordination services after a health outcome is achieved along one of the 20 evidence-based care Pathways. This model incentivizes collaboration across the HUB network to provide non-duplicative, coordinated services. This will require additional training for care coordinators, other providers, and financial decision makers within community organizations.
- Anticipated opportunity: Statewide partners have stepped up to develop training opportunities that will help organizations determine whether this model is one they can incorporate, and if yes, transition to this new revenue model. The Foundation for Healthy Generations, in conjunction with Care Coordination Systems and with funding from the Washington Department of Health, has created three training cohorts dedicated to educating CHWs and their supervisors on the elements of this outcome-based reimbursement model. The CHW and CHW supervisor training consists of 10 days of classroom instruction and case studies to build competency in health knowledge, care coordination, relational skills, coaching skills, community outreach, and basic organizational skills, with integrated care coordination software training. These trainings will be provided at no cost to CCAs and their care coordination staff, and hold significant promise in addressing our region's identified need for professional growth opportunities within the CHW workforce.

Advocacy for other ACH Initiative areas: The North Sound ACH plans to advocate at the city, county, and state level for policies that will support this work and reduce regulatory barriers to successful project implementation. The cross-sectoral partnerships required of the HUB in conjunction with the

Project 2B: Care Coordination

centralized tracking of health outcomes and social service referrals in the HUB data system (CCS) allows a unique opportunity to identify unmet needs across our region. This ability to illustrate needs in turn gives the HUB powerful leverage in advocating for additional resources. This includes advocacy for policies that affect bi-directional integration and clinical transformation, and social determinants of health such as housing, access to transportation, child care, employment, food access, and environmental pollutants. Additionally, the ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Alignment of the North Sound Community HUB with Health Homes Model: The North Sound ACH has worked extensively with MCO and Health Homes leads in our region to develop a bi-directional system of referrals between the Hub and Health Homes. Our goal is to avoid conflict by ensuring good communication and information sharing about who is eligible for Health Homes on a monthly basis and warm handoffs between the Hub and Health Homes leads. This has included discussion about “what-if” scenarios, such as the following:

- What happens if someone has opted out of Health Homes?
- What happens if the HUB reaches someone who is eligible for Health Homes who has not yet been reached by Health Homes?
- What happens if the CCA makes a referral to Health Homes?
- Is there a way for a North Sound Community HUB CCA to receive payment for their effort in linking an individual to Health Homes?
- What will the timelines, documentation, and processes for patient handoff between the models look like, keeping in mind the patient-centered approach of a warm handoff?

Ongoing Engagement of CHW Workforce: The North Sound Community HUB model also incorporates avenues for ongoing collaboration at the level of community care coordinators’ supervisors. This model allows for bottom-up driven adjustments to workflow and process development. Most HUBs currently in operation convene their CCA Network staff, including CCA leadership, supervisors, and care coordination staff, to discuss successes and barriers in programmatic operation of the HUB. These ongoing avenues for collaboration between HUB staff, CCA leadership, and frontline care coordination staff allow for a more empowering model of programmatic operations inclusive of the workforce’s unique perspective.

2. 2017 Target Populations identified in the Project Plan for 2B:

Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (e.g., arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe SUD and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).

2018 Initiative Target Populations and Strategy Populations of Focus for 2B:

People experiencing:

- Access, care, and utilization disparities
- Serious mental illness
- Substance abuse, including opioid abuse

Project 2B: Care Coordination

With additional risk factors:

- Abuse, trauma, adverse childhood experiences
- Arrested
- Chronic conditions (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke)
- High system utilization
- Homelessness

NOTE: 2B'S P4P metric will be analyzed to determine disparities:

- All-Cause Emergency Department Visits, per 1,000 MM
- Follow-up after Emergency Department Visit for AOD Dependence
- Follow-up after Emergency Department Visit for Mental Illness
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization, per 1,000 Members
- Mental Health Treatment Penetration
- Percentage Arrested
- Percentage Homeless
- Plan All-Cause Readmission Rate (30 Days)
- SUD Treatment
- Pregnancy

North Sound HUB Identification of Population of Focus

Because of the rapid implementation timeline of the Pathways model, the North Sound ACH broke down the selection of our HUB population of focus into four phases, from 2017 through fall 2018. The phases are captured in the following graphic and detailed further thereafter.

Figure 7: Key Stages in North Sound ACH HUB Population Selection Process



Stage 1 January to November 2017

Information gathering for North Sound ACH Project Plan submission:

- Identified ACH Project Plan partners and key informants
- Convened regional stakeholders
- Initial scan of relevant data to illustrate health outcomes and disparities
- Submitted North Sound ACH final project plan, with high-level identification of HUB population selection criteria

Stage 2 January to April 2018

Environmental Scan included:

- Key informant interviews including the following:
 - County Resource Centers in Island and San Juan Counties
 - Home Health Care Coordination Organizations
 - The North Sound Behavioral Health Organization
 - Community-Based Organizations: Opportunity Council, Compass Health, Planned Parenthood
 - North Sound ACH Leadership: Program Council
 - Medicaid Managed Care Plans
 - High-utilizer initiatives serving Skagit, Snohomish, and Whatcom Counties
 - Partner convenings including the North Sound ACH Program Council, the North Sound ACH Convening of Community-Based Organizations
 - Meetings with MCO partners and Health Homes leads to map of bi-directional referral strategy

Project 2B: Care Coordination

Stage 3 May 2018 to June 2018

- Validation by the following experts and key partners:
 - Consultation with Foundation for Healthy Generations
 - Development of criteria for HUB care coordination agencies, including partner readiness assessment questions

Stage 4 July 2018 to Fall 2018

Layering population criteria to manage scope. The major bodies of work and key findings in this phase included the following:

- Release of Supplement to North Sound ACH Call for Partners, resulting in 32 applications
- Refinement of final pilot population determined by the scope and geographic reach of agencies that apply
- The application's partner readiness and capacity questions can be utilized to further refine eligible CCAs

(See full list of key informant interviews and interview themes in CSA)

Based on the work above, the initial population of focus for the North Sound Community Hub will be individuals with co-occurring behavioral health and physical health conditions, along with either one chronic illness OR are of childbearing age. Individuals must also have one of the following additional risk factors: high utilization of care across systems (including EMS and criminal justice), homelessness, or failed attempts linking to other social services.

3. Expansion or Scaling of Transformation Strategies and Approaches

Please see description on Page 32.

North Sound Community HUB Strategies

Scaling of Initial Population of Focus: Based on recommendations from national and regional HUB experts (Foundation for Healthy Generations and The Redding Institute), we used a broad definition for *population* in our initial Call for Partners. Narrow definitions can deter potential partners, and the North Sound ACH sought to ensure a wide and inclusive network of collaborators. The ACH will work with contracted partners to narrow population scope based on responses to our call for CCA Partners. For example, some HUBs made the mistake of narrowing their population too much and found that no agencies in their region responded to be CCAs. In May 2018, we released the North Sound ACH Call for CCA Partners.

The Pathways HUB model has a unique quality improvement component built into the model and uses the Pathways platform, CCS. After the HUB is operational, there is typically a 6- to 9-month-period post-HUB launch when initial workflow adjustments are made and there are enough clients being served through the HUB to show initial results. After this threshold is met, the HUB can use the CCS platform to produce and disseminate progress reports and analytics to identify which Pathways (health outcomes) are being met, which are not, and other areas of success, gaps, or variance across the CCA network. These reports are sent to the HUB Advisory Council, a body composed of representatives from each CCA, Medicaid MCOs, community members, and some of the HUB's referral partners, who

Project 2B: Care Coordination

each play roles in stating where the HUB's operational strengths align with population needs across the region.

Partner Readiness Assessment: The Pathways Community HUB model requires organizations to increase readiness for outcome-based reimbursement. This may require changes to workflows, organizational capacity for reporting and financial modeling, Pathways-specific trainings, development of new internal policies and procedures, and adaptation of staffing models. In recognizing that this is a significant commitment of a CCA's time and resources, the North Sound ACH is providing a significant portion of upfront costs in the form of no-cost trainings, funding for CHW and supervisor staff time, and bridge payments for Pathways key payment steps and closures. North Sound ACH is investing in startup costs and supporting initial activities associated with establishing the HUB model, with the expectation that CCAs develop sustainable business models by fundamentally transforming organizational processes, capacity, and workflow.

Project 2C: Transitional Care

1. Transformation Strategies and Approaches

Evidence-based Approaches

Through a deliberative process, review of evidence-based care transitions models, and evaluation of current care transitions activities in the region, our partners have identified the Care Transitions Intervention (CTI) model as the key strategy for reducing hospital length of stay and readmissions rates. Additionally, use of HIE tools such as PreManage, elements of the Collaborative Care model, and integration with Pathways Community Hub will support patients transitioning out of inpatient acute care and mental health facilities.

Transformation Activities

Transitions from Inpatient Care

The CTI model, as outlined in the Medicaid Transformation Toolkit, uses transition coaches, transition planning, and enhanced care management to support patients discharging from acute inpatient care. The CTI has demonstrated regional success at reducing readmission rates and improving patient outcomes, and the North Sound ACH seeks to expand on this work. Additionally, implementation can be supported by drawing on assets including local CTI master trainers who can "train the trainer" in all settings that elect to integrate the CTI model, building a community of transition coaches from the current workforce. The North Sound ACH will coordinate with regional hospital partners to explore implementation of the CTI model in their systems. Past or current implementations of the CTI model, such as that at PeaceHealth St. Joseph's Hospital, will be drawn upon to establish best practices and spread experience in the model. Additionally, enhancements of the CTI model to integrate community services and in-home assistance for patients after discharge, such as at Providence Medical Center Everett, will be evaluated for feasibility of implementation at additional hospital settings or mental health facilities.

Medical respite care for people experiencing homelessness is also a potential element of our post-acute transitions strategy. This model can serve patients with comorbid disorders who have been

Project 2C: Transitional Care

recently treated at medical facilities and are ready for discharge but lack housing. The goal of the model is to provide short-term, medically assisted housing that allows the patient to stabilize medically and begin the process of engaging in behavioral health services and connecting with stable housing. Respite programs and pilot programs will be assessed for support and enhancement to build capacity.

Jail Transitions: Reentry into the Community

During the planning phase, the North Sound ACH will convene partners from jail services and law enforcement in the five counties to share lessons and collaborate on collective activities to improve jail transitions for their systems. Partners have suggested the following additional strategies to improve transitions for the jail population:

- Business Associate Agreements between county services and the BHO and MCOs, which would allow jail-based physical health providers to better coordinate care. The current contract with the BHO provides reports on which inmates are enrolled with the BHO so that the jail can collaborate with behavioral health providers on medication management. With the move toward fully integrated managed care, these same BAAs will need to be put in place with the MCOs.
- Use of criminogenic risk assessment tools to target inmates who are most likely to benefit from the services provided. Criminogenic screens help to determine which inmates are most likely to reoffend and most likely to benefit from the interventions provided.

Across all the target population areas and strategies, the North Sound ACH will work closely with regional partners to ensure that projects enhance and do not duplicate efforts, gathering partners across the five counties to share successful strategies in their sectors. As plan implementation begins, these cross-county conversations will help identify areas of overlap and synergy to improve coordination and reduce redundancy of work.

Cross-Cutting Strategies for Care Transitions

Regardless of the target populations or the strategies employed, there are significant infrastructure gaps that will need to be addressed to allow traditional and nontraditional providers to better serve and coordinate care for patients/clients. The following are some of the cross-cutting strategies for improving transitions from all care settings:

- Support widespread adoption and expansion of HIE tools such as PreManage for care management at physical health, behavioral, social service providers, including jail-based health providers. Access to these tools will help providers identify when shared clients have entered the emergency department and share care plans across clinical settings so that care and services are coordinated and not duplicated.
- Build capacity to serve targeted populations: across all three strategies, we will need to expand capacity for services to be delivered to the identified target populations and to make sure we can sustain the workforce for the projects.
- Establishment of sustainable funding sources for transitional care planning through value-based payment systems for health care providers or dedicated county funding for jail transition services.
- Integration of behavioral health screening in non-behavioral health provider settings through the collaborative care model, whether in inpatient physical health facilities or at booking in

Project 2C: Transitional Care

jails to identify which patients need behavioral health services. By standardizing and spreading this, we allow for quicker coordination with behavioral health providers to engage patients in services and reduce stigma related to behavioral health needs.

- Additionally, we expect that implementation of the North Sound Community HUB will positively affect most of the care coordination measures for Transitional Care because of the importance of effective community-based care coordination for follow-up after discharge, hospitalization, emergency department utilization, and readmission.

Relationship to North Sound ACH Initiatives

The evidence-based approaches and strategies described above as part of the Transitional Care Area (2C) will be integrated into the North Sound ACH's Care Coordination Initiative. In this initiative, the North Sound ACH will use or enhance services in the community to promote care coordination across the continuum of health, ensuring that individuals with complex health needs are connected to the appropriate interventions and services needed to improve and manage their health. In addition, this initiative will develop linkages between care coordinators by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination practices, and promotes accountable outcome monitoring for beneficiaries being served. Strategies within the initiative will be designed and implemented to meet the needs of the region's identified high-risk, high-needs target populations.

Strategies included in this initiative come from the following project areas:

- Community-Based Care Coordination (2B)
- Transitional Care (2C)
- Diversion Interventions (2D)

Please see pages 5-7 for a full description of the North Sound ACH Initiatives.

2. Target Populations Identified in Project Plan for 2C:

Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with serious mental illness discharged from inpatient care, and clients returning to the community from prison or jail.

2018 Initiative Target Populations and Strategy Populations of Focus for 2C:

Care Coordination Initiative Target Populations

People experiencing:

- Access, care and utilization disparities
- Serious mental illness

With additional risk factors:

- Abuse, trauma, adverse childhood experiences
- Arrested
- High system utilization
- Homelessness

Project 2C: Transitional Care

NOTE: 2C'S P4P metric will be analyzed to determine disparities:

- All-Cause Emergency Department Visits, per 1,000 MM
- Follow-up after Emergency Department Visit for AOD Dependence
- Follow-up after Emergency Department Visit for Mental Illness
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization, per 1,000 Members
- Mental Health Treatment Penetration
- Percentage Arrested
- Percentage Homeless
- SUD Treatment

Strategy Populations of Focus (to be finalized with partnering providers)

Target population segments:

- Characteristics: All age groups, other characteristics to be determined collaboratively with partnering providers
- Place-based: To be determined collaboratively with partnering providers
- Socioeconomic Status: Experiencing poverty, unemployed, uninsured and/or underinsured
- Medicaid beneficiary groups: To be determined collaboratively with partnering providers

Project 2D: Diversion Interventions

1. Transformation Strategies and Approaches

Description of Evidence-Based Approaches

The North Sound ACH will promote more appropriate use of emergency care services through the implementation of two complementary, person-centered, evidence-based approaches focused on different population needs: Community Paramedicine and Cross-Sector Collaboratives for Complex Cases. The goals of these projects—complementary strategies focused on different needs in the community—are to improve health outcomes for the medically underserved target population by supporting the development and implementation of coordinated systems that address the complex needs of high utilizers. This includes improving access to primary care and social services and care coordination for people with complex needs, which should also result in reduction of unnecessary cost and inappropriate utilization in health care, social service, criminal justice, and emergency systems.

The evidence-based approach selected from the Medicaid Transformation Project Toolkit for this project area is the Community Paramedicine Model. As the Toolkit states, “the Community Paramedicine Model is an evolving model of community-based health care, in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations” (*Healthier Washington Medicaid Transformation Toolkit, October 2017*). A key focus of the Community Paramedicine model is to connect underutilized resources to underserved populations (communities in rural or remote geographical areas, or with limited ability to access

Project 2D: Diversion Interventions

primary care, such as populations with disabilities or experiencing homelessness) (*The Community Healthcare and Emergency Cooperative (CHEC) Community Paramedic Program*).

Community paramedicine programs serve as a bridge between emergency departments and long-term case management and care providers. Community paramedics act as an alternative to emergency departments by working in partnership with other social service agencies to expedite coordinated care and referrals. Because community paramedics can meet community members where they live, they are better able to identify and address barriers to accessing care and addressing health challenges, including broader social determinants of health. Successful community paramedicine programs focus on efficiency and effectiveness in connecting people with timely and appropriate levels of care, therefore reducing the overall strain placed upon the emergency health care system. Community paramedicine programs also have the potential for decreasing the burden placed on clinics, allowing them to offer more in-home care options, resulting in improved overall care management and enhancing the patient experience. Community paramedicine programs have the potential to significantly improve the health of underserved and vulnerable populations, as demonstrated by current pilot projects in Snohomish and Whatcom counties in the North Sound region. This approach was recommended by our region's many EMS providers, adopted by the North Sound ACH Diversion Workgroup, and submitted in the 2017 Project Plan.

Additionally, to complement the Community Paramedicine project, the North Sound ACH will pursue pilots of cross-sector collaboratives for complex cases (included in the 2017 Project Plan). When persons in the target population (people who frequently utilize the emergency department and/or are involved in the criminal justice system) require coordination efforts that exceed the scope of community paramedicine, they will be referred to pilot cross-sector collaborations for complex cases. Local networks will be engaged in cross-sector identification and case management for high utilizers. The goal of this strategy is to support local care coordination structures by pooling resources for shared functions and utilities, particularly tools for information sharing and methods of engagement of high-cost individuals with complex needs.

Both evidence-based approaches, and the specific strategies they entail, aim to improve health outcomes for high-risk, high-utilizer (of emergency departments and the criminal justice system) individuals in our region. Both will use a patient-centered approach to meet the complex needs of these community members and address regional priorities like homelessness. Both strategies engage first responders as key partners, in fire departments, EMS, and law enforcement.

List of Transformation Activities/Strategies

Under the two approaches selected (Community Paramedicine and cross-sector collaboratives for complex cases) work in the North Sound region will be built upon and expanded or replicated.

Community Paramedicine

There are multiple community paramedicine programs in the North Sound region. Fire and EMS partners across the region will implement tailored versions of these programs in their communities, learning from these programs' successes and challenges. Examples include:

Project 2D: Diversion Interventions

- *Community Paramedic Program in Whatcom County (Bellingham Fire Department):* The Established in 2014, the purpose of the program is to help connect frequent utilizers of 911 services for non-emergent medical needs to more appropriate services. The benefit of the program is twofold: citizens are connected to medical and social services that better meet their needs and it creates capacity for the fire department to more quickly respond to true emergencies. The Community Paramedic program most frequently serves citizens dealing with complex medical issues including substance abuse, mental illness, and complications related to aging, disability, fall-risk, and homelessness by assessing their needs and coordinating their care with appropriate community resources.
- *Snohomish County (Fire District 1):* The Community Paramedic Program in Fire District 1 began in 2014 as the first program of its kind in the state. It is funded by a grant from Verdant Health Commission. South Snohomish County Fire & Rescue (SSCFR) partners with Compass Health to identify and assist area residents whose needs surpass a simple medical fix. Patients who have called 911 two times in 24 hours or three times over 30 days are automatically referred to the program. Hospital and social service staff may also make referrals. The community paramedic follows up with at-risk patients through a telephone call or a home visit to identify underlying causes and needs related to the use of 911 services. In addition to a medical assessment, a home safety survey is conducted to prevent falls and other risks. A mental health counselor and a peer counselor from Compass Health work at SSCFR headquarters to assist in responding to behavioral and social service needs. SSCFR partners with more than 50 social service agencies that can provide patients with nonmedical assistance that is often less costly and more effective in meeting their true needs. The goal is to help clients remain in their home. The program is free to patients, as it is part of the services paid for through property taxes that support SSCFR. The Snohomish County Community Paramedic program currently serves approximately 300 individuals.

Cross-Sector Collaborative for Complex Cases

Two programs will be used as the models for this project: the Chronic-Utilizer Alternative Response Team (CHART) in Everett, for cases referred from law enforcement, fire departments, hospitals, and corrections, and the Ground-level Response and Coordination Engagement (GRACE) in Bellingham, which provides intensive case management for people experiencing homelessness and 911 high utilizers. Clinical providers, social service providers, and law enforcement partners across the region will collaborate to implement tailored versions of these programs in their communities, learning from these programs' successes and challenges.

- *Ground-level Response and Coordinated Engagement (GRACE):* GRACE blends elements of the Law Enforcement Assisted Diversion model (LEAD) and the Jail Transition and Emergency Department Diversion models, while incorporating homeless outreach strategies to address unmet needs of high utilizers before arrest or contact with EMS. GRACE represents a partnership among the City of Bellingham, Whatcom County Health Department, the Opportunity Council, PeaceHealth St. Joseph Medical Center, the Whatcom Alliance for Healthcare Advancement, and other organizations serving Whatcom County residents who have frequent contact with the police, fire departments, hospitals, courts, and jail. GRACE provides connections to behavioral and physical health services and treatment to address underlying causes or unmet needs that result in avoidable high utilization of services. Community-based case managers coordinate with law enforcement, fire departments,

Project 2D: Diversion Interventions

corrections, emergency medical providers, and hospitals to collaborate on strategies to meet the needs of patients utilizing multiple systems to provide a coordinated approach to services, prevent unnecessary use of emergency departments, reduce duplication, and track and manage care.

- *Chronic-Utilizer Alternative Response Team (CHART)*: CHART consists of a team of criminal justice, emergency response, social service, and research partners collaborating to reduce the impact of chronic utilizers on those systems. CHART also contains elements of the LEAD and the Jail Transition and Emergency Department Diversion models. The CHART program's goal is to decrease the system impacts associated with the disproportionate overlapping service utilization by high-risk, high-utilizer individuals, and improve the lives and health outcomes for these individuals. In Snohomish County, a core team consisting of representatives from the Everett Police Department, Everett Fire Department, Snohomish County Department of Human Services, Snohomish County Jail, the Everett City Attorney's Office, and Providence Regional Medical Center Everett works with patients to help craft an alternative care plan for high utilizers, such as connection to SUD treatment and mental health services, public defenders, social workers, or other medical professionals. The CHART program has identified five systems that were typically utilized: police, fire departments, courts, jail, and the emergency department. CHART's clients had more than six contacts with three or more of those systems in a six-month timeframe. Many of the clients had no interaction with services outside of the five systems listed above, and because of lack of information sharing between the five agencies, little was known about the severity of needs. Many clients were using jail as a housing option, and with little to no family or other source of support, many relied on EMS to meet medical needs that could be otherwise met in a physical health care setting, exacerbating emergency department usage and overburdening EMS services. CHART has shown great promise in meeting its goal of reducing unnecessary and repeated systems' utilization among the target population, and early results are promising, including a 78% decrease in arrests, an 80% decrease in EMS contacts, and a 92% decrease in jail days for CHART participants, saving costs to taxpayers and freeing those services to respond to emergencies.

Relationship to North Sound ACH Initiatives

The evidence-based approaches and strategies described above as part of the Diversions Interventions Project Area (2D) will be integrated into the North Sound ACH's Care Coordination Initiative. In this initiative, The North Sound ACH will use or enhance services in the community to promote care coordination across the continuum of health, ensuring that individuals with complex health needs are connected to the appropriate interventions and services needed to improve and manage their health. In addition, this initiative will develop linkages between care coordinators by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination practices, and promotes accountable outcome monitoring for beneficiaries being served.

Strategies within the initiative will be designed and implemented to meet the needs of the region's identified high-risk, high-needs target populations. Strategies included in this initiative come from the following project areas:

- Community-Based Care Coordination (2B)
- Transitional Care (2C)

Project 2D: Diversion Interventions

- Diversion Interventions (2D)

Please see pages 5-7 for a full description of the North Sound ACH Initiatives.

2. Target Populations Described in the Project Plan for 2D:

Medicaid beneficiaries presenting at the emergency department for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

2018 Initiative Target Populations and Strategy Populations of Focus for 2D:

People experiencing:

- Access, care and utilization disparities

With additional risk factors:

- Abuse, trauma, adverse childhood experiences
- Arrested
- High system utilization
- Homelessness
- Serious mental illness

NOTE: 2D'S P4P metric will be analyzed to determine disparities:

- All-Cause Emergency Department Visits, per 1,000 MM
- Follow-up after Emergency Department Visit for AOD Dependence
- Follow-up after Emergency Department Visit for Mental Illness
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization, per 1,000 Members
- Mental Health Treatment Penetration
- Percentage Arrested
- Percentage Homeless
- Plan All-Cause Readmission Rate (30 Days)
- SUD Treatment

3. Expansion or Scaling of Transformation Strategies and Approaches

Please see description on Page 32.

Project 3A: Addressing the Opioid Use Public Health Crisis

1. Transformation Strategies and Approaches

Description of Evidence-based Approaches

The North Sound ACH will support the achievement of the state's goals to reduce opioid-related morbidity and mortality by implementing strategies that target prevention, treatment, overdose prevention, and recovery supports. Building on the [North Sound Behavioral Health Organization 2017 Opioid Reduction Plan](#), and collaborating closely with partners in our region, this project will implement

Project 3A: Addressing the Opioid Use Public Health Crisis

community-prioritized strategies to address the opioid crisis in the North Sound ACH region.

The evidence-supported approaches selected from the Medicaid Transformation Project Toolkit for this project area are pulled from multiple resources, including the *2017 Washington State Interagency Opioid Working Plan*, the *CDC Guidelines for Prescribing Opioids for Chronic Pain*, and the *Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan*. This project area's strategies also follow the four-pronged approach described in the toolkit:

1. *Prevention*: Prevent Opioid Use and Misuse
2. *Treatment*: Link Individuals with Opioid Use Disorder (OUD) with Treatment Services
3. *Overdose Prevention*: Intervene in Opioid Overdoses to Prevent Death
4. *Recovery*: Promote Long-Term Stabilization and Whole-Person Care

List of Transformation Activities/Strategies

Strategies in this project area are aligned with the North Sound Behavioral Health Organization's Opioid Reduction Plan, and fall into the categories of prevention, treatment, overdose prevention, recovery, and capacity building to support providers in successful implementation. These strategies are listed below:

Prevention: Prevent Opioid Use and Misuse

- *Prescribing Practices*: Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain:
 - Support efforts to promote prescribing best practices following the recommended clinical guidelines and in accordance with the updated HCA Opioid Prescribing Policy. Recommended clinical guidelines include the Washington Agency Medical Directors' Group's (AMDG) *Interagency Guideline on Prescribing Opioids for Pain* and the *CDC Guidelines for Prescribing Opioids for Chronic Pain*
 - Dovetail with state efforts related to the Prescription Monitoring Program (PMP)
 - Train providers on best practices for prescribing practices through the Six Building Blocks model
- *Social Marketing and Public Awareness*: Together with the Center for Opioid Safety Education and other partners, raise awareness and knowledge of the possible adverse effects of opioid use (including overdose) among opioid users, while reducing the stigma of treatment and recovery programs.
- *Safe Medication Storage and Disposal*: Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse and addiction, especially among youth:
 - Promote patient access to safe, DEA-approved, convenient medication take-back options
 - Create and disseminate promotional materials to promote community engagement on safe medication storage and disposal; partner with pharmacies on distributing these materials
 - Provide medicine safe storage lock boxes to patients with opioid prescriptions
 - Coordinate with local stewardship ordinances on pharmaceutical take-back programs
- *Prevent Opioid Use in Youth and Families*:

Project 3A: Addressing the Opioid Use Public Health Crisis

- Conduct a regional resource assessment/gaps analysis of primary prevention services, especially in elementary and middle schools; then expand evidence-based prevention programming to fill identified gaps in coordination with regional partners
- Develop intergenerational prevention, intervention, treatment, and recovery support services for families starting with the family members and significant partners of OUD-affected individuals to promote healing and wellness; this is an opportunity to utilize the Pathways Community HUB model that will be implemented in the Care Coordination project area
- Expand screening practices into youth access points to identify risks for OUD; coordinate efforts to leverage services for youth by facilitating collaborations between local stakeholders, including child welfare/foster care, juvenile justice, the North Sound BHO, coalitions, schools, ESD 189, and health care

Treatment: Link Individuals with OUD with Treatment Services

- *Increase Provider Capacity to Screen and Refer to Treatment:* Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify OUD, and link patients to appropriate treatment resources. This is an opportunity to collaborate with other project areas including Bi-Directional Integration of Physical and Behavioral Health and Care Coordination.
 - Increase SBIRT services across the North Sound Region: Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice for adults entering a health care or other service provider setting to receive universal screening for SUD and early intervention for individuals showing signs of SUD.
 - Facilitate coordination between primary health care and OUD treatment systems to promote system improvements, such as screening, collaborative treatment models, co-location of services and integrated pain management services.
- *Expand Access to and Utilization of Treatment, particularly Medication Assisted Treatment (MAT):* Expand access to, and utilization of, clinically appropriate evidence-based practices for OUD treatment in communities, particularly MAT:
 - Scale up the Comprehensive Opioid Treatment Model:
 - Increase access to evidence-based MAT for individuals with OUD
 - Provide comprehensive services such as behavioral health care, primary care, and nurse care management for this complex patient population
 - Coordinate with and expand the North Sound Hub & Spoke Project
 - Mobile Treatment and Outreach: Fund mobile treatment vans (providing outreach, assessment, treatment referral, waived prescriber of buprenorphine options, syringe exchange, naloxone distribution, public health nurses, housing case management and oral health) across the region, especially for rural and remote locations such as Eastern Whatcom, Skagit and Snohomish counties, and San Juan and Island counties.
- *Expand Workforce Capacity to Address the Epidemic:*
 - Increase the number of OUD service providers by promoting CDPs and paraprofessionals, nurse care managers, behavioral health aides, outreach workers, and case managers as career paths by providing tuition waivers and funding for professional development

Project 3A: Addressing the Opioid Use Public Health Crisis

- Increase the number of waived prescribers to provide MAT by partnering with health care partners to reduce barriers for physicians and midlevel health professionals to become certified to prescribe buprenorphine
- Create a coordinated regional system of diverse multidisciplinary paraprofessional care coordinators specializing in outreach and engagement, connecting OUD-affected persons with concierge-level “no wrong door” access to MAT, recovery coaching, case management and essential supports, such as housing, in a variety of community locations. Begin by coordinating staff (nurse care managers, behavioral health aides, outreach workers, and case managers) already in place at treatment agencies, health care facilities, and community service agencies and expand from there
- *Expand Access to Treatment for Underserved Populations:*
 - Youth: Expand youth intervention, treatment, and recovery support capacity into the community, including outreach and/or case management in schools, youth shelters, juvenile court, and other venues to catch early use and connect youth with treatment; support the implementation of Teen Intervene, an evidence-based, youth SBIRT model.
 - Criminal Justice System: Expand access to and utilization of MAT in the criminal justice system by partnering on work in the Transitional Care project area on the development of comprehensive transitional services for individuals with OUD being released from jail and Department of Corrections, ensuring continuity of care and stable housing.
 - Access to treatment at syringe exchanges: Support efforts to expand syringe exchange programs and provide co-located services such as treatment outreach, buprenorphine prescribing, housing case management, distribution of Naloxone, primary care nurses, and other care coordination services.
 - Maternal and Child Health: Identify and treat OUD among pregnant and parenting women and Neonatal Abstinence Syndrome among newborns.

Overdose Prevention: Intervene in opioid overdoses to prevent death

- *Education:* Educate individuals who use heroin and/or prescription opioids, and those who may witness an overdose, on how to recognize and appropriately respond to an overdose. Utilize service networks, such as syringe exchange, outreach, and other community programs to disseminate preventive information to individuals and families affected by OUD. Together with the Center for Opioid Safety Education, promote awareness and understanding of Washington State’s Good Samaritan Law.
- *Increase Availability and Use of Naloxone:* Make system-level improvements to increase availability and use of Naloxone. Partner with the BHO, counties, the University of Washington, tribal nations, housing providers, hospitals, emergency services, syringe exchange programs, and other stakeholders to expand the availability and use of Naloxone, and promote awareness of the Good Samaritan Law, especially for high-risk populations, such as individuals being released from jail, detox, or residential services. Casinos and other tribal properties will also be areas of focus for Naloxone expansion.
- *Coordinate Overdose Prevention Efforts:* Facilitate partnerships between hospitals, EMS, and other first responders to connect persons who experience overdose with Naloxone kits, outreach, engagement, and treatment services.

Recovery: Promote long-term stabilization and whole-person care

- *Support Community Recovery Services:* Enhance or establish community-based recovery

Project 3A: Addressing the Opioid Use Public Health Crisis

support systems, networks, and services designed to improve treatment access and retention and support long-term recovery.

- Develop partner capacity to employ recovery coaches, behavioral health aides, peer counselors, and other paraprofessionals to enhance the care coordination network to support people in their recovery long-term.
- Facilitate enhanced connections between treatment stakeholders and the larger recovery community, including 12 Step groups, Recovery Cafes, and faith-based recovery programs. Utilize these partnerships to increase understanding of MAT and its effectiveness in treating OUD to reduce the stigma associated with its use.
- Work collaboratively with tribal nations, counties, the North Sound BHO, the Oxford House system, and other partners to fund and develop additional housing for those in need of or engaging in OUD treatment, including expanding the network of Recovery Houses available for tribal members, other individuals, and other communities in need.
- Facilitate conversations between regional stakeholders and supported employment resources to explore the feasibility of offering vocational services and life skills training on-site at treatment facilities, recovery centers, and other strategic venues to help recovering individuals fully transition back into their communities.
- Reduce barriers by supporting the development of system incentives for the co-location of treatment and recovery services in centralized locations. “One-Stop” campus models and integrated care sites mitigate transportation challenges for individuals seeking services.
- *Support Whole-Person Health in Recovery:* Connect SUD providers with primary care, behavioral health, social service and peer recovery support providers to address access, referral, and follow-up for services. Collaborate with partners working on Bi-Directional Integration of Physical and Behavioral Health and Care Coordination projects.

The strategies in this project area have continued to evolve since the submission of the Project Plan in 2017, largely because of increased alignment and collaboration with the North Sound BHO. As we complete the CSA and learn more about regional needs, priorities, and existing work, these strategies may expand or narrow in scope before Implementation Plan submission in October 2018.

Relationship to North Sound ACH Initiatives

The evidence-based approaches and strategies described above as part of the Addressing the Opioid Crisis project area (3A) will be integrated into multiple North Sound ACH initiatives, with the majority of 3A strategies falling into the Care Transformation Initiative.

In the Care Transformation initiative, the North Sound ACH will support implementation of prevention and health promotion strategies for targeted populations to prepare the region’s providers for outcome-based reimbursement, population health strategies, and efforts to address health disparities and achieve health equity. Strategies within this initiative will require the full engagement of clinical and community-based nonclinical providers.

Some 3A strategies will also fit into the Care Integration Initiative that focuses on implementing innovative models or standards of care in a clinical setting, which will improve the quality, efficiency, and effectiveness of care processes, and adoption of evidence-based standards of integrated care.

Some strategies above will also fit into the Capacity Building Initiative by supporting partners in

Project 3A: Addressing the Opioid Use Public Health Crisis

implementing transformation projects related to population health management and workforce development.

Please see pages 5-7 for a full description of the North Sound ACH Initiatives.

2. Target Populations Described in Project Plan for 3A:

Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin

2018 Initiative Target Populations and Strategy Populations of Focus for 3A

Care Transformation Initiative Target Populations

People experiencing:

- Co-occurring disorders/conditions (behavioral and physical health and SUD)
- Pregnancy
- Serious mental illness
- Substance abuse includes opioid abuse

With additional risk factors:

- Abuse, trauma, adverse childhood experiences
- Arrested
- Chronic conditions
- High system utilization
- Homelessness

NOTE: 3A'S P4P metric will be analyzed to determine disparities:

- All-Cause Emergency Department Visits, per 1,000 MM
- Child and adolescent access to primary care
- Childhood Immunization Status (Combo 10) by age 2
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Contraceptive Care—Most & Moderately Effective Methods
- Contraceptive Care—Postpartum
- Dental Sealants for Children at Elevated Caries Risk
- Inpatient Hospital Utilization, per 1,000 Members
- Medication Management for People with Asthma Medication Compliance 75%
- Mental Health Treatment Penetration
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Periodontal Evaluation in Adults with Chronic Periodontitis
- Primary Caries Prevention Intervention as Part of Well/III Child Care as Offered by Primary Care Medical Providers
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)
- SUD Treatment Penetration

Project 3A: Addressing the Opioid Use Public Health Crisis

- SUD Treatment Penetration (Opioid)
- Timeliness of Prenatal Care: Prenatal care in the first trimester of pregnancy—all ages
- Utilization of Dental Services by Medicaid Beneficiaries
- Well-child visits

3. Expansion or Scaling of Transformation Strategies and Approaches

Please see description on Page 32.

Project 3B: Reproductive and Maternal/Child Health

Transformation Strategies and Approaches

Description of Evidence-Based Approach

The North Sound ACH will ensure that people of reproductive age in our region have access to high-quality reproductive health care and promote the health and safety of Washington’s children by implementing two evidence-based approaches. These approaches, taken from the Medicaid Transformation Toolkit, are:

1. The CDC’s [*Recommendations to Improve Preconception Health and Health Care*](#), designed to promote strategies to ensure that families have intended and healthy pregnancies that lead to healthy children. Specifically, the goal of this approach is to improve health before conception, whether before a first or a subsequent pregnancy, and increase the capacity of physical and behavioral health care providers throughout the North Sound region to reduce unintended pregnancy and support healthy planned pregnancies.
2. The Bright Futures model, which is intended to improve regional well-child visit rates and childhood immunization rates. Specifically, the goal of this approach is to increase the capacity of physical health care practices in the North Sound Region to support the health and development of young children and their families.

The main goals of the project are to reduce unintended pregnancy, increase healthy planned pregnancies, strengthen and support young families, and promote early childhood health and well-being, setting the foundation for good health throughout life.

Description of Transformation Activities

To increase the capacity of physical and behavioral health care practices to reduce unintended pregnancy and support healthy planned pregnancies, partners in the North Sound region will implement the strategies described below. The North Sound ACH will partner with Upstream USA, a nationwide nonprofit quality improvement organization that provides training and technical support to eliminate barriers at health centers that prevent a woman from obtaining the birth control method of her choice, improving outcomes for parents, children, and society. Upstream USA has recently operations in Washington and will be working in multiple ACH regions statewide.

- **One Key Question Screening:** Establish the systems and supports needed to integrate and evaluate One Key Question® pregnancy intention screening, counseling, and support into physical health care practices and behavioral health settings, with a focus on settings serving low-income (at or below 185% of the Federal Poverty Line) women. The One Key Question®

Project 3B: Reproductive and Maternal/Child Health

screening asks patients “Would you like to become pregnant in the next year?” with optional responses including Yes, No, Unsure, and OK Either Way. This screening will help providers determine the level of contraceptive care appropriate for each patient and have a discussion about family planning. One Key Question® is an evidence-based strategy and considered a best practice for contraceptive counseling to improve utilization of effective reproductive health strategies, including pregnancy intention counseling, healthy behaviors and risk reduction, effective contraceptive use, safe and quality perinatal care, and general preventive care. Providers in diverse settings (including physical health care providers, behavioral health care providers, specialty providers, case managers, social workers, and more) will be trained on this screening method and how to connect patients with access to contraceptive methods if desired.

- **Promote access to Long Acting Reversible Contraception (LARC):** Link pregnancy intention screening and counseling with access to effective contraception, particularly LARC, as well as preconception care, counseling, and risk reduction for individuals planning for pregnancy. This is the critical next step to screenings like One Key Question®: after patients have identified that they do not want to become pregnant in the next year (or are unsure or satisfied either way), a discussion of effective contraception methods is essential. Providers will be trained in how to counsel patients on highly effective methods like LARC (including intrauterine devices, implants, and injections), as well as how to provide these methods to patients. Pregnancy intention counseling and LARC placement are also done with postpartum women to support healthy family planning and pregnancy spacing. The North Sound ACH’s regional partners deem access to LARC and postpartum access to LARC as priorities to ensure that the North Sound ACH region is successful at reducing unintended pregnancies.

To increase the capacity of physical health care practices to support the health and development of young children and their families, partners in the North Sound region will implement the following strategies:

- **HealthySteps Program (Bright Futures Model) in pediatric/family practices:** The strategy used to increase capacity of physical health care practices to support the health and development of children and their families is the HealthySteps model implemented in targeted practices serving large numbers of pediatric patients covered by Medicaid. HealthySteps adds a child development professional (HealthySteps Specialist) to the practice as an integral part of the physical health care team. The model supports implementation of Bright Futures recommendations (the evidence-based model listed in the Toolkit to promote well-child visits), supports early childhood behavioral health integration into pediatric physical health care, and includes opportunities to ensure identification of parental behavioral health concerns and support parental connections to family planning for healthy pregnancy spacing.

Relationship to North Sound ACH Initiatives

The evidence-based approaches and strategies described above as part of the Reproductive, Maternal and Child Health project area (3B) will be integrated into two North Sound ACH initiatives: Care Transformation and Care Integration. In the Care Transformation initiative, the North Sound ACH will support implementation of prevention and health promotion strategies for targeted populations to prepare the region’s providers for outcomes-based reimbursement, population health strategies, and efforts to address health disparities and achieve health equity. Strategies within this initiative will

Project 3B: Reproductive and Maternal/Child Health

require the full engagement of clinical and community-based nonclinical providers. 3B strategies that fall into this initiative include increasing access to LARC.

In the Care Integration Initiative, strategies will focus on implementing innovative models or standards of care in a clinical setting, which will improve the quality, efficiency, and effectiveness of care processes, and adoption of evidence-based standards of integrated care. 3B strategies that fall into this initiative include One Key Question and HealthySteps specialists in pediatric practices.

Please see pages 5-7 for a full description of the North Sound ACH Initiatives.

2. Target Populations Described in the Project Plan for 3B:

Medicaid beneficiaries who are women of reproductive age, pregnant women, mothers of children ages 0–3, and children ages 0–17.

2018 Initiative Target Populations and Strategy Populations of Focus for 3B

People experiencing:

- Access, care and utilization disparities
- Pregnancy
- Substance abuse includes opioid abuse

With additional risk factors:

- Abuse, trauma, adverse childhood experiences

NOTE: 3B'S P4P metric will be analyzed to determine disparities:

- All-Cause Emergency Department Visits, per 1,000 MM
- Child and adolescent access to primary care
- Childhood Immunization Status (Combo 10) by age 2
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Contraceptive Care—Most & Moderately Effective Methods
- Contraceptive Care—Postpartum
- Dental Sealants for Children at Elevated Caries Risk
- Inpatient Hospital Utilization, per 1,000 Members
- Medication Management for People with Asthma Medication Compliance 75%
- Mental Health Treatment Penetration
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Periodontal Evaluation in Adults with Chronic Periodontitis
- Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)
- SUD Treatment Penetration

Project 3B: Reproductive and Maternal/Child Health

- SUD Treatment Penetration (Opioid)
- Timeliness of Prenatal Care: Prenatal care in the first trimester of pregnancy—all ages
- Utilization of Dental Services by Medicaid Beneficiaries
- Well-child visits

3. Expansion or Scaling of Transformation Strategies and Approaches

Please see description on Page 32.

Project 3C: Access to Oral Health Services

1. Transformation Strategies and Approaches

Description of Evidence-Based Approach

North Sound ACH oral health capacity-building strategies aim to expand access to and utilization of dental care by addressing barriers to care caused by lack of capacity and location of care. These strategies include expansion of clinic capacity, implementation of new provider models, integration of dental screening and referral into primary care practices, and mobile dental services in community settings. A second set of regional strategies are designed to introduce and inculcate population management approaches that are now only in rudimentary form in the oral health delivery system. The ACH and partner organizations will work to include more diverse partners in this work and conduct outreach to private dentists to increase participation and collaboration in serving Medicaid patients.

Oral Health Workforce Development

These strategies build capacity by adding to the oral health workforce or use that workforce in different ways. Strategies are intended to coordinate and enhance projects currently underway without duplicating the work these partners are engaged in. Each strategy is built off of pilot projects with demonstrated success in the region that demonstrate opportunity for enhancement and expansion.

- Pilot New Dental Workforce Models in Tribal Settings
 - North Sound ACH will engage with interested tribes in the region to assess workforce expansion opportunities using the DHAT (Dental Health Aide Therapist) program. To date, several tribes in the region have expressed an interest in exploring this opportunity. The North Sound ACH will leverage work with the Swinomish Tribe and Skagit Community College and partner with Northwest Indian Health Board and Olympic Community of Health to bring DHAT training to Washington State. The North Sound ACH will partner with Arcora Foundation to strategize capital expansion opportunities for those tribal clinics, so that there is infrastructure to support this new workforce.
 - Initial partners will include Swinomish Tribe with possible expansion to additional tribal dental clinics and training centers, including Lummi and Tulalip Tribal Health Centers.
 - Implementation Steps:
 - Establish region-based DHAT training program
 - Recruit students and secure scholarship funds

Project 3C: Access to Oral Health Services

- Mobile Dental Hygiene in Community Settings
 - Recruit currently underutilized dental hygienists to provide a range of Medicaid-billable dental services in community settings using mobile dental equipment, focusing on the most underserved areas in the region. This model leverages mobile care strategies as described in the Medicaid Transformation Project Toolkit by combining a workforce currently underutilized to meet the needs of the region and equipment that can provide billable oral hygiene services outside the walls of a dental clinic and bring dental hygiene services to people in community settings including hospitals, schools, and community centers. This strategy will also support referral of patients into dental clinics for care that cannot be delivered through mobile equipment.
 - Implementation partners will include a new regional network of approximately 30 hygienists to be recruited and trained for this purpose. Registered dental hygienists throughout the region are already practicing independently, and this strategy seeks to build on and connect with this workforce.
 - Implementation Steps:
 - Assess workforce needs and hygienist supply regionally
 - Recruit hygienists to form network
 - Secure Medicaid provider numbers
 - Train new workforce and assist in establishing practices across the region
 - Determine and execute outreach strategy to consumers

Implementing the Oral Health Delivery Framework

This toolkit strategy trains medical assistants and other personnel in medical practices to screen and refer patients with specific oral health conditions while directly providing certain preventive services.

- Several large medical groups will expand integration of dental services into medical primary care, using the Oral Health Delivery Framework as an evidence-based model. Potential partners will include:
 - Providence Medical group, which has already piloted integration in a single clinic and plans to expand the practice to additional clinics
 - FQHCs with co-located and integrated medical/dental clinic sites
 - Additional hospital-associated and independent primary care clinics will be solicited to participate
- Implementation Steps:
 - Secure final commitments from specific sites, emphasizing underserved geographic areas
 - Provide training (via Arcora Foundation Program) to providers and clinic staff
 - Finalize which preventive services will be offered
 - Finalize referral pathways from primary care to dental clinics

Implement Population Health Management Tools in Dental Settings

These tools are used primarily within provider organizations to more effectively organize services, so that the provider system produces improved results for patients. Because most of these tools are not typically in place, the work involves setting up new internal business procedures and then using them to reorganize care processes.

Project 3C: Access to Oral Health Services

- Develop the following internal procedures within provider organizations that will allow for improved care outcomes:
 - Increased use of registries to monitor performance in priority populations:
 - Adults with chronic periodontitis
 - People with diabetes
 - Pregnant women
 - Sealant status
 - High-risk adults (for dental issues)
 - High-risk children (for dental issues)
 - Create linkages between registry populations and practice call-back systems
 - Develop use of care management personnel within dental practices (see also B.3) and between medical practices and dental practices to improve patient navigation to services
 - Institute use of ICD-10 coding at the practice level to allow disease severity measurement and improve efficiency of benchmarking
 - Increase use of silver diamine fluoride
 - Improve organization-level dental analytics capability as a way to focus efforts on improved outcomes
 - Initially this strategy will focus on the three regional FQHC systems and then expand to independent private practice dentists and dental hygienists
- Implementation Steps:
 - Provide technical assistance to clinical partners for setting up these new internal systems
 - Monitor implementation progress
 - Track progress on metrics
 - Adjust processes as needed

Relationship to North Sound ACH Initiatives

The evidence-based approaches and strategies described above as part of the Access to Oral Health Services project area (3C) will be integrated into multiple North Sound ACH initiatives, primarily Care Integration and Care Transformation. In the Care Integration Initiative, the North Sound ACH will support strategies that focus on implementing innovative models or standards of care in a clinical setting, which will improve the quality, efficiency, and effectiveness of care processes, and adoption of evidence-based standards of integrated care. Strategies within this initiative will focus on innovative models of care that improve the quality, efficiency, and effectiveness of care processes, and adoption of evidence-based standards of integrated care, such as co-location of providers and team-based approaches to care delivery that address physical, behavioral, and social barriers to improved outcomes for all populations.

Please see pages 5-7 for a full description of the North Sound ACH Initiatives.

2. Target Populations Described in the Project Plan for 3C:

All Medicaid beneficiaries, especially adults.

2018 Initiative Target Populations and Strategy Populations of Focus for 3C

Project 3C: Access to Oral Health Services

People experiencing:

- Access, care and utilization disparities
- Pregnancy

With additional risk factors:

- Chronic conditions
- High system utilization
- Homelessness

NOTE: 3C'S P4P metric will be analyzed to determine disparities:

- All-Cause Emergency Department Visits, per 1,000 MM
- Child and adolescent access to primary care
- Childhood Immunization Status (Combo 10) -by age 2
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Contraceptive Care—Most & Moderately Effective Methods
- Contraceptive Care—Postpartum
- Dental Sealants for Children at Elevated Caries Risk
- Inpatient Hospital Utilization, per 1,000 Members
- Medication Management for People with Asthma Medication Compliance 75%
- Mental Health Treatment Penetration
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Periodontal Evaluation in Adults with Chronic Periodontitis
- Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)
- SUD Treatment Penetration
- SUD Treatment Penetration (Opioid)
- Timeliness of Prenatal Care: Prenatal care in the first trimester of pregnancy—all ages
- Utilization of Dental Services by Medicaid Beneficiaries
- Well-child visits

3. Expansion or Scaling of Transformation Strategies and Approaches

Please see description on Page 32.

Project 3D: Chronic Disease Prevention and Control

1. Transformation Strategies and Approaches

Description of Evidence-Based Approach

Project 3D: Chronic Disease Prevention and Control

The North Sound ACH will integrate health system and community approaches to improve chronic disease prevention and management (with a specific focus on asthma, heart disease, and diabetes) by implementing the Chronic Care Model (CCM), the evidence-based approach in the Medicaid Transformation Project Toolkit.

The CCM of chronic disease prevention and management is an evidence-based and patient-centered methodology for reducing chronic disease burden through clinician-patient teams and community-based resource referral links. Developed at the MacColl Center for Healthcare Innovation by Ed Wagner in 2004, the Chronic Care Model has been tested and expanded throughout the nation during the last decade. Most clinical organizations in the North Sound region report successful implementation of the Chronic Care Model, using clinician/medical assistant teams to identify, prevent, and manage chronic disease.

Transformation Activities/Strategies

With a focus on preventing and managing asthma, heart disease, and diabetes, the clinical and nonclinical community-based partners in the North Sound region will implement the following strategies under the Chronic Care Model:

Enhancement and Expansion of the Chronic Care Model in Primary Care Practices

- Training providers in the most current clinical guidelines on screening, diagnosing, and intervening to prevent and manage the chronic diseases in the scope of this project
- Educating providers on local community-based chronic disease prevention and management programs
- Implementing population health management techniques, including Health Information Technology (HIT) tools, to identify patients who are at risk of or diagnosed for chronic diseases
- Recalling identified at-risk or diagnosed patients for prevention, intervention, and potential for referral to community-based programs
- Using available billing options and processes for referring or prescribing patients to home-based chronic disease management (such as at home blood pressure management) or community-based chronic disease prevention and management programs

In addition, specific work will be done to implement practice improvement and provider education activities related to the North Sound ACH's chronic disease focus areas: asthma, diabetes, and heart disease (hypertension).

- *Asthma*: Ensure that clinics implement national clinical guidelines on diagnosis and treatment for asthma with home-based assessments and remediation through training sessions on:
 - Effective asthma diagnosis through spirometry
 - Stepwise approach to medication management
 - Patient education on use of inhalers with spacers
 - Asthma action plans
- *Diabetes*: Ensure that clinics implement national clinical guidelines for diagnosing and treating prediabetes and diabetes; linking with other community-based programs like Chronic Disease Self-Management Education (CDSME) and other community- and school-based programs that will help promote healthy lifestyles (increase activity, healthy eating/portion control, etc.).
- *Heart Disease/Hypertension*: Implementing national clinical guidelines on diagnosis and

Project 3D: Chronic Disease Prevention and Control

treatment for hypertension through application of tools and protocols such as the Million Hearts initiative; referring patients to community-based programs that focus on healthy lifestyle, smoking cessation, and so on; prescriptions for home blood pressure monitoring equipment.

Expand Regional Capacity for Community-based Chronic Disease Prevention and Management programs

A key part of this project will be to expand regional capacity to provide evidence-based, community-based chronic disease prevention and management programs. A critical element of the Chronic Care Model is referral to community-based resources, which requires strong, available community programs where patients can receive support in self-management and lifestyle modification. Several evidence-based environmental, patient education, and self-management programs will be implemented where appropriate to address asthma, diabetes, and heart disease/hypertension.

Strategies in this project area will build on programs currently operating in communities to prevent and manage chronic diseases and look to examples of successful programs that are accessible and effective at improving health outcomes. A significant part of the 2018 planning phase will be identifying these community-based programs to ensure that all partners are engaged and to avoid duplication of programs. Projects in this area will aim to build on or scale up the work that is already happening in communities. Implementation partners will collaborate with the North Sound ACH in a financial analysis of intervention cost compared to the impact on health outcomes and performance measures. The programs listed below are strong candidates for enhancement or expansion. Further refinement of this list will happen through partner engagement in July-August 2018.

- *Asthma Home-Based Multi-trigger, Multicomponent Environmental Intervention (Healthy Homes)*: Healthy Homes targets persons with asthma or chronic obstructive pulmonary disease and provides a holistic housing assessment coupled with environmental health education that includes a home education visit to help families take action to create a healthier home; inventory to support households in improving indoor air quality; comprehensive home assessment to identify indoor air health and safety hazards; referral to weatherization and home repair programs to improve indoor air quality, reduce asthma triggers and increase energy efficiency; and one year of follow up service, both in-home and via phone. CHWs can become certified to conduct environmental assessments and refer to Healthy Homes.
- *National Diabetes Prevention Programs (NDPP)*: The goals of NDPP are to increase healthy eating and activity and promote healthy weight loss. NDPP are based in community organizations like the YMCA (one-year program is composed of 25 small group one-hour sessions), Washington State University (WSU Extension DPP consists of 16 weekly core classes and followed by six monthly post-core classes).
- *Chronic Disease Self-Management Programs (CDSMP)* is an effective small group self-management education program for people with chronic health problems to help them control their symptoms and better manage their health problems. The program specifically addresses arthritis, diabetes, and lung and heart disease, but teaches skills useful for managing a variety of chronic diseases.
- *Eating Smart, Being Active*, an eight-week food and nutrition series.
- *ACT!*, a partnership between Seattle Children's Hospital and regional YMCAs, which coaches overweight kids (8-11), and teens (12-14), and their families to lead healthy lifestyles.
- *Fruit and Vegetable Prescription Program*: A partnership between local food banks and primary

Project 3D: Chronic Disease Prevention and Control

care providers to prevent and treat food insecurity and chronic diet-related diseases (type 2 diabetes, hypertension). Participants are enrolled by a health care provider, screened for food insecurity, and work with a counselor to discuss nutrition goals and strategies each month. Participants are referred to WIC/SNAP if appropriate and receive a Fruit and Vegetable Rx voucher that is redeemable at farmers' markets, mainstream grocers, and corner stores.

Relationship to North Sound ACH Initiatives

The evidence-based approaches and strategies described above as part of the Chronic Disease Prevention and Control project area (3D) will be integrated into two North Sound ACH initiatives: Care Transformation and Care Integration. In the Care Transformation initiative, the North Sound ACH will support implementation of prevention and health promotion strategies for targeted populations to prepare the region's providers for outcome-based reimbursement, population health strategies, and efforts to address health disparities and achieve health equity. Strategies within this initiative will require the full engagement of clinical and community-based nonclinical providers. 3D strategies that fall into this initiative include community-based chronic disease management and prevention referral from clinical settings.

In the Care Integration Initiative, strategies will focus on implementing innovative models or standards of care in a clinical setting, which will improve the quality, efficiency, and effectiveness of care processes, and adoption of evidence-based standards of integrated care. 3D strategies that fall into this initiative include clinical transformation related to chronic disease best practices (training, screening, treatment, etc.).

Please see pages 5-7 for a full description of the North Sound ACH Initiatives.

2. Target Populations Described in the Project Plan for 3D:

Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity, and stroke, with a focus on populations experiencing the greatest burden of chronic disease(s) in the region.

2018 Initiative Target Populations and Strategy Populations of Focus for 3D

People experiencing:

- Access, care and utilization disparities

With additional risk factors:

- Abuse, trauma, adverse childhood experiences
- Chronic conditions (e.g., arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity, and stroke)
- High system utilization

NOTE: 3D'S P4P metric will be analyzed to determine disparities:

- All-Cause Emergency Department Visits, per 1,000 MM
- Child and adolescent access to primary care
- Childhood Immunization Status (Combo 10) by age 2
- Chlamydia Screening in Women

Project 3D: Chronic Disease Prevention and Control

- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Contraceptive Care—Most & Moderately Effective Methods
- Contraceptive Care—Postpartum
- Dental Sealants for Children at Elevated Caries Risk
- Inpatient Hospital Utilization, per 1,000 Members
- Medication Management for People with Asthma Medication Compliance 75%
- Mental Health Treatment Penetration
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Periodontal Evaluation in Adults with Chronic Periodontitis
- Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by Primary Care Medical Providers
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)
- SUD Treatment Penetration
- SUD Treatment Penetration (Opioid)
- Timeliness of Prenatal Care: Prenatal care in the first trimester of pregnancy—all ages
- Utilization of Dental Services by Medicaid Beneficiaries
- Well-child visits
- Co-occurring disorders/conditions (behavioral and physical health and SUD)

3. Expansion or Scaling of Transformation Strategies and Approaches

Please see description on Page 32.

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:

Across all project areas and initiatives, the North Sound ACH expects to achieve the following outcomes by the end of the Medicaid Transformation Project period:

- Physical and behavioral health purchasing and service delivery are integrated to better meet whole-person needs
- Increased provider capacity to adopt new payment and care models
- Population health strategies that improve health equity are successfully implemented
- System, practice, and policy changes have supported and sustained transformation
- Collaboration model is effective, integral, and sustainable
- Health improvement is measurable, scaled, and spread

Specific to the North Sound ACH's four initiatives (see page 5-7 for a description of these initiatives and associated strategies), the North Sound ACH expects to achieve the following outcomes by the end of the Medicaid Transformation Project period if the ACH and our partnering providers are successful:

Care Coordination:

- Promote community-based care coordination by launching a Community HUB that will connect care coordinators who reach Medicaid enrollees. The Pathways model provides a starting point from which to pilot, scale and sustain community-based care coordination. (2B)
- Improve community transition efforts by enhancing communication between emergency departments, hospital discharge, behavioral health settings, law enforcement, courts, and jails. As well as using the HUB as a communication and coordination tool, strategies in this initiative will identify transitional gaps, initiate referral to community-based partners, and foster continued collaboration around populations experiencing high-needs. (2C)
- Divert community members from avoidable emergency room visits by supporting cross-partner coalitions who are developing and implementing coordinated systems that promote care coordination for people with complex needs that intersect with health care, social service, criminal justice, and emergency systems; and promoting access to appropriate non-emergency services through community-based programs. (2D)

Care Transformation:

- Address the high rate of opioid use by supporting the implementation of the region's Opioid Plan with its goals to reduce opioid-related morbidity and mortality, targeting prevention, treatment, overdose prevention, and recovery supports. (3A)
- Increase the number of people of reproductive age who have access to high-quality reproductive health, support efforts that reduce unintended pregnancy, increase healthy planned pregnancies, strengthen and support young families, and promote early childhood health and well-being, setting the foundation for good health across the life course. (3B)
- Increase access to oral health services by addressing barriers to care due to lack of capacity and location of care. (3C)
- Support chronic disease prevention and control by integrating health system and evidenced-based community approaches to improve chronic disease prevention and management. (3D)

Care Integration:

- Support the bi-directional integration of physical and behavioral health. Bi-directional integration of care has the potential to impact all Medicaid enrollees in the North Sound ACH by targeting the expansion of health services to two key demographics—enrollees with behavioral health needs currently using the primary care system, and people with serious mental illness currently using the North Sound BHO system of behavioral health care. (2A)
- Address the capacity and protocols needed for bi-directional integration of care by offering training to providers on how to adopt the required changes and creating integrated care delivery protocols and models. (2A)
- Ensure bi-directional integration partners are prepared for MCO payment changes by assessing partner readiness for MCO billing and invest in billing support for MCO billing. (2A)
- Adopt care integration strategies that work upstream to prevent chronic disease, improve maternal and child health, increase access to oral health services, and address the opioid epidemic via engagement of traditional and non-traditional providers. (integration-specific activities for 3A, 3B, 3C, 3D)

Capacity Building:

- Support the state’s value-based payment (VBP) goals by distributing VBP readiness tools and resources, connecting providers to state VBP training and technical assistance.
- Promote a health workforce that supports comprehensive, coordinated, and timely access to care by assessing workforce readiness, capacity and needs.
- Leverage and expand infrastructure for systems of population health management by assessing system use and barriers, current status of health information technology (HIT) and health information exchange (HIE) and the interoperability capacity for community-based, integrated care.
- Expand opportunities for clinical and community-based organizations to build a diverse workforce with shared lived experience between health workers and patients, while promoting the value of this workforce in driving health equity.
- Embed health equity as a foundational element in its transformation strategy, supporting partners to implement strategies that will reach populations experiencing disparities in outcomes and access to move toward reaching universal goals of health and well-being.

These expected outcomes will help the North Sound ACH and its partners to meet regional transformation objectives (increase health systems and community capacity; achieve financial sustainability through VBP; integrate physical and behavioral health; improve community-based whole-person care; improve health equity and reduce health disparities). The initiatives and strategies designed to produce these outcomes (described in the table in Milestone 3, questions 1-3) are often focused on the regional transformation objectives described above (e.g., the Care Integration initiative is largely focused on the bi-directional integration of physical and behavioral health and the Capacity Building initiative is focused on building provider capacity through improving population health management systems, strengthening the workforce, and supporting provider transition to VBP). Health equity and improving whole-person care are core values embedded in all strategies, as demonstrated by a focus on target populations experiencing significant health disparities and promotion of connection and collaboration among partners and sectors.

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.

Item D.1 in the Semi-Annual Report Workbook is completed.

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

ACH Organizational Updates

- 1. Attestations: In accordance with the Transformation’s STCs and ACH certification requirements, the ACH attests to complying 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: primary care providers, 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 community-based organizations 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.

ACH Response: A revised Organizational Chart is included as Attachment D.

	Yes	No
Changes to Key Staff Positions during Reporting Period	X	

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.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
Department of Social and Health Services Regional Tribal Coordinating Council Meeting	3/13	Tribal representatives and state agency representatives	DSHS Regional Tribal Coordinating Council	Ongoing collaboration between tribes and DSHS services. Bimonthly meetings.
Since Time Immemorial Lummi Advisory Committee	3/15	Lummi leaders, school administrators, and FSD board member	Collaborate resources available for the STI curriculum	Introductory meeting with educational and cultural representatives. Schedule next meeting—2 weeks.
Lummi Nation School Board & Ferndale School Board	3/19	Superintendent, Education Director, School Board reps and admin team	Collaboration of Native student education and services	Collaboration of Indian Education for Native students. Ongoing monthly meeting.
Stillaguamish Health Facility Open House	3/20	Stillaguamish community and public	Grand opening of new health facility	Grand opening for new health facility. Open to the public and tribal members.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
North Sound ACH Tribal Alignment Committee	3/20	Tribal Alignment Committee members, ACH staff, guests	Collaborate ACH	Coordinate & provide updates for the North Sound ACH eight tribes. Bimonthly meeting.
Washington State Indian Education Committee	3/21	Committee members	Planning annual conference	Native education conference planning, keynote & breakout session presenters, monthly meeting.
Northwest Indian College Community Action Board	3/22	CAB members	Native Transformations Project	Tribal communities' wellness model monthly meeting.
Whatcom Family & Community Network	3/22	Board members	Monthly meeting	Community capacity building. Monthly meeting.
Since Time Immemorial Lummi Advisory Committee	3/22	LIBC Vice Chairman, Advisory Committee members	Collaborate resources available for the STI curriculum	Design project plan and assign tasks. Next meeting TBD.
Lummi Indian Business Council	3/23	Board members, Secretary of Interior	Tribal relations	Meet & greet with Secretary of Interior. Discussion included opioid epidemic in Indian country, natural resources, and tribal relations. One-time visit/meeting.
Ferndale School District Student Services (Native American Student Services)	3/23	Student Services Director & Ferndale School Board member	Native American student services	Discuss programs and services for Native students. Success, challenges, and future opportunities. Meeting upon request.
State Epidemiological Outcomes Workgroup	3/28	SEOW members and presenters	Review studies/research presentations	Presentation of the Native Transformation Program to the WA State Epidemiological Outcomes Workgroup. One time.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
HCA Accountable Communities of Health Tribal Liaison	3/30	HCA Tribal Liaison & North Sound ACH Tribal & Community Liaison	HCA Tribal relations	Tribal liaison updated by the HCA with ACH Tribal Liaisons. Ongoing.
Washington State Indian Education Conference	4/4-4/6	Native elders, students, teachers, education representatives	Collaborate Native education	Native education conference, keynote & breakout session presenters.
Northwest Indian College Community Action Board	4/9	CAB members	Native Transformations Project	Tribal communities' wellness model monthly meeting.
Indian Policy Advisory Commission/Governor's Office of Indian Affairs	4/11-4/12	Tribal leaders, State agency representatives	To provide Indian policy updates to tribal leaders	IPAC policy review & updates for tribal leaders. Ongoing.
Since Time Immemorial Lummi Advisory Committee	4/13	LIBC Vice Chairman, Advisory Committee members	Collaborate resources available for the STI curriculum	Design project plan and assign tasks. Next meeting TBD
Northwest Indian College Community Action Board	4/16	CAB members	Native Transformations Project	Native Transformation Opioid Project
Washington Indian Education Association Conference Planning	4/18	Tribal leaders, tribal representatives	Collaborate Native education conference planning	Native education conference planning, keynote & breakout session presenters, monthly meeting.
Lummi Indian Child Welfare	4/19	Native grandparents, adult foster care children, committee members, tribal judges	Review children in care/foster care, propose code/policy amendments	Tribal code & policy review by tribal elders & community leaders for children in care Title IV-E. Develop working group TBD.
Lummi Nation School Board & Ferndale School Board	4/20	Superintendent, Education Director, School Board reps and admin team	Collaboration of Native student education and services	Collaboration of Indian Education for Native students. Ongoing monthly meeting.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
Western Washington University Multicultural Center Groundbreaking	4/20	Ethnic students, diversity groups, alumni, students, staff, community and public	Diversity	Ground breaking. To share communities & relations. One-time event.
Northwest Washington Indian Health Board (NWWIHB)	4/25	NWWIHB Executive Director, Nooksack leadership	Collaborate native health care services	Public health services and advocates for improvements in Native health for tribes in Northwest Washington.
HCA Tribal Consultation	4/30	Tribal leaders, HCA staff, administrators	Tribal consultation, relations, collaborations	Government to government relations with tribal leaders.
Health & Human Service Tribal Consultation	5/2	Tribal leaders, HHS staff, administrators	Tribal consultation, relations, collaborations	Government to government relations with tribal leaders.
Ferndale School District Student Services (Native American Student Services)	5/4	Student Services Director & Ferndale School Board member	Native American student services	Discuss programs and services for Native students. Success, challenges, and future opportunities. Meeting upon request.
Meeting with John Powell, author of Targeted Universalism	5/15	Team	Discuss how targeted universalism and health equity will be centered in the ACH work	Schedule meeting with John Powell for next steps
North Sound Behavioral Health Organization Tribal Mental Health Conference	5/16-5/17	Tribal leaders, elders, communities, health care providers & professionals	Provide tribal conference for tribal behavioral health	Annual tribal behavioral health conference. Planning for next year's conference.
Vine Deloria, Jr. Indigenous Studies Symposium	5/18-5/19	Tribal College University students, scholars, tribal and public community members, tribal self-governance enthusiast	Engaging indigenous knowledge to transform communities	Tribal self-governance & indigenous studies symposium. Planning for next year's conference.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
Lummi Nation School Board & Ferndale School Board	5/18	Superintendent, Education Director, School Board reps and admin team	Collaboration of Native student education and services	Collaboration of Indian Education for Native students. Ongoing monthly meeting.
Ferndale School District Culture Fair	5/18	Diverse communities' members participating, presenting and performing at cultural event	Celebrate diverse communities, sharing extracurricular activities	Celebrate diverse communities, sharing extracurricular activities. Planning for annual event.
Tribal Culture Curriculum meeting w/Michelle Vendiola	5/21	Michelle Vendiola, a consultant	Discuss prospect to provide training for tribal curriculum	Design goals and training plan for tribal curriculum. Next meeting TBD.
Girl Scouts Western Washington Annual Luncheon	5/22	Participants, supporters, funders and media relations.	Annual campaign to celebrate honorees and to share the mission of Girl Scouts of America.	Celebration and promotion of success of Girl Scout honorees and special recognition of alumni. Collaborate with networks.
Lummi Community Development Financial Institute	5/23	LCDFI Executive Director, and Executive Assistant.	Communicate & collaborate Medicaid transformation with tribal partner. Economic & human development in tribal communities.	Communicate & collaborate Medicaid transformation with tribal partner. Next meeting TBD.
Johnson O'Malley, Native Student Recognition	5/23	Native communities, students, parents, guardians, grandparents, family & friends. Educational professionals.	Recognition & celebration of Native student accomplishments.	Community celebration of Native student success & accomplishments. Bureau of Indian Education subsidize education, medical attention, and other services provided by states to Native Americans. Planning for annual event.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
HCA Accountable Communities of Health Tribal Liaison	5/24	ACH tribal liaisons, HCA staff	Communicate and collaborate ACH tribal liaison information.	Communicate and collaborate ACH tribal liaison information and share ACH & HCA support.
Sauk Suiattle tribal visit	5/29	Tribal leaders, HCA Tribal Administrator & North Sound ACH Tribal Liaison	Communicate & collaborate Medicaid transformation project with tribal government.	Communicate & collaborate Medicaid transformation project with tribal government. Next meeting TBD.
Northwest Washington Indian Health Board Meeting	5/30	Executive Director & North Sound ACH Tribal Liaison	Communicate & collaborate Medicaid transformation project with tribal organization.	Communicate & collaborate Medicaid transformation project with tribal organization serving five tribes.
Lhaq'temish Foundation Board Meeting	5/31	Tribal board members and staff. Tribal community members.	Sharing our gifts funds distribution for promotion of health & wellness activities.	Sharing our gifts funds distribution for promotion of health & wellness activities. Quarterly meeting.
HCA Department of Health Monthly Tribal Meeting	6/6	HCA & DOH executive staff & tribal relations with tribal leaders/representatives	HCA & DOH Healthier Washington Initiative tribal updates	HCA & DOH Healthier Washington Initiative tribal updates. Monthly.
Lummi Community Development Financial Institute Meeting	6/7	LCDFI Executive Director, and Executive Assistant.	Communicate & collaborate Medicaid transformation with tribal partner. Economic & human development in tribal communities.	Communicate & collaborate Medicaid transformation with tribal partner. Poverty reduction. Financial literacy. Next meeting TBD.
North Whatcom Health Center	6/7	Ferndale community, health care professionals, Ferndale Chamber of Commerce community, Ferndale City Council, Ferndale School Board, public	Groundbreaking Ceremony at North Whatcom Health Center	Groundbreaking Ceremony at North Whatcom Health Center. Celebrate future project. Grand opening TBD.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
Lummi High School Graduation	6/7	Native students, parents, guardians, grandparents, families and communities	Student recognition of high school diploma	Traditional student recognition and celebration of high school diploma.
North Sound Interlocal Leadership Structure Meeting	6/8	Behavioral health care professionals and administrative support	Communicate and collaborate North Sound Interlocal Leadership Structure	North Sound Interlocal Leadership Structure. Behavioral Health. Ongoing meeting.
Whatcom County Sheriff & Lummi Island Community Leadership Meeting	6/8	Whatcom County Sheriff & Lummi Island Community Leadership	Communicate and collaborate jail inmate reentry into communities with life skills and vocational access.	Communicate and collaborate jail inmate reentry into communities with life skills and vocational access.
Ferndale High School Graduation	6/9	Ferndale students, parents, guardians, grandparents, families and communities	Student recognition of high school diploma	Student recognition and celebration of high school diploma.
Ferndale/Lummi Emergency Communications Committee Meeting	6/11	Lummi Chief of Police, Ferndale Communication Volunteer, Tribal & Community Liaison	Communicate and collaborate on emergency communications systems. First meeting	Communicate and collaborate emergency communications systems. Setup testing and trial system TBD.
Lummi Indian Business Council Meeting	6/11	Tribal council leadership, administration and tribal & community liaison	Communicate and collaborate tribal policy and relations working with local and state agencies	Communicate and collaborate tribal policy and relations working with local and state agencies.
North Sound Behavioral Health Organization Meeting	6/11	Regional behavior health care professionals (public and tribal organizations).	Communicate and collaborate on behavior health care services in region	Communicate and collaborate on behavior health care services in region. Ongoing.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
Whatcom Parkscriptions Advisory Team Meeting	6/12	Medical, health care, and fitness professionals	Parkscriptions connects patients with positive outdoor experiences for healthier lifestyles and improved mental and physical health	Parkscriptions collaboration for patients with positive outdoor experiences for healthier lifestyles and improved mental and physical health. Ongoing.
Department of Social and Health Services Regional Tribal Coordinating Council Meeting	6/12	Tribal representatives and state agency representatives	DSHS Regional Tribal Coordinating Council	Ongoing collaboration between tribes and DSHS services. Bimonthly meetings.
Windward High School Graduation	6/15	Ferndale students, parents, guardians, grandparents, families and communities	Student recognition of high school diploma	Student recognition and celebration of high school diploma
Northwest Washington Indian Health Board	6/13	Executive Director and Tribal & Community Liaison	Collaborative native health care policies and services	Public health services and advocates for improvements in Native health for tribes in Northwest Washington.
Northwest Indian College Dean of Curriculum	6/14	Dean of Curriculum, Northwest Washington Indian Health Board Executive Director, and Tribal & Community Liaison	Discuss prospect to provide training for tribal Dental Health Therapy (DHAT), behavior health aide, Community Health Aide Program (CHAPs)	Consider the training for tribal Dental Health Therapy (DHAT), behavior health aide, Community Health Aide Program (CHAPs) at Northwest Indian College. Next meeting in two weeks TBD.
Northwest Washington Indian Health Board	6/14	Executive Director and Tribal & Community Liaison	Follow-up meeting with NWIC DHAT/BHA/CHAPs collaborate native health care policies and services	Public health services and advocates for improvements in Native health for Tribes in Northwest Washington.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
Community Forum on Medicaid (Healthier Washington Initiatives)	6/14	Community members	Discuss the Healthier Washington initiatives and changes to Medicaid	Update of the Healthier Washington initiatives and changes to Medicaid. Next event TBD.
Lummi Nation School Board & Ferndale School Board	6/15	Superintendent, Education Director, School Board reps and admin team	Collaboration of Native student education and services	Collaboration of Indian Education for Native students. Ongoing monthly meeting.
HCA Accountable Communities of Health Tribal Liaison	6/15	HCA Tribal Liaison & North Sound ACH Tribal & Community Liaison	HCA Tribal relations	Tribal liaison updated by the HCA with ACH Tribal Liaisons. Ongoing.
Northwest Indian College Graduation	6/15	Native students, parents, guardians, grandparents, families and communities	Student recognition of high school diploma	Traditional student recognition and celebration of high school diploma.
Community Leadership Council (CLC)	6/18	Community members and representatives of CBOs	To help understand the needs, strengths, and challenges that residents face each day in trying to move toward better health	The CLC helps ensure that the North Sound ACH addresses the needs of residents who have coverage through Apple Health or Medicaid, provides feedback on project ideas and plans, helps design effective community engagement strategies.
RE Sources Sustainable Communities Meeting	6/19	Board members, staff and open to public	Promote and protect healthy environment for healthy communities by policy and leadership	Promote and protect healthy environment for healthy communities by policy and leadership. Stewards. Monthly meeting.
Department of Social and Health Services, Office of Indian Policy	6/20	DSHS Tribal Administrator, DSHS Tribal Liaison, and Tribal & Community Liaison	Tribal relations for DSHS services	Collaboration for tribal relations for DSHS services. Follow-up at next Indian Policy Advisory Council

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
				meeting.
RE Sources Sustainable Communities Meeting	6/20	Board Chair, Executive Director and Tribal & Community Liaison	Follow-up meeting for healthy environment for healthy communities by policy and leadership	Share community relations for healthy environment for healthy communities by policy and leadership. TBD.
Washington State Indian Education Committee	6/20	Committee members	Planning annual conference	Native education conference planning, keynote & breakout session presenters, monthly meeting.
Children of the Setting Sun Productions	6/20	Tribal and community members	Communicate and learn tribal traditions and teachings with community	Communicate and collaborate tribal traditions and teachings with community. Promote culture and story with community. Next meeting TBD.
Northwest Washington Indian Health Board	6/21	Tribal Leader, Executive Director and Tribal & Community Liaison	Update meeting with NWIC DHAT/BHA/CHAPs collaborate native health care policies and services	Public health services and advocates for improvements in Native health for Tribes in Northwest Washington.
HCA Accountable Communities of Health Tribal Liaison	6/22	HCA Tribal Liaison & North Sound ACH Tribal & Community Liaison	HCA Tribal relations	Tribal liaison updated by the HCA with ACH Tribal Liaisons. Ongoing.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
Department of Social and Health Services Region 2 Meeting	6/25	Tribal and community representatives, North Sound Behavioral Health Organization, and DSHS staff	Update of Division of Behavior Health and Recovery	Transition of Division of Behavior Health and Recovery from DSHS to HCA
HCA American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Swinomish Indian Tribal Community	6/26	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Executive Director and Tribal & Community Liaison, with Swinomish representative	Medicaid Transformation communication and collaboration	Medicaid Transformation communication and collaboration tribal funds and tribal ACH planning. Next meeting TBD.
HCA American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Upper Skagit Indian Tribe	6/26	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Executive Director and Tribal & Community Liaison, with Upper Skagit Tribal Council and administrative staff	Medicaid Transformation communication and collaboration	Medicaid Transformation communication and collaboration tribal funds and tribal ACH planning. Next meeting TBD.
Ferndale School Board Meeting	6/26	School board members, Ferndale School District Executive Administration, and community members	Review board policies and updates by administration	Action of board policies and discuss student education updates by administration.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
HCA, American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit--Samish Indian Nation	6/27	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Executive Director and Tribal & Community Liaison, with Samish tribal council and administration	Medicaid Transformation communication and collaboration	Medicaid Transformation communication and collaboration tribal funds and tribal ACH planning. Next meeting TBD.
HCA, American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Tulalip Tribes	6/27	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Executive Director and Tribal & Community Liaison, Tulalip tribal leaders and members of Tribal Clinic staff	Medicaid Transformation communication and collaboration	Medicaid Transformation communication and collaboration tribal funds and tribal ACH planning. Next meeting TBD.
Ferndale School Board Study Session	6/27	School board members, Ferndale School District Executive Administration, and community members	Review board policies and updates by administration	Discuss board policies and student education updates by administration.
HCA, American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Lummi Indian Business Council	6/28	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Tribal & Community Liaison, with tribal council and administration	Medicaid Transformation communication and collaboration	Medicaid Transformation communication and collaboration tribal funds and tribal ACH planning. Next meeting TBD.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
Whatcom Family & Community Network Meeting	6/28	Board members, staff and community	Review and discuss board policy building capacity through health and wellness in communities with partners	Discuss board policy building capacity in communities with partners and networks. Promote health and wellness. Monthly meeting.
HCA, American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Stillaguamish Tribe of Indians	6/29	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Tribal & Community Liaison, with tribal representative and administration	Medicaid Transformation communication and collaboration	Medicaid Transformation communication and collaboration tribal funds and tribal ACH planning. Next meeting TBD.

Project Reporting Requirements

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

Table 9: Project Status Updates

Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Investment in technical assistance expertise from Foundation for Healthy Generations	2B	Y	Weekly technical assistance calls. Development of quarter by quarter timeline of deliverables (NS Staff and Technical assistance team) and anticipated areas of TA team content expertise
Investment in shared IT platform for North Sound Community HUB across ACHs, with options to build interoperability to EDIE, OneHealthPort, PreManage, and Health Homes	2B	Y	Ongoing discussion among interested ACHs

Table 9: Project Status Updates

Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Cross-ACH discussions on shared evaluation platform (Center for Outcomes Research and Education)	2B	Y	Cross-ACH in-person discussion May 9 Release of CORE proposal on shared ACH contract CORE and North Sound ACH follow up discussion June 2018
HUB startup funds and budget projections (initial pro forma)	2B	Y	Initial pro forma in development; assistance provided by North Sound ACH finance team and Care Coordination Systems
Call for 2018 Partners	All	Y	First call for partners released, with more than 70 partners responding from across the region.
Call for Care Coordination Agencies (CCA)	2B	Y	32 partners responded; HUB staff have developed criteria for scoring the applications
North Sound hosting convening of HUB CCAs and their care coordinators/ supervisors	2B	Y	Agenda and content drafted Guest speakers secured (2 Washington State Pathways Master Trainers) to discuss the Department of Health’s Pathways summer trainings
“Core HUB” team identified; representatives across 5 counties attending meeting with Sara Redding and the Foundation for Healthy Generations.	2B	Y	Core HUB team met on twice in June 2018 and will continue meeting on an ad-hoc basis to assist in areas of HUB implementation The group will sunset after the HUB has its CCAs selected, and can begin convening those agencies in a formal advisory group role
Discussions with key partners about CHW workforce-opportunities, concerns, current/ideal state	2B	Y	CHW Symposium co-hosted by North Sound ACH, PeaceHealth, and Chuckanut Foundation: planning discussions in May and June 2018 and ongoing planning for event date in November

Table 9: Project Status Updates

Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Progressing toward MCO reimbursement for Pathways	2B	Y	North Sound Community HUB contracting discussions with 2 Medicaid MCOs in progress
Partnership formed with North Sound BHO to collaborate on project management and strategy implementation for Addressing the Opioid Crisis	3A	Y	Finalize scope of work and memorandum of understanding (MOU); BHO and ACH staff continue to meet regularly to develop work plan and plan partner engagement activities
Partnership formed with North Sound BHO to collaborate on project management and strategy implementation for Bi-directional Integration of Physical and Behavioral Health	2A	Y	Finalize scope of work and memorandum of understanding (MOU); BHO and ACH staff continue to meet regularly to develop work plan and plan partner engagement activities
Relationship formed with Upstream WA staff and clinical providers in the region on practice transformation in support of reproductive health goals	3B	Y	Formalize MOU with Upstream on implementing 3B strategies
Relationship formed with Arcora Foundation on practice transformation in support of access to oral health goals	3C	Y	Formalize MOU with Arcora on implementing 3C strategies
Reporting Portal Selection Process (CSI)	All	Y	Contract with CSI to support performance measure reporting portal for implementation partners

Table 9: Project Status Updates

Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Interlocal Leadership Structure meetings held monthly basis	2A	Y	Interlocal meetings to continue
Meetings with Healthier Washington Practice Transformation Support Hub	2A	Y	Information sharing and collaboration to continue with PT Support Hub staff for partner engagement and consulting
Integrated Managed Care System Design Meetings for Behavioral Health and Physical Health Providers	2B	Y	Bi-directional workgroup to be convened through Interlocal Leadership Structure
Meetings with Pediatrics TCPI	2A, 3B	Y	Information sharing and collaboration to continue with P-TCPI staff for partner engagement and consulting

Portfolio-Level Reporting Requirements

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:

Between January and June 2018, the North Sound ACH regularly coordinated with other ACHs to discuss planning for implementation of Medicaid Transformation Projects. This coordination happened in the following ways:

- Weekly all-ACH Director Calls
- Monthly in person ACH director meetings (9 ACHs)
- Cross-ACH meetings for those implementing the Pathways Community HUB model (6 ACHs)
- Cross-ACH meetings and calls for those using the Center for Evidence-Based Policy as a consultant (5 ACHs)
- Cross-ACH meetings and calls for regions that are mid-adopters of integrated managed care (6 ACHs)
- Biweekly ACH program staff calls (9 ACHs)
- Slack channel collaboration for ACH program staff (including data leads and project managers) (HCA and ACHs)
- Weekly ACH opioids and tribal affairs calls for ACH project staff (9 ACHs)
- Informational calls and meetings with multiple ACHs to view presentations and discuss engagement with potential partners and vendors with cross-ACH scope, including:
 - Providence Health System
 - Collective Medical Technologies
 - Care Coordination Systems
 - Foundation for Healthy Generations
 - Washington State Hospital Association (WSHA)
 - University of Washington
 - Association of Washington Public Hospital Districts
 - Healthier Washington Practice Transformation Support Hub (Washington Department of Health and Qualis Health)

During the reporting period, the North Sound ACH began coordinating with other ACHs to coordinate engagement of partnering providers participating in Medicaid Transformation projects that cross ACH boundaries (such as large hospital systems and FQHCs). During summer and fall 2018, the North Sound ACH anticipates increased coordination with other ACHs to discuss engagement with specific partnering providers in multiple regions.

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

ACH Response:

The North Sound ACH has developed a strategic plan for engaging partnering providers at key points in the Medicaid Transformation Project, particularly during the planning and early implementation phases. This includes mapping out the North Sound ACH's implementation process and designing opportunities for providers to be engaged throughout. Special attention has been paid to which type of partners should be engaged and at what points, as well as to identifying appropriate engagement methods, opportunities for feedback and transparency, and developing clear plans on how input will be incorporated. The North Sound ACH intends to build long-term relationships through meaningful engagement that will last beyond the Medicaid Transformation Project. The ACH's expectations for partnering provider engagement in support of transformation activities are described below, first generally for all partners and strategies, and then specifically for North Sound Community HUB.

Planning Phase

For the remainder of the planning phase (through end of 2018), the North Sound ACH expects to collaborate with partners who successfully responded to the first Call for Partners (released in May 2018, with applications received by June 21, 2018). This collaboration will include gathering input on the planned evidence-based approaches and strategies, target populations selected, partner reporting mechanism, monitoring and evaluation plans, and more. In addition to gathering input, the North Sound ACH will convene partners to provide updates on the Medicaid Transformation Project.

The North Sound ACH will provide training sessions (in person and web-based) on strategies and evidence-based models (e.g., targeted universalism, the Chronic Care Model). Additionally, the North Sound ACH expects to formalize partnerships with several external partners to collaborate on project management (including planning and implementation of transformation strategies). Examples include the North Sound BHO for project management of bi-directional integration and opioids strategies, the Arcora Foundation for oral health strategies, and Upstream USA for reproductive health strategies.

Through fall 2018, the following meetings, forums, and convenings are tentatively planned:

July 2018:

- Pathways training for Pathways CCAs
- Core Concepts Training on the Nuka system of care (facilitated by the Southcentral Foundation)
- Integrated Managed Care workgroup meetings with physical and behavioral health providers
- Regular ACH "office hour" calls and FAQ webinars, where partners can call in to get questions answered

August 2018:

- Large multiday convening of all approved partners, with breakout sessions to foster partner collaboration within initiatives and support implementation planning among partners
- Initiative-specific meetings (for Care Coordination, Care Transformation, Care Integration, and Capacity Building)
- Pathways training
- Tribal partners training

September 2018:

- Launch of Equity Learning Cohort (centered on equity in transformation project planning and implementation)

Expectations of Partners during 2018 Planning Phase

During the 2018 Planning Phase, all participating partners are expected to participate in all planning activities. In the North Sound ACH's first Call for Partners, released in May 2018, respondents were asked to sign a Memorandum of Participation (included in Attachment B) along with their completed application form affirming their commitment to the North Sound ACH's vision. In this Call for Partners, partnership was explained as follows: "When an organization partners with the North Sound ACH, it commits to aligning its work with our vision of improved health, a transformed health system, and improved health equity for our region. Partners also join us in showing our impact by completing planning, reporting, and implementation deliverables tied to our goals for our region. Partners that require supplemental funds to align their work with the North Sound ACH can receive funds for doing so." All applicants needed to meet the following five requirements, in addition to attesting to these statements in the Memorandum of Participation:

- Be committed to improving the health of the people who live in the North Sound region, starting with people on Medicaid
- Provide services currently in the North Sound region in at least one of the initiative areas
- Deliver care and/or services to at least one of the populations of focus
- Can demonstrate commitment to improving equity and reducing disparities
- Can dedicate/assign staff from to work on individual and regional implementation planning

Implementation Phase

Beginning in January 2019, the North Sound ACH will support partnering providers with implementing transformation projects (which will continue to be detailed between now and submission of the Implementation Plan on October 1, 2018). This will include technical assistance in clinical and nonclinical settings; trainings on strategies and evidence-based models; regular meetings of the Data and Learning Team as we begin to monitor and evaluate projects; and regular meetings of the Equity Learning cohort to ensure that equity is centered in project implementation. The North Sound ACH also expects regular individual engagement with partners to support them with implementation, and that partners will engage and find ways to partner with each other.

North Sound Community HUB Specific Partner Engagement

A Community HUB is to be developed and driven by the community. The success of a Community HUB relies on two main expectations being met by partnering providers:

- The partner's commitment to ongoing development of HUB strategic, implementation, and operational elements
- Organizational capacity to serve the HUB's population and to sustain this work after ACH funding launch

Each of these areas of partner expectations and North Sound's approach to them are addressed below:

- Expectation of CCAs within HUB Network: North Sound ACH has been proactive in communicating the CCA's role, responsibilities, and commitments in numerous ways.
 - Call for CCAs: After release of the 2018 Call for Partners, a supplemental application was added for interested CCAs (See Attachment C). This supplemental application contained a

detailed breakdown of the roles and responsibilities for a CCA within a HUB network; the responsibility of CCAs to participate in Advisory Council meetings where HUB strategy will be set; HUB data and analytics; and quality improvement projects (see Table 10 for list of HUB partnership bodies and areas of work).

- Informational Sessions: Two sessions were held to address questions, concerns, and provide more clarity on HUB.
- Core Team Meetings: In June 2018, the North Sound ACH hosted meetings with representatives from each of the 5 counties. Dr. Sarah Redding, co-developer of the Community Pathways HUB model, attended to outline the level of collaboration required between the agencies and CCAs and the HUB.
- CCA convenings: In August 2018, there will be a meeting devoted to the North Sound Community HUB to lay out contracting requirements and the bodies of work that are to be developed collaboratively among the HUB and its network of CCAs. It will be hosted by the Washington State Pathways Trainers, who have undergone training and practicum in the Pathways model, and who in turn will serve as the local experts in training the CCA staff at all ACH HUBs.

Table 10: North Sound Strategic Partners

Body	Purpose	Optimal Roster	Meeting frequency
Executive Committee	<ul style="list-style-type: none"> • High level direction setting • Policies and procedures • Development of timeline and considerations for phasing out ACH funding. • Development of forms that vary HUB population: Assessment checklists, intake forms, ROI/ consent 	CCA Leadership, important referral sources, community member representation, payers.	Monthly.
Advisory Group	<ul style="list-style-type: none"> • Lend content expertise to topics of concern. • Examine HUB Data and set direction on any QI initiatives that the HUB and its partners should undertake. 	Community partners, content experts for service population, Program managers (or CCA staff dedicated to QI, QA work).	bi-monthly.
Learning Cohorts	<ul style="list-style-type: none"> • Shared learning; discussion of successes and/ or challenges in Pathways workflow, more programmatic “nuts and bolts.” 	Staff level. CHWs, Care Coordinators, and their supervisors.	Ad-Hoc; based on training needs or topics requiring discussion.

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:

During the January to July 2018 reporting period, the North Sound ACH developed a plan to meaningfully engage partnering providers that are critical to success in transformation activities. This included mapping the implementation process and design opportunities for partners to be engaged during the planning process. The North Sound ACH paid special attention to what type of partners should be engaged and at

what points and identified appropriate engagement methods and opportunities for feedback and transparency, and we developed clear plans on how input will be incorporated. Ensuring that large health systems, primary care, and behavioral health entities were engaged was a critical part of the region's strategy. The North Sound ACH intends to build long-term relationships through meaningful engagement that will last beyond the Medicaid Transformation project.

Primary perceived barriers and our attempts to mitigate those barriers include:

- Local and county-based partners felt left out of the earlier steps of the process and were therefore reluctant to engage during this period. Individual meetings have been held with three of the region's five counties and community coalitions in each of the region's five counties.
- Tribal partners did not feel that the regional ACH, set up as a nonprofit corporation, was an appropriate entity to negotiate with sovereign nations. The North Sound ACH has hired a tribal liaison, who is assisting with relationship building and potential partner opportunities. We have had individual meetings with all of the tribes in the North Sound region, and three tribal organizations responded to our Call for Partners in May 2018.
- The North Sound ACH is also contracting with tribal partners to train the board, staff, and partners on tribal governance, protocols, and tribal sovereignty.
- We have been successful in reaching large health care provider organizations, but we still lack engagement with smaller and rural practices. We continue to contact those potential partners through county and practice associations. We believe this is critical to reaching providers in rural and remote areas of the five counties.
- For individuals with limited English language proficiency, we have first focused on the primary second language in the region, Spanish. The North Sound ACH has two staff members who speak Spanish, we have added a translation option to our website, and we are actively seeking community partners who reach diverse populations. The North Sound ACH has a community engagement liaison on staff who attends community coalitions across the region, including those that primarily serve communities of color and Spanish-speaking community members. We are currently seeking community partners who work in other limited English-speaking communities.

Partner engagement activities during the reporting period included:

- A series of partner convenings to provide feedback to North Sound ACH staff on Project Plan refinement and implementation plan development:
 - Former Workgroup Lead (March 2018)
 - Health Systems and Primary Care Leadership (March 2018)
 - Community-based Organization (May 2018)
 - Behavioral Health Providers related to Integrated Managed Care (March 2018)
 - Physical Health Providers related to Integrated Managed Care (June 2018)
 - Community Forums: focus on community members (those enrolled in Medicaid and those working with people on Medicaid) (June 2018)
 - Bimonthly Program Council meetings
- Ongoing informational calls or ad hoc meetings with the following partners and regional stakeholders to support partner engagement:
 - North Sound BHO
 - Local Health Jurisdictions
 - Upstream USA

- Providence Health and Services
 - PeaceHealth
 - Mount Baker Planned Parenthood
 - Planned Parenthood of the Great Northwest and Hawaiian Islands
 - Skagit Regional Health
 - Unity Care NW
 - Skagit Pediatrics
 - Healthier Washington Practice Transformation Support Hub
 - Pediatrics Transforming Clinical Practice Initiative (TCPI) Practice Transformation Network (PTN)
 - UW Medicine TCPI PTN
 - Arcora Foundation
 - Qualis Health
- When the May 2018 Call for Partners was released, it was shared broadly with our email list (contains close to 900 members); board members and work group partners were asked to share it broadly within their networks and associations.

Table 11 identifies other general barriers to participation for partners and what steps the ACH has taken to address those barriers:

Table 11: General Barriers to Participation	
Barrier	Steps taken to mitigate barriers
Limited provider capacity to attend meetings	<ul style="list-style-type: none"> ● Scheduling flexibility, including before workday or after-hours meetings ● Use email and short phone calls when meetings aren't possible
Travel barriers, especially for providers who would need to travel via ferry	<ul style="list-style-type: none"> ● The North Sound ACH has rotated locations for meetings including having meetings in San Juan and Island counties so that the burden is shared among the region ● Integration of remote options for almost all meetings, including video link if possible
Lack of knowledge about the ACH role and Medicaid Transformation Project objectives	<ul style="list-style-type: none"> ● General community education: share information online ● Provide "ACH 101" presentations at partner meetings ● Attend community coalitions and events to provide information about ACH activities ● Open meetings to broad, large audience to engage more partners (e.g., CBO convening) ● Collaborate with partners like the North Sound BHO to provide partner education on ACH activities and the Medicaid Transformation Project

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. How has the ACH identified, or plan to identify, the needs of Medicaid behavioral health providers?

ACH Response:

The ACH is participating in the Interlocal Leadership Structure and in partnership with the North Sound BHO to evaluate the current capacity and readiness of the BHAs in the region. XPIO Health has been contracted through the North Sound BHO to evaluate both the general readiness and the status of the BHA's HIE/HIT systems to determine readiness and needs. As part of the scope of work, XPIO Health will conduct a readiness evaluation to review and assess the current BHA EHR environment and how it is set up to support the BHA in terms of contract and cost, hardware, systems, network, and staff. The work plan will also include an assessment of existing EHR capacity and needs at BHAs, and how well the HIT infrastructure will support BHAs for the following:

- Moving into fully integrated managed care in 2019
- VBP models
- Integration and information exchange with other care partners
- Use of outcomes and analytics to drive improvements in care and/or operational efficiency
- Changes in state or other regulatory and contractual reporting
- Meaningful Use, MIPS/MACRA, or other federal programs as appropriate
- Maintaining compliance with HIPAA requirements (including disaster recovery and continuity of operations)
- BHA goals for growth or service delivery
- Mitigating risks of staff turnover
- Risk of information loss
- Ongoing support needs and if the current team supporting the environment is sufficient
- Other areas of need or concern based on our conversations with BHA

Based on outcomes from this assessment process, XPIO Health will also provide assistance to BHAs necessary for each of the items below to help them prepare for the transition to integrated managed care in 2019:

- Coding assistance to set up new practice management systems including templates and billing rules
- Implementation of new claims, encounter adjudication, and remittance processes, in accordance with managed care plan companion guides
- Testing of claims generation and remittance posting
- Review of managed care plan claims and remittance specifications and configuring of IT systems
- Generation of reports from new systems
- Training for administrative staff to submit HIPAA-compliant claims and encounters and to perform billing and reconciliation processes in new practice management systems in compliance with MCO requirements
- Modification to encounter generation processes to eliminate systemic recurring encounter errors and to include results received from TPL processing
- Creation or modification of procedures for service authorization, monitoring of batch file creation and submission, review of error files, correction and resubmission of rejected encounters, TPL billing, and eligibility verification, as needed

The information from XPIO Health's assessment and recommendations will be used by the Billing, Data, and Contract Support Interlocal Leadership Structure workgroup, in combination with information from the BHA participants in the workgroup, to develop a work plan for consideration by the Interlocal Leadership Structure.

The Interlocal Leadership Structure group has made and will continue to make recommendations to the ACH on the use of Mid-Adopter funds to support the changes needed by BHAs. Initial allocation of Mid-Adopter funds will support technical assistance to BHAs as they transition to billing MCOs directly, including the work of XPIO Health.

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.**

In the 2017 community engagement plan, submitted in the Project Plan Template, the North Sound ACH described community engagement as a circular process rather than a linear process, with seven objectives:

1. Develop and foster relationships with partners and stakeholders
2. Identify and implement community engagement activities
3. Community participation in governance and program oversight
4. Training, support, and accommodations
5. Public education and communication
6. Integration of community feedback
7. Periodic evaluation and improvement

Since January 2018, with the 2017 community engagement plan as a template, the North Sound ACH engaged the community in the activities listed in the Table 12 which follows. For each activity, it is noted in the table which of the above objective(s) it falls under.

Table 12: Community Engagement Activities for the Reporting Period

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Community Engagement Fellows Meeting	1/9/2018	1,2,	Community Engagement Fellows	All	Western Washington University	-New ideas and solutions for community engagement generated	N
Island County Community Resource Network	1/11/2018	1, 5	human service workers	All	Community collaboration held at the Island County Public Health Department	-Messages communicated -Increased understanding of community assets -Increased community knowledge of the North Sound ACH and Medicaid Transformation	N
Generations Forward: Integrated Health Care Action Team	1/31/2018	1	Medical providers, care coordinators, parents	2B, 3B	Collaborative Effort between Opportunity Council & the Whatcom County Health Department	-Messages communicated -Greater understanding of community assets -Increased community knowledge of the North Sound ACH	Y
Key informant interview	2/1/2018	2,6	Community Leadership Council (CLC) members, community	3A, 3C	North Sound ACH	-Knowledge of community needs and assets -New ideas and solutions for engagement planning -Feedback provided	N

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
North Sound BHO Advisory Board Pre-Meeting	2/6/2018	5	Advisory Board Members, community	2A, 2B, 3A	North Sound BHO	-Increased knowledge of transition to whole person behavioral health integration services	Y
Community Engagement Fellows/ACH/Generation Forward Coordinating	2/7/2018	1	ACH staff and community members	3B	North Sound ACH	-Greater understanding of community assets -Increased community knowledge of the North Sound ACH	N
Island County Community Resource Network	2/8/2018	1, 2, 5	Community-based organizations (CBOs)	All	N/A	-Messages communicated -Greater understanding of community assets -Increased community knowledge of the North Sound ACH	N
Key Informant on Island Co	2/8/2018	2, 3, 6	CLC members and community	All	North Sound ACH	-Knowledge of community needs and assets -New ideas and solutions for engagement planning -Feedback provided	Y

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Western Washington University student engagement opportunities	2/12/2018	1, 2,	Academia, Students enrolled in Medicaid	All	North Sound ACH	-Potential engagement opportunities for university students	N
Outreach and Marketing for Snohomish county CLC meeting	2/14/2018	1, 2,	Community members, Medicaid enrollees, community college students, FQHC staff, CBO staff	All	North Sound ACH	-Public attendance at the February CLC meeting	Y
North Sound ACH 101	2/14/2018	1, 5	Community members, tribal organization	All	North Sound ACH	-Messages communicated -Greater understanding of community assets -Increased community knowledge of the North Sound ACH	N

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Key Informant Interview	2/28/2018	3, 6	CLC members	2A, 3A	North Sound ACH	-Knowledge of community needs and assets -New ideas and solutions for engagement planning -Feedback provided	Y
Community Forum	2/28/2018	1, 2, 5	Community members in Granite Falls	2A, 3A	Sno-Isle Libraries	Mental Health first aid as a desired community training	N
Whatcom County Data Walk	2/28/2018	1	Community Members	All	Opportunity Council	Needs assessment released for public consumption	N
Key Informant Interview	2/28/2018	2, 6	CLC members and community members	All	North Sound ACH	Connections with CBOs that provide services to those on Medicaid	N
Generations Forward quarterly meeting	3/6/2018	1,	Generations forward community collaborative	2B, 3B	Community Collaborative	-Community collaboration on RMCH issues	Y
Key Informant Interview	3/7/2018	2, 6	North Sound ACH	All	North Sound ACH	-Knowledge of community needs and assets -New ideas and solutions for engagement planning -Qualitative feedback	Y

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
North Sound ACH 101	3/7/2018	1	CBOS and Island Senior Services	2B, 2C	North Sound ACH	Qualitative data on community needs and updates on local community paramedicine program	N
Island County Community Resource Network	3/8/2018	1, 2, 5	Human Service Workers in Island County	All	Community Collaborative	Presented updates and invited participants to hear more during our CBO convening on May 1	N
North Sound ACH 101 w/ Camano Health Dept	3/8/2018	1, 2, 5	Camano Island Public Health Department Staff	All	North Sound ACH	-Messages communicated -Greater understanding of community assets -Increased community knowledge of the North Sound ACH	N
South Whidbey Family Community Resource Center	3/15/2018	1, 2	Community members and CBOs in South Whidbey Island		North Sound ACH	-Knowledge of community needs and assets	N
1:1 North Sound ACH and Camano Island Public Health	3/16/2018	1, 5	Camano Island Public Health Department Staff	All	North Sound ACH	-Messages communicated -Greater understanding of community assets -Increased community knowledge of the North Sound ACH	N

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Stillaguamish Health Facility Grand Opening	3/20/2018	1	Providers and patients	3A	Stillaguamish Tribe	-Knowledge of community needs and assets	Y
2017 Skagit Low-Income Needs Assessment Data Release	3/27/2018	1, 6	Community	All	Skagit Community Action	-Knowledge of community needs and assets	N
Networking Meeting	3/28/2018	1, 2, 5	CBOs	All	N/A	-Knowledge of community needs and assets related to housing	N
Molina presentation to community-based organizations	3/28/2018	1,5	CBO & MCO	2B	San Juan County Public Health	-Collaboration between Molina's care coordination model, North Sound Community HUB, & local CBOs -Knowledge of local workforce capacity for CHWs	N
Coffee Hour w/ Community	4/6/2018	1, 2, 5	Latino community members	All	Hand in Hand	-Greater understanding of community needs -New ideas and solutions for engagement planning	Y

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Whatcom Dispute Resolution Center Equity Conversation	4/19/2018	1, 5	Community	All	Whatcom Dispute Resolution	-Knowledge of equity work happening in the region	Y
STEP UP: Moving Racial Equity Forward	4/20/2018	1,	Community	All	Snohomish Leadership	-Knowledge of equity work happening in the region -Knowledge of community needs and assets	N
YWCA Community Event	4/25/2018	1,5	Community	All	Snohomish YMCA	-Knowledge of equity work happening in the region -Knowledge of community needs and assets	Y
North Sound Regional Care Coordination Summit	4/27/2018	1,2,5	CBOs providing care coordination services	2B	Transforming Clinical Pediatrics Initiative	-Knowledge of care coordination services available in the north sound	Y
Communities of Color-North Sound Talk on Race	4/28/2018	1, 5	Community	All	Communities of Color Coalition	-North Sound ACH participation in communities of Color Coalition and the Health Justice committee -Knowledge of organizations in the region working on equity	Y

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Convening of Community-Based Organizations	5/1/2018	1,5,6	CBOs	All	North Sound ACH	-Messages communicated -Greater understanding of community assets -Increased community knowledge of the North Sound ACH	Y
Whatcom Prevention Coalition Meeting	5/3/2018	1,2,5	Community	2A, 3A	Whatcom Community & Families Network	-Knowledge around youth prevention activities in the region -Greater understanding of community assets	Y
Health Fair with Casino Road Coalition	5/5/2018	1,5	Community	All	Snohomish County Human Services	-Messages communicated -Greater understanding of community assets related to families and wellness -Increased community knowledge of the North Sound ACH	Y
Community Resource meeting (Friday Harbor)	5/30/2018	1,2,5,6	CBOs	2A, 3A	N/A	-Knowledge of behavioral health services available in the region	N

Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Community Forum-Whatcom	6/14/2018	1, 2,5,6	Community	All	North Sound ACH	-Increased community knowledge of Healthier WA initiatives -Increased community knowledge of the North Sound ACH -Understanding of community needs related to health and Medicaid	Y
Communities of Color Coalition (C3)	6/19/2018	1,5	Community	All	C3	-Knowledge of health inequities and disparities in the region -Greater understanding of community assets	N

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

ACH Response:

In the North Sound, there is slight variability in languages spoken compared to the overall population of Washington State. Using the Washington Tracking Network, the North Sound ACH identified the top languages spoken by Medicaid populations in the region: 89% of residents identify English as their primary language and 7% identify Spanish as their primary language (compared to 9% in Washington State). Only 2% of Medicaid enrollees in the North Sound region identify a language other than Spanish or English as a primary language. As part of our CSA, the North Sound ACH will utilize opportunity mapping to further identify limited English proficiency (LEP) Medicaid enrollees by geographic region. To date, the North Sound ACH has implemented the following activities to reach LEP populations in the region:

- Hired a community engagement coordinator fluent in Spanish
- Participated in outreach as part of the Latino Advisory Council
- Partnered with CBOs actively engaged in community outreach to Spanish-speaking populations
- Recruited and oriented a Community Leadership Council member from Siberia fluent in Russian, one of the other 2% languages in our region
- Integrated a translation tool on the North Sound ACH website
- Began the process of contracting with a communications firm to professionally translate North Sound ACH marketing materials

A specific question about partnering provider activities to reach LEP populations in the region will be asked in a July 2018 partner survey for those who submitted Part 1 of the North Sound ACH's Call for Partners application. Part 2 of the Call for Partners application (which will include the partner survey) will include an attestation of commitment to supporting LEP populations in partners' individual implementation plans.

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:

Challenges to engaging underrepresented community groups and strategies the North Sound ACH has undertaken or is currently undertaking are listed in Table 13 on the following page.

Table 13: Engagement Challenges

ACH Challenge	ACH Strategies to Address Challenge
Meaningful engagement of communities of color	Creating opportunities for leadership; for example, the chair of the Community Leadership Council (CLC) and board member of the North Sound ACH is a woman of color
	Joining the communities of color coalition of Snohomish County, reaching out to the NAACP in Snohomish County
	Learning successful strategies for engaging communities of color from across the nation via Equity Summit
	Attending Latino-led workshop on culturally responsive engagement during Step-up Snohomish: Moving Racial Equity Forward, a community training on equity and racial inclusion
	Attending North Sound Conference on Race with over 200 community members working on race, equity, and inclusion in the North Sound
Engagement of tribes	Collaborating with and learning culturally responsive engagement with Candice Wilson, North Sound ACH Tribal & Community Engagement Coordinator
CBO knowledge of North Sound ACH and the work on Medicaid Transformation	Conducting key Informant interviews with representatives of CBOs
	Presenting North Sound ACH 101 presentations/talks with key CBO staff
	Convening of CBOS on 5/1/2018, where information about the Medicaid Transformation Project was presented, and attendees had opportunities for discussion and to ask questions
Meaningful engagement with rural communities	Participated in Western Washington University Community Engagement Fellows, a collaboration of individuals from diverse organizations and backgrounds working on engagement work in rural communities
	Recruited and collaborated with CLC members from rural communities to advise on local engagement strategies
	Partnering with rural libraries in community engagement activities
Meaningful engagement of Medicaid Enrollees for the CLC	Rotating meeting schedule in 2018, one CLC meeting per county, providing transportation reimbursement, and offering child care
	Scheduled evening and daytime CLC meetings
	Consulted with Colorado-based organization that provides community

ACH Challenge	ACH Strategies to Address Challenge
	engagement for their MCOs
	Recruited members from advisory groups: housing, Developmental Disabilities Agency advisory groups, North Sound BHO advisory council, community members participating in county Community Health Improvement Plan workgroups
	Community learning sessions to level-set terminology related to ACH work and agenda, date, and time of public meetings for Medicaid enrollees

Partnering Providers: A specific question about partnering provider challenges and strategies for engagement of community groups that may be underrepresented in Transformation efforts in the region will be asked in a July 2018 partner survey for those who responded to the North Sound ACH’s Call for Partners application. The Partner Self-Assessment was released July 13, 2018, and further attestation of commitment to engaging underrepresented populations in partners’ individual implementation plans.

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:

Health Equity is central to the North Sound ACH’s approach to Medicaid Transformation Projects and is intricately tied to our overarching framework and commitment to targeted universalism. Below is an example of a decision the North Sound ACH and its partnering providers have made during the reporting period (January to June 2018) about project planning and implementation based on equity considerations.

Formal Partner Engagement

In May 2018, the North Sound ACH released its first Call for Partners, an invitation for partners to apply to participate in the 2018 planning process and receive funding for that participation. (See Attachment B 2018 Call for Partners). North Sound ACH leadership decided that to successfully apply, a potential partner needed to commit to aligning its work with the North Sound ACH vision of improved health, a transformed health system, and improved health equity for our region. Specifically, partners needed to sign an attestation demonstrating their commitment to health equity and addressing disparities, which included commitments to the following:

- Commitment to participate in shared learning on equity and disparities (e.g., an Equity Learning Cohort will be formed in fall 2018, and partners will be required to participate in trainings and other learning opportunities)
- Commitment to participate in shared learning about the tribes of the North Sound region

- Commitment to partner with upstream (social determinants of health) organizations and strategies to address underlying conditions that affect health and disparities.

These commitments will be worked into partners' individual implementation plans (change plans) so that partners can be held accountable and supported.

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:

During the Medicaid Transformation Project period, the North Sound ACH and its partnering providers will assess and prioritize community health equity issues in the North Sound region in the following ways:

- Form a regional equity coalition that will identify gaps in health equity knowledge and plan education opportunities to address gaps
- Continue to work with all five county health departments to review, analyze, and report on health disparities as new HCA data products are released
- Promote the use of targeted universalism as an operational and communication framework that ensures health equity is featured strongly throughout the lifespan of project planning and implementation. Please see page 8 for a brief description of targeted universalism.
- Collaboratively develop health equity measures for the regional implementation plan with experts from the Haas Institute at UC Berkeley
- Establish expectations of the 70+ potential partners to affirm their commitment to health equity by attesting to key activities with the Call for Partners application:
 - *My organization will participate in shared learning around equity and disparities.*
 - *My organization will participate in shared learning about the tribes of the North Sound region.*
 - *My organization is committed to partner with upstream (social determinants of health) organizations and strategies to address underlying conditions that impact health and disparities.*

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:

The North Sound ACH has taken the following steps to provide the North Sound ACH board, staff, and partnering providers with tools to address health equity:

Workshops/Trainings:

- In July 2017, Lummi Nation Councilmember and North Sound ACH Board Member Nickolaus Lewis presented to the board, staff members, and the public on tribal sovereignty, including history of treaties, federal trust responsibility, the Indian Health Service, health disparities in native communities, and a discussion of the eight regional tribal nations' relationship with the North Sound ACH.
- In October 2017, Ben Duncan, Chief Diversity & Equity Officer for Multnomah County in Oregon, presented a workshop entitled "Bridging Leadership and Equity: Purpose driven work for

Accountable Communities of Health.” This workshop was attended by project area workgroup participants (many of whom are now or will become partnering providers), board members, program council members, and staff. The agenda for this workshop was to 1) Explore definitions of equity, establishing a baseline for ongoing work and growth in this area; 2) Learn from Multnomah County’s journey toward developing the infrastructure for advancing equity in policy, program, and practice; 3) Discuss our organizational and collective purpose toward equity; 4) Identify areas of potential focus and prioritization for clinics and 5) Commit to action.

- In April 2018, nearly all North Sound ACH staff members (and multiple board members who attended independently) participated in the PolicyLink Equity Summit in Chicago to learn more about the equity movement, discuss ways to address health disparities in our communities, and build relationships with equity leaders (including [John A. Powell](#), Director of the Haas Institute for a Fair and Inclusive Society and the author of the targeted universalism model, who will be partnering with the North Sound ACH on our use of this model in summer and fall 2018.) Please see page 8 for a brief description of targeted universalism).

The North Sound ACH anticipates providing many additional health equity tools (such as trainings and formation of regional coalitions) to partnering providers, staff, and board members during the remainder of 2018 and into 2019. In addition, partnering providers will be required to participate in health equity-focused activities such as the Equity Learning Cohort, trainings on cultural humility, disparities in our region, and trainings on tribal governance and sovereignty.

The North Sound ACH will monitor partnering providers’ use of these and other health equity tools in the following ways:

- The North Sound ACH has committed to implementing targeted universalism in our strategy selection process. As an element of this approach, partners will describe in their individual implementation plans how selected strategies will serve populations of focus and reduce disparities of access, care delivery, and health outcomes across geographic and demographic categories. For a brief description of targeted universalism, please see page 8.
- As part of the ongoing monitoring and continuous improvement process, partners will report on their progress on meeting health equity goals including proxy measures of care gaps for populations of focus and reduction in health disparities across geographic and demographic categories, and they will report progress engaging and serving populations experiencing health disparities.

Budget and Funds Flow

1. Required Attachments

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:

Not Applicable

- 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:

North Sound ACH became an independent entity on February 1, 2017 and selected an auditing firm in spring 2018. The first audit will be of 2018 financials and will occur in spring 2019. The auditing firm, Larson Gross, is working with the North Sound ACH CFO to assure that our systems are being built out in a way to ensure that the audit goes smoothly.

The North Sound ACH contracts with an external accounting firm, Powell Business Solutions. Their principal, Cami Powell, acts as the organization’s CFO.

2. Design Funds

Tab G.2 of the Semi-Annual Report Workbook is completed.

3. DY 1 Earned Incentives

Tab G.3 of the Semi-Annual Report Workbook is completed.

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 fully integrated managed care. 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:

The North Sound ACH board of directors, in approving the 2018 Fund Allocation strategy, agreed that after funds are earned by the region they are considered all one fund, therefore not specifically earmarking any funds for specific purposes. The board also agreed to have the Interlocal Leadership Structure make recommendations to the executive director regarding expenditures that would support

BHAs preparing for integrated managed care billing and items that would align integrated managed care and Bi-Directional Integration of Behavioral and Physical Health.

The ACH is a participant of the Interlocal Leadership Structure and is working in partnership with the North Sound BHO to evaluate the current capacity and readiness of the behavioral health agencies in the region.

The North Sound BHO has contracted with XPIO Health to evaluate the general readiness and the status of the BHAs HIE/HIT systems to determine readiness and needs. XPIO has worked extensively in SW ACH region (early adopter) and North Central ACH (mid-adopter).

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:

As noted earlier, the Interlocal Leadership Structure is making recommendations to the ACH executive director related to needs of BHAs for preparedness for integrated managed care and bi-directional integration activities. The North Sound ACH Board, in approving the 2018 Fund Allocation Strategy, did not set a purpose for Integration Incentives. Instead, it requested the Interlocal Leadership Structure to make recommendations to the ACH related to priority needs.

The Call for Partners issued by the North Sound ACH in May 2018 requires partners to attest that they currently serve people enrolled in Medicaid and that they will continue to do so. Only partners who commit to serving people on Medicaid will be eligible to receive payment from the region's earnings. The North Sound BHO recommended to the BHAs they are currently contracted with to respond to the Call for Partners application, and many of these BHAs submitted applications for 2018. Those that did not apply in June 2018 will have an opportunity to be added in Fall 2018 as we shift to Implementation.

A brief summary of the 2018 Board Approved Fund Allocation Strategy is included as Attachment F.

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 items in this tab of the Workbook.

ATTACHMENT A: North Sound ACH Initiatives and Strategy Portfolio

North Sound ACH Initiatives and Strategy Portfolio

Initiative	Initiative Description	Initiative Project Areas	Initiative Strategy Objectives
Care Coordination	<p>The North Sound ACH will use or enhance existing services in the community to promote care coordination across the continuum of health, ensuring those with complex health needs are connected to the appropriate interventions and services needed to improve and manage their health. In addition, this initiative will develop linkages between care coordinators by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination practices, and promotes accountable outcome monitoring for beneficiaries being served.</p> <p>Strategies within the initiative will be designed and implemented to meet the needs of the region’s identified high-risk, high-needs target populations.</p> <p>Project Areas include:</p> <ul style="list-style-type: none"> • Community-Based Care Coordination (2B) • Transitional Care (2C) • Diversion Interventions (2D) 	2B, 2C, 2D	<ul style="list-style-type: none"> • Promote community-based care coordination by launching a Community HUB that will connect care coordinators who reach Medicaid enrollees. The Pathways model provides a starting point from which to pilot, scale and sustain community-based care coordination. (2B) • Improve community transition efforts by enhancing communication between emergency departments, hospitals discharge, behavioral health settings, law enforcement, courts, and jails. As well as using the North Sound Community HUB as a communication and coordination tool, strategies in this initiative will identify transitional gaps, initiate referral to community-based partners, and foster continued collaboration around populations experiencing high-needs. (2C) • Divert community members from avoidable emergency room visits by supporting cross-partner coalitions who are developing and implementing coordinated systems that promote care coordination for people with complex needs that intersect with health care, social service, criminal justice, and emergency systems; and promoting access to

Initiative	Initiative Description	Initiative Project Areas	Initiative Strategy Objectives
			appropriate non-emergency services through community-based programs. (2D)
Care Transformation	<p>The North Sound ACH will support implementation of prevention and health promotion strategies for targeted populations to prepare the region’s providers for outcomes-based reimbursement, population health strategies, and addressing health disparities and achieve health equity.</p> <p>Strategies within this initiative will require the full engagement of traditional and nontraditional providers.</p> <p>Partners implementing these strategies will be supported through training in evidence-based approaches and best practices, as well as workforce development, HIT/HIE tools to connect clinical and community settings, technical assistance and training for billing and reporting on transformational care services, and other investments to support sustainable activities in this initiative.</p> <p>Project areas include:</p> <ul style="list-style-type: none"> ● Addressing the Opioid Use Public Health Crisis (3A) ● Reproductive and Maternal/Child Health (3B) ● Access to Oral Health Services (3C) ● Chronic Disease Prevention and Control (3D) 	3A, 3B, 3C, 3D	<ul style="list-style-type: none"> ● The region will address the high rate of opioid use by supporting the implementation of the region’s Opioid Plan with its goals to reduce opioid-related morbidity and mortality, targeting prevention, treatment, overdose prevention, and recovery supports. (3A) ● The region will increase the number of people of reproductive age who have access to high quality reproductive health, support efforts that reduce unintended pregnancy, increase healthy planned pregnancies, strengthen and support young families, and promote early childhood health and well-being, setting the foundation for good health across the life course. (3B) ● The region will increase access to oral health services by addressing barriers to care due to lack of capacity and location of care. (3C-access) ● The region will support chronic disease prevention and control by integrating health system and evidenced-based community approaches to improve chronic disease prevention and management. (3D)

Initiative	Initiative Description	Initiative Project Areas	Initiative Strategy Objectives
Care Integration	<p>The North Sound ACH will support the integration of physical and behavioral health services through new care models, consistent with the state’s path to fully integrated managed care by January 2020. As a 2019 mid-adopter region, the ACH is working in partnership with the North Sound BHO to evaluate, assist, and support the local physical and behavioral health systems transition toward integrated care.</p> <p>Strategies within this initiative will focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes, and adoption of evidence-based standards of integrated care, such as co-location of providers and team-based approaches to care delivery that address physical, behavioral, and social barriers to improved outcomes for all populations with behavioral health needs.</p> <p>Partners will be supported in their integration activities through trainings in evidence-based models of integrated care, as well as ongoing practice coaching, learning collaboratives, population health management tools, and other clinical transformation supports.</p> <p>Project areas include:</p> <ul style="list-style-type: none"> • Bi-directional Integration of Care and Primary Care Transformation (2A) • Addressing the Opioid Use Public Health Crisis (3A) 	2A, integration specific activities for 3A, 3B, 3C, 3D	<ul style="list-style-type: none"> • The region will support the bi-directional integration of physical and behavioral health. Bi-directional integration of care has the potential to impact all Medicaid enrollees in the North Sound ACH by targeting the expansion of health services to two key demographics—enrollees with behavioral health needs currently using the primary care system, and people with serious mental illness currently using the North Sound BHO system of behavioral health care. (2A) • The region will address the capacity and protocols needed for bi-directional integration of care, by offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models. (2A) • The region will ensure bi-directional partners are prepared for MCO payment changes by assessing partner readiness for MCO billing and invest in billing support for MCO billing. (2A) • The region will support care integration efforts that support upstream strategies for chronic disease prevention, maternal and child health, and access to oral health services, and strategies to address the opioid epidemic through the full engagement of traditional and nontraditional providers. (Integration specific activities

Initiative	Initiative Description	Initiative Project Areas	Initiative Strategy Objectives
	<ul style="list-style-type: none"> • Reproductive and Maternal/Child Health (3B) • Access to Oral Health Services (3C) • Chronic Disease Prevention and Control (3D) 		for 3A, 3B, 3C, 3D)
Capacity Building	<p>The North Sound ACH will create appropriate health systems capacity in order to expand effective community-based-treatment models; reduce unnecessary use of intensive services and settings without impairing health outcomes; and support prevention through screening, early intervention, and population health management initiatives.</p> <p>The North Sound ACH will support state Medicaid transformation efforts that contribute meaningfully to moving the state forward on VBP. Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation.</p> <p>Strategies within this initiative will address the core health system capacities to be developed or enhanced to transition the delivery system according to Washington’s Medicaid Transformation.</p> <p>Project areas include:</p> <ul style="list-style-type: none"> • Financial Sustainability - VBP • Workforce • Systems for Population Health Management 	Domain 1	<ul style="list-style-type: none"> • The region will support the state’s VBP goals by distributing VBP readiness tools and resources, connecting providers to state VBP training and technical assistance. • The region will promote a health workforce that supports comprehensive, coordinated, and timely access to care by assessing workforce readiness, capacity and needs. • The region will leverage and expand infrastructure for systems of population health management by assessing system use and barriers, current status of HIT and HIE and the interoperability capacity for community-based, integrated care. • The region will expand opportunities for clinical and community-based organizations to build a diverse workforce with shared lived experience between health workers and patients, while promoting the value of this workforce in driving health equity. • The region will embed health equity as a foundational element in its transformation strategy, supporting partners to

Initiative	Initiative Description	Initiative Project Areas	Initiative Strategy Objectives
			<p>implement strategies that will reach populations experiencing disparities in outcomes and access to move toward reaching universal goals of health and well-being.</p>

ATTACHMENT B: North Sound ACH Call for Partners

A call for partners

2018 North Sound ACH Call for Partners: Medicaid Transformation Project Initiatives

The North Sound ACH is seeking clinical and non-clinical partners to improve health in the North Sound region, who are currently working in the North Sound region, in North Sound ACH Project Areas, and serving the North Sound ACH Populations of Focus.

This an open call – please share this packet with organizations in your community and networks who you feel meet the framework laid out in this Call for Partners.

The Application Packet

Please make sure to read all sections of this packet before submitting your application to the North Sound ACH, including:

- Entire narrative description of the Call for Partners
- Application, Part 1
- All Attachments
 - A. Initiatives and Populations of Focus
 - B. Getting Set Up with the Financial Executor Portal
 - C. Memorandum of Participation

Introduction

The North Sound Accountable Community of Health (North Sound ACH) is a nonprofit organization working with partners from multiple sectors in Island, San Juan, Skagit, Snohomish and Whatcom counties, and tribes, to transform systems that impact health. Launched in 2014, and one of the first ACHs recognized in Washington, North Sound ACH is governed by a Board of Directors who set the strategic direction for the organization.

The North Sound ACH is a partner in the statewide Healthier Washington initiative, which includes an agreement between Washington State and the federal government providing opportunities to support new and innovative approaches to transform health and community services that will: 1) build healthier communities through a collaborative regional approach; 2) integrate the physical and behavioral health payment and delivery system to foster focus on the whole person; and 3) prepare providers for contracts that pay for quality and outcomes rather than quantity. You can learn more about Healthier Washington at this link (<https://bit.ly/2xBa5M0>).

North Sound ACH is one of nine region-based ACHs in Washington. During 2017, each ACH was required to select project focus areas within which initiatives would be planned and implemented. To plan and carry out these projects, the ACH will establish partner agreements with regional and statewide partners, build upon their history and mission, and augment and leverage the great work already underway.

Current Opportunity for Partnership with North Sound ACH

Currently, we are looking for partners to join us in planning and implementing our Transformation Initiatives for our Populations of Focus (see Attachment A).

What does partnership mean?

When an organization partners with the North Sound ACH, it commits to aligning its work with our vision of improved health, a transformed health system, and improved health equity for our region. Partners also join us in showing our impact by completing planning, reporting, and implementation deliverables tied to our goals for our region. Partners that require supplemental funds to align their work with the North Sound ACH can receive funds for doing so.

If partners need funds, how do they earn them?

It is important that applicants understand that the Medicaid Transformation Project (and this Call for Partners) is **not a grant program**. Partners will earn revenue by completing deliverables tied to planning, reporting, and implementation. Please also note that the intent of the funds available through this 2018 Call for Partners is to provide partners with short-term funding to *supplement existing resources* for implementing health systems transformation activities that align with North Sound ACH's transformation initiatives. **The intent is not to build new programs. These funds are not renewable and are not to be considered sustaining funds.**

Additional Future opportunities

While we have targeted needs at specific times - such as this 2018 Call for Partners - the North Sound region can add new partners at any time, as the need arises. We expect to offer the following opportunities in the future:

- Contracts with organizations that will address IT infrastructure, workforce assessment and development, training on evidence-based models, and core infrastructure needs of clinical and nonclinical partners.
- Community-based care coordinators and Community Health Workers, which will have an additional Call for Partners later this month;
- Behavioral Health and Physical Health providers who are working toward Integrated Managed Care, and/or Bi-directional Integration should respond to this Call for Partners; you may also be contacted directly by either the North Sound ACH or the North Sound Behavioral Health Organization (BHO) to engage in the projects/initiatives during upcoming months.
- Regional collaboration, including leveraging community health assessments, workforce capacity, educational and other technical assessment services.
- 2019 partners to implement strategies laid out in the fall regional Implementation Plan.

Please go to our website (www.NorthSoundACH.org) and join the North Sound ACH newsletter mailing list so you are informed when these and other opportunities are announced.

Who Should Respond to this 2018 Call for Partners?

This Call for Partners is intended for organizations who share our vision of improved health, a transformed health system, and improved health equity for our region.

We know that in order to improve health, we need to also account for services that are not health care-specific, like care coordination, food, housing and transportation. So, in addition to clinical providers, we are looking for Community-Based Organizations who work with our Populations of Focus, intersect with the health care delivery system, and are willing to partner because they can see where their work impacts health. We are especially looking for partner organizations who serve communities of color, have diverse geographic and demographic reach, and represent residents who experience health disparities. This depth of knowledge and community will help us reach our objectives to improve health equity and take steps to eliminate disparities.

We know that there are many organizations that touch the lives of people on Medicaid. In this May 2018 Call for Partners, we are seeking public, private and tribal organizational partners who are currently engaged in work in our initiative areas *and* working with our initial populations of focus (see Attachment A). Potential partners include:

- Physical health providers, including primary care, emergency department, specialists in diabetes, heart disease and asthma and oral health services.
- Community-Based Organizations, especially those providing care coordination services, housing assistance, transportation, food and nutrition.
- Behavioral Health Practices, including those who provide mental health and substance use disorder services
- Counties who are providing direct services in alignment with Attachment A.
- Tribes or tribal organizations working in care integration, coordination or transformation activities as outlined in Attachment A.
- Long-Term Care Partners, working in care integration, coordination or transformation activities as outlined in Attachment A.
- First responders, especially EMS providers.

What are the requirements for partners?

All applicants must meet all of the following five requirements and will need to affirm those same commitments in the Memorandum of Participation.

- **Be committed to improving the health of the people who live in the North Sound region, starting with people on Medicaid.**
- **Provide services currently in the North Sound region, in at least one of the initiative areas.**
- **Deliver care and/or services to at least one of the populations of focus.**
- **Can demonstrate commitment to improving equity and reducing disparities.**
- **Can dedicate/assign staff from to work on individual and regional implementation planning.**

Our region has great assets, a strong history of collaboration among the five counties and eight tribes, and a deep commitment to improving the health of the people who live here. *These and other commitments required from applicants are included in the “Memorandum of Participation” page of the Application Packet.*

Two-Part Application Process

The North Sound ACH 2018 Application Process will be conducted in two parts. All potential partners to the North Sound ACH transformation initiatives must complete all steps in Part 1 and Part 2 of this process.

Important notes about the 2018 Partner Process:

- Completion of Part 1 does not guarantee payment for any subsequent steps, including Part 2.
- Part 1 must be returned by June 21, 2018.
- Only organizations who fully complete and submit Part 1 will be sent Part 2 of the Partner Process.
- Part 2 must be completed and submitted by September 1, 2018.

Part 1:

- 1) (May 2018 release) Completion of the Part 1 Partner Application, which includes questions about, at a minimum:
 - a. Initiatives that the organization commits to working on;
 - b. North Sound ACH Populations of Focus that the organization is working with;
 - c. Key personnel designated to the initiatives;
 - d. Workforce development needs related to initiatives;
 - e. Attestations that organization is not using multiple sources of Medicaid funds to support work for the ACH; and
 - f. Attestations that organization is committed to working with Medicaid enrollees.
- 2) Successful registration in the Financial Executor portal, which includes a 'click' Master Service Agreement. (see Attachment B – Getting Set Up With the Financial Executor Portal)
- 3) Signed Memorandum of Participation with the North Sound ACH, which includes agreement to share reporting data in the North Sound ACH reporting portal (See Attachment C – North Sound ACH 2018 Partner Application: Memorandum of Participation).

Part 1 Payment: For completion of all Part 1 deliverables there will be a stipend payment of up to \$40,000 to the partner organization, which will be paid through the Financial Executor portal.

Part 2: *Please note that only Applicants who successfully complete Part 1 of the Partner Process will be invited to complete Part 2 when it is released on or before July 6, 2018.*

- 1) Creation of an account in the North Sound ACH reporting portal (TBD).
- 2) Completion of the Part 2 Partner Self-Assessment, including and uploading responses into the reporting portal. Part 2 will include an assessment related to Health Information Exchange (HIE) and Health Information Technology (HIT) and will ask much more detailed questions about how your organization works with people on Medicaid, the data you collect, what initiatives you are currently supporting, your organization's capacity to participate in the initiatives, and workforce and infrastructure challenges you face.
- 3) Designation of key staff to work with North Sound ACH and other partnering providers to finalize the region's implementation plan and specific performance measures.
- 4) Concurrently with 3) above, designation of key staff to develop an organization-specific implementation plan in the reporting portal.
- 5) Signing of a Partner Contract with North Sound ACH that commits the partner to undertaking capacity building and readiness activities laid out in the regional and individual implementation plans.

Part 2 Payment: The payment in mid-fall 2018 will vary among partners who complete the Part 2 deliverables.

Payment factors will be further detailed in the Part 2 packet, including:

- Size, complexity of organization, with possible metrics to include:
 - Medicaid beneficiaries served ("lives")
 - Medicaid engagements (services rendered)
 - Workforce that will be engaged in implementation initiatives
- Number of initiatives that organization commits resources to
- Target populations that the organization commits to
- Services that reach rural/remote populations
- Organization's reach/commitment to underserved populations and/or those experiencing disparities

Important note on availability of funds:

The North Sound ACH has no guarantee of receiving earnings from the Medicaid Transformation Project. These are the funds to be shared under this Call for Partners with partnering organizations, therefore completion of the 2018 milestones does not guarantee any earnings to organizations beyond 2018.

Additionally, the North Sound ACH retains the authority to support none, some, or all of the initiatives described in this Call for Partners. There is no guarantee that all initiatives with all populations of focus will receive revenue from the North Sound ACH.

You can view the Project Plan that the North Sound ACH submitted in describing its approach to the Medicaid Transformation Project at this link (<https://bit.ly/2G5gGzl>). The detailed implementation plan is due on October 1, 2018, which we will develop jointly with partners who participate through this Call for Partners.

Timeline

To be considered during this first Call for Partners, applications and attachments must be received by 5:00 pm Thursday, June 21, 2018.

All applications - whether hard copy or electronic - should be directed to attention of Hillary Thomsen at the North Sound ACH.

By email: Hillary@NorthSoundACH.org

By mail:
North Sound ACH
PO Box 4256
Bellingham, WA 98227

In person:
North Sound ACH
1204 Railroad Avenue, Suite 200
Bellingham, WA

For additional questions, contact Hillary at 360-543-8858 or Hillary@NorthSoundACH.org.

NORTH SOUND ACH 2018 PARTNER APPLICATION: Part 1

Please provide the following information in the form below. Additional pages can be used if you need more space.

Organization Name:	EIN/Tax ID:
Organization Name Listed on W9:	
Physical Address:	
Mailing Address, if different:	
CEO/ED Name:	
CEO/ED Email:	Phone:
Application Completed by:	
Name:	Title:
Email:	Phone:

Counties Served by Your Organization: (check all that apply):

- Island San Juan Snohomish Skagit Whatcom
-

Select sectors that best describes your organization: (You can select more than one)

- Behavioral Health Primary Care Hospital/Health System
 Education Employment Emergency Medical Services
 Food/Nutrition Housing Public Health
 Social Services Transportation Tribal
 Other (please identify)
-

Select the best descriptive type for your organization: (you can select more than one)

- Medical Provider (Primary Care, Specialty, Hospital, or Emergency Department)
 Behavioral Health Provider (Substance Use Treatment and Mental Health Treatment)
 Tribal Health Clinic
 Tribal Behavioral Health
 Fire & Rescue with EMS
 Law Enforcement
 Education Organization
 Community Action Agency/Program
 County Public Health, Health or Human Services
 Area Agency on Aging
 Other Agencies (not otherwise described) _____

How many employees does your organization have in the North Sound region?

- 1 - 25 Employees
- 26 - 99 Employees
- 100 - 999 Employees
- 1000 or more Employees

Which North Sound ACH project area(s) is your organization prepared to work on (refer to Attachment A for more information about each project area before responding):

- | | |
|--|---|
| <input type="checkbox"/> Community Based Care Coordination | <input type="checkbox"/> Diversion Interventions |
| <input type="checkbox"/> Care Coordination During Care Transitions | <input type="checkbox"/> Chronic Disease Prevention and Management |
| <input type="checkbox"/> Reproductive/Maternal Child Health | <input type="checkbox"/> Access to Oral Health Services |
| <input type="checkbox"/> Addressing the Opioid Crisis | <input type="checkbox"/> Bi-Directional integration of Physical and Behavioral Health |

Does your organization provide care and/or services to people who are eligible for/enrolled in Medicaid (Apple Health)? Yes No

Does your organization track the Medicaid status of your patients or clients? Yes No

If yes, for the calendar year 2017, how many Medicaid enrollees (unduplicated) did your organization serve?

North Sound ACH will be facilitating trainings on evidence-Based Models for the initiatives. Some may be in-person while others will be web-based. Partnering providers must commit that staff will learn about models and best practices for any initiative area the organization commits to. How many employees does your organization anticipate taking part in trainings in each of the initiative areas below?

- | | |
|---|--|
| _____ Community Based Care Coordination | _____ Diversion Interventions |
| _____ Care Coordination During Care Transitions | _____ Chronic Disease Prevention and Management |
| _____ Reproductive/Maternal Child Health | _____ Access to Oral Health Services |
| _____ Addressing the Opioid Crisis | _____ Bi-Directional integration of Physical and Behavioral Health |

Does your organization enter data in WA's immunization registry (WAIS)? Yes No

Does your organization enter data in WA's Prescription Monitoring Program (PMP)? Yes No

Does your organization use an electronic health/service record (EHR)? (Check only one)

- Yes, all charts are electronic; no paper charts
- Yes, although we still have some paper charts
- No, but we plan to implement
- No, and we have no plan to implement

If Yes, what system does your organization use?

Does your organization allow patients/clients access to their records/charts? Yes No

Does your organization allow patients/clients access to narrative notes in their records/charts?

Yes No

What services does your organization currently provide to people on Medicaid? (select all that apply)

- Physical Health Services (Primary Care, Pediatrics, Inpatient Hospital services)
 - Emergency Department or EMS Diversion Interventions
 - Reproductive and Maternal Health Services
 - Behavioral Health Services (Mental Health or Substance Use services)
 - Substance Use Disorder Prevention, Overdose Prevention, Treatment and Recovery
 - Inpatient Mental Health Hospital and Facility Transitional Care Services
 - Dental Care and other Oral Health Services
 - Food Security & Nutrition Services
 - Housing & Homelessness Services
 - Transportation Services
 - Care Coordination with external services/organizations (beyond your own organization)
 - Law Enforcement or Jail Diversion Interventions
 - Jail and Incarceration Transition Services
 - Pharmacy Services
 - Community-based Chronic Disease Prevention & Management (i.e., diabetes, heart disease, asthma)
-

Identify populations that your organization serves (check all that apply):

- Chronic and/or high system utilizers (medical, law enforcement and/or social services)
- At-risk and/or experiencing homelessness
- Experiencing serious mental illness
- At-risk and/or previously arrested and/or incarcerated
- At-risk, misusing, using and/or abusing opioids
- At-risk and/or experiencing Adverse Childhood Experiences, Abuse and/or Trauma
- At-risk and/or experiencing co-occurring disorders/conditions (MI/SUD/Chronic Conditions)
- At risk and/or experiencing disparities in access and utilization of health services
- At risk and/or experiencing health outcome disparities
- Women (15-44 year) with high-risk or unintended pregnancy

Does your organization currently have an internal practice transformation, quality improvement, or population health management team that supports transformation activities through data and coaching? Yes No

If yes, identify key personnel for these activities _____

Is your organization willing to measure and assess progress and continuously improve processes?
 Yes No

Is your organization able to participate in an online reporting system that may require the upload or submission of data and information related to transformation efforts?
 Yes No

Does your organization include patients and/or clients in:

_____ Governance (please describe)

_____ Operations (please describe)

_____ Decision making (please describe)

Does your organization have the current capacity to implement significant change(s) (e.g., will it compete with other major changes currently being instituted in your organization)?

_____ Yes, we have the capacity currently to transform because:

_____ No, we do not have the capacity currently to transform because:

Organization's Authorized Signer:

I attest that I, the undersigned, have the authority to sign on behalf of my organization, and that the responses provided above are accurate and understand that by submitting the completed Application I am agreeing to the criteria laid out for participation in the 2018 Implementation Planning phase of the Medicaid Transformation Project with the North Sound ACH.

Name (Printed): _____ Title: _____

Signature: _____ Date: _____

Attachment B: Getting Set Up with the Financial Executor Portal

The Washington Health Care Authority has contracted with Public Consulting Group (PCG) to serve as the statewide financial executor for the Medicaid Transformation Project. PCG has created a web-portal for partner organizations where payments will be issued from.

While the North Sound ACH does not manage this portal, we can help get the process started by doing the initial registration of your organization. Subsequent steps will occur by email between your organization and the Financial Executor.

To ensure that the email is sent to the correct person, we need the information requested below. We will use this information to set up your initial account in PCG's Financial Executor web portal.

Once the initial account is set up with PCG, which includes a process of verifying your tax ID number with the IRS, your designated point of contact will receive an email to complete your organization's registration in the portal. To complete the registration process, you will need to provide:

- Bank account information, if your organization wishes to receive payments by direct deposit.
- Payee information and address, if your organization wishes to receive payments by physical check.

If you are registered with the portal through work with another Accountable Community of Health (ACH), you will **not** be asked to register twice or have multiple accounts; PCG will track payments issued under different ACH projects. To get started, please identify:

1) **Public, private or tribal organization name:** _____

CRITICAL: Please enter official business name as recognized by the Internal Revenue Service.

2) **Employer Identification Number:** _____

You may know this as your EIN, TIN or FEIN.

3) Point of Contact: (this person must be someone who has the authority to respond to "click" agreements on the Financial Executor portal)

First Name: _____ **Last Name:** _____

Email Address: _____ **Phone Number:** _____

If you have questions, please contact Hillary Thomsen, at (360) 543-8858.

You may return this form by:

- 1) Attachment to an email to Hillary@NorthSoundACH.org;
- 2) FAX (360-933-3653); or
- 3) Via physical mail to:

North Sound ACH
PO Box 4256
Bellingham, WA 98227

Attachment C: North Sound ACH Memorandum of Participation

Please read, complete and sign this Memorandum, and return it with the Completed Application Form. This agreement is in addition to any and all requirements outlined in the Master Service Agreement that partners must agree to in registering in the Financial Executor’s portal.

An organization that partners with the North Sound ACH commits to align its work with our vision of improved health, a transformed health system, and improved health equity for our region. In signing this Memorandum of Participation organizations commit to complete planning, reporting, and implementation deliverables tied to the goals for our region. Please initial by each statement below, signifying commitment and understanding of the partner expectations.

In applying to be a partnering organization with the North Sound ACH, my organization is agreeing to the following

- My organization is not using funds through this initiative to supplant other Medicaid funds.
- My organization is committed to serving people on Medicaid in the North Sound region, providing the highest quality care and services.
- My organization is committed to partnering with other clinical and nonclinical organizations in the North Sound region to advance the Medicaid Transformation Project goals.
- We will identify staff from our organization to take part in regional implementation planning with the North Sound ACH.
- We will identify staff from our organization to develop our own individual implementation plan.
- My organization will participate in shared learning around equity and disparities.
- My organization will participate in shared learning about the tribes of the North Sound region.
- My organization will enter into data share agreements with the ACH, to the extent that is allowable under HIPAA or other laws or regulations.
- My organization will measure and assess progress to continually improve internal processes.
- My organization will report required information into an ACH-selected reporting portal.
- My organization will adapt current its practices to incorporate process and quality improvement.
- My organization is committed to partner with upstream (social determinants of health) organizations and strategies to address underlying conditions that impact health and disparities.

Organization’s Authorized Signer:

I attest that I, the undersigned, have the authority to sign on behalf of my organization, and that the responses provided above are accurate and understand that by submitting the completed Application I am agreeing to the criteria laid out for participation in the 2018 Implementation Planning phase of the Medicaid Transformation Project with the North Sound ACH.

Name (Printed): _____ Title: _____

Signature: _____ Date: _____

ATTACHMENT C: Supplemental Call for Care Coordinating Agencies (CCAs)

A call for partners

2018 North Sound ACH Call for Partners

Supplemental Application for Community-Based Care Coordination Agencies (CCA)

North Sound ACH is seeking partners who are currently providing care coordination service in the North Sound region to the populations of focus described within this document, and that would like to serve as a Care Coordination Agency within a Pathways HUB model.

Introduction

The North Sound Accountable Community of Health (North Sound ACH) is a nonprofit organization working with partners from multiple sectors in Island, San Juan, Skagit, Snohomish and Whatcom counties, and tribes, to transform systems that impact health. Launched in 2014, and one of the first ACHs recognized in Washington, North Sound ACH is governed by a Board of Directors who set the strategic direction for the organization.

The North Sound ACH is a partner in the statewide Healthier Washington initiative, which includes an agreement between Washington State and the federal government providing opportunities to support new and innovative approaches to transform health and community services that will: 1) build healthier communities through a collaborative regional approach; 2) integrate the physical and behavioral health payment and delivery system to foster focus on the whole person; and 3) prepare providers for contracts that pay for quality and outcomes rather than quantity. You can learn more about Healthier Washington at this link: (<https://bit.ly/2xBa5M0>).

North Sound ACH is one of nine region-based ACHs in Washington. As part of the region's commitment to advancing community-based care coordination, we are launching a Community Care Coordination Hub applying the Pathways model to make care coordination more efficient and focused on outcomes. We are looking for agencies interested in joining a network of Care Coordination Agencies (CCA) devoted to linking our initial populations to necessary clinical and social services and resources.

NOTE: This application is supplemental to the [North Sound ACH Call for Partners](#). Any agency that is interested in becoming a Pathways Care Coordination Agency will **also need to complete the North Sound ACH Call for Partners**.

Initial Population of Focus

The initial population of focus for the Community Hub will be individuals with co-occurring behavioral health and physical health conditions. Specifically, this population will be individuals that have a mental health condition **and** substance use disorder (SUD) **with either** one chronic illness **OR** are of childbearing age. Individuals must **also** be illustrating one of the following additional risk factors: high utilization of care across systems (including EMS and criminal justice), homelessness, or failed attempts linking to other social services.

Depending on responses to this call for CCA partners, the exact pilot population might be a narrower subset of this population including additional segmentation based on (for example) county or specific region.

The startup phase will be small and focused to insure we're learning crucial lessons early on and optimizing HUB operations prior to expanding to include additional populations. Recognizing that there are multiple populations in the North Sound ACH region that could benefit from a Community HUB, we encourage you to view this population of focus as a starting point, and to remain engaged as the HUB scales up to incorporate additional populations over time.

See additional information on the initial population of focus in Appendix B.

Who Should Respond to this Call for Care Coordination Agencies?

Organizations eligible to become a Care Coordination Agency are those which provide some form of care coordination services for Medicaid beneficiaries within the North Sound region. Successful partners will have a trusted presence within the community and are already working with the initial service population in some capacity. These agencies might already utilize community-based care coordinators, community health workers, or outreach workers to connect individuals within the pilot population to social or clinical services (additional care coordinator description below). Agency types might include:

- ❖ Community-based organizations
- ❖ Behavioral Health organizations
- ❖ First responders or EMS agencies
- ❖ County resource agencies
- ❖ Federally Qualified Health Centers (FQHC)
- ❖ Health Home Care Coordinating Agencies

A Community-Based Care Coordinator under the HUB model are those who serve as community care coordinators, including community health workers, social workers, nurses, and case managers. By definition, these individuals spend the majority of their time meeting face-to-face with clients in the community or their home.

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If your organization is not currently providing care coordination services, there are still ways to partner with the HUB outside of becoming a CCA. If you do not think your agency meets the requirements to be a CCA, we will be identifying agencies and individuals during the summer who might best assist the HUB in the following capacities:

- ❖ **Referral Partners:** The HUB network relies on agencies that serve as primary referral sources. Referral partners are agencies that interact with the HUB population of focus and are seeking appropriate resources to help individuals remove barriers that may be keeping them from optimal health.
- ❖ **HUB Advisory Council:** The HUB will form an Advisory Council that will be made up of members who reflect the community and the North Sound region. This group will inform the direction of the HUB through data analysis, policy development and strategic guidance. Contracted CCA partners, additional community partners and referral sources will be invited to participate on the HUB Advisory Council.
- ❖ **Service Provider:** Any organization that provides services which will help a HUB care coordinator complete a Pathway on behalf of a care coordination client. Build out of our referral and provider networks will be an ongoing process throughout the life of the HUB.

Primary Roles of the Care Coordination Agency and the HUB

The Care Coordination Agency will:

- ❖ Use community health workers or community care coordinators who have been trained in the Pathways Community HUB model and its electronic platform;
- ❖ Identify unserved and underserved individuals within the initial focus population and enroll them through the HUB;
- ❖ Track services to clients using one of twenty Pathways to document progress and outcomes in the HUB's electronic platform;
- ❖ Work collaboratively with HUB Advisory Council members to identify community needs, inform HUB initiatives, and evaluate initiative results;
- ❖ Support community health workers and care coordinators through:
 - Attendance at required care coordination training sessions hosted by the HUB.
 - Supervision of care coordinators and community health workers, in order to achieve a high standard of care for its clients and high quality of service.
- ❖ Work collaboratively with other HUB CCAs and direct service providers around quality improvement activities.

The HUB will:

- ❖ Refer clients to an appropriate care coordination agency;
- ❖ Offer training to CCA care coordinators in the Pathways Community HUB model and software;
- ❖ Develop referral network(s) with providers, clinics, hospitals, and government, as appropriate, to increase the community members served and reached;

NOTE: This application is supplemental to the [North Sound ACH Call for Partners](#). Any agency that is interested in becoming a Pathways Care Coordination Agency will **also need to complete the North Sound ACH Call for Partners**.

- ❖ Provide quality supervision, data processing, reporting, invoicing, and collection services to the care coordination agency;
- ❖ Support the CCA in performing quality improvement and quality assurance activities;
- ❖ Communicate and report HUB initiative results and achievements to the HUB advisory board, contracted payers and the community.

Payments

The goal of the HUB is to develop contracts with health plans and other funders to support the CCA network, with the HUB acting in a consolidating intermediary role (negotiating contracts and invoicing payers) and in turn paying CCAs.

The North Sound ACH recognizes that becoming a Pathways CCA requires an organization to devote time and resources to development of new workflows, policies, and staff training. North Sound ACH will be supporting all CCA development (start-up) costs for much of the first year while simultaneously leading the effort towards long term HUB sustainability through MCOs and other funding sources. Startup costs covered by the HUB will include Pathways training for CCA staff, as well as reimbursement for CCA staff time dedicated to buildout of Pathways related policies or procedures.

Timeline and How to Apply

If you are interested in becoming a Pathways Care Coordination Agency, please read the following steps to apply. **To be considered during this pilot phase of the Community HUB, applications and attachments must be received by 5:00 pm on June 21, 2018.**

- ❖ **Step One:** Fill out the [North Sound ACH Call for Partners](#).
- ❖ **Step Two:** Review this supplemental packet, including the frequently asked questions and the timeline of population selection.
- ❖ **Step Three:** Fill out the application questions on the next page in a separate document. The total page limit for applications is 6 pages.
- ❖ **Step Four:** Submit (see below).

All applications - whether hard copy or electronic - should be directed to attention of Hillary Thomsen at the North Sound ACH.

By email: Hillary@NorthSoundACH.org

By mail:

PO Box 4256
Bellingham, WA 98227

In person:

1204 Railroad Avenue, Suite 200
Bellingham, WA

For additional questions, contact Hillary at (360) 543-8858 or Hillary@NorthSoundACH.org.

NOTE: This application is supplemental to the [North Sound ACH Call for Partners](#). Any agency that is interested in becoming a Pathways Care Coordination Agency will **also need to complete the North Sound ACH Call for Partners**.

Application Questions

These questions are meant to be completed in a separate narrative file. Please copy the questions and respond to them in full and submit that file in MS Word or PDF format.

Agency Specific Questions

- ❖ **How are you serving the initial pilot population (in any capacity) including via partnership?**
 - Mental Health and Substance Use Disorder population - (describe)
 - Chronic Disease OR women of childbearing age population?

- ❖ Do you provide in-home or community-based services, including assessment? Yes No
 - If yes, please describe.
 - In no, would you consider adding this?

Does your agency have experience working with or receiving referrals from:

- ❖ Emergency Departments (and other medical providers) Yes No
 - If yes, please describe.

- ❖ EMS (Emergency Medical Services) Yes No
 - If yes, please describe.

- ❖ Policy Yes No
 - If yes, please describe.

- ❖ Courts Yes No
 - If yes, please describe.

- ❖ Jails/Prison Yes No
 - If yes, please describe.

- ❖ County Resource Centers Yes No
 - If yes, please describe.

- ❖ Schools Yes No
 - If yes, please describe.

NOTE: This application is supplemental to the [North Sound ACH Call for Partners](#). Any agency that is interested in becoming a Pathways Care Coordination Agency will **also need to complete the North Sound ACH Call for Partners**.

- ❖ Churches Yes No
 - If yes, please describe.
- ❖ Housing providers Yes No
 - If yes, please describe.
- ❖ 211 Yes No
 - If yes, please describe.
- ❖ Crisis Centers Yes No
 - If yes, please describe.
- ❖ Other? Yes No
 - If yes, please describe.
- ❖ What relationships do you have with organizations similar to yours in other communities or regions outside your direct service area?
- ❖ Do you employ, contract with, or are you in the process of hiring community health workers (CHWs)? Yes No
 - If yes, please describe.

Capacity and Readiness Questions

- ❖ Describe your organization's data infrastructure.
- ❖ Describe your organization's data sharing capabilities.
- ❖ Is your organization willing to take part in an outcome-based model of care coordination, with care coordinator supervision requirements?
- ❖ Identify revenue/funding sources that your organization has to pay for care coordination or outreach today.
- ❖ Identify anticipated revenue/funding sources that your organization may use in the future to pay for care coordination or outreach as the HUB expands (i.e., capacity building capabilities, hiring additional staff).
- ❖ Describe the academic, professional or lay experience of staff providing care coordination services at your agency.

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- ❖ Are you prepared to dedicate time of a staff member to supervision of a Pathways HUB care coordinator?

Awareness of the Pathways Community HUB Model

- ❖ Have you received education or attended information sessions on the Pathways Community HUB model?
- ❖ Do you see your agency fitting into the model? Please describe.
- ❖ The Pathways Community HUB model requires CCAs to enter data into a separate data system for the HUB. What are your concerns or challenges with this?

NOTE: This application is supplemental to the [North Sound ACH Call for Partners](#). Any agency that is interested in becoming a Pathways Care Coordination Agency will **also need to complete the North Sound ACH Call for Partners**.

Appendix A: Frequently Asked Questions Regarding Pathways Community HUB and Care Coordination Agency Partnership

Q: How would this model be different from others currently underway (Health Homes, or other case management care coordination services offered via various providers and health plans)?

A: “Three fundamental business model problems exist with the current approach to care coordination— lack of meaningful work products, duplication of effort, and failure to focus on those most at risk. The fragmentation and duplication of services and poor outcomes resulting from poor care coordination increase health care costs.¹”

- *Outcomes as Work Products: Whereas typical care coordination models center on **completion of actions or work products**, Pathways is centered on **completion of outcomes** that will directly mitigate an individual’s risks to health. The Pathways Community HUB model is also designed to create direct reimbursement channels between care coordinating agencies and the outcomes they produce with their clients.*
- *Reducing Duplication of Effort: Pathways empowers clients to identify the care coordinator with whom they have developed a trusted relationship, who is then authorized to work across service and funding silos to coordinate care in a comprehensive way. This direct link of payment to outcomes further incentivizes care coordination services to communicate or collaborate with each other, leading to less duplication and inefficiencies.*
- *Focus on Multiple Risks: When a client is referred to the HUB, an initial assessment of risk areas is done across the 20 Pathways, which encompass the many life domains that determine a person’s health status. The centralized infrastructure of the HUB model also allows for identification of care breakdowns and resource gaps, and coordinated quality improvement or advocacy efforts to address such gaps.*
- *Regarding Health Homes, this care coordination model pays on a contracted per-member-per-month basis for clients contacted during the month, and the payment rate requires a caseload of 50-55 clients for providers to break even. The incentive is to limit contact for some clients in order to manage a higher intensity of service for other clients. Under Pathways, rates are negotiated with plans on the basis of cost to achieve outcomes, and can be stratified based on intensity of need.*

¹ <https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf>

NOTE: This application is supplemental to the [North Sound ACH Call for Partners](#). Any agency that is interested in becoming a Pathways Care Coordination Agency will **also need to complete the North Sound ACH Call for Partners**.

Q: What if my agency provides care coordination, but it is not our main service?

A: Organizations eligible to become a Care Coordination Agency are providing some form of care coordination services for Medicaid beneficiaries within the North Sound region. Additionally, it is important to think of this work as not just the HUB + CCAs. The needs of the HUB’s population will require varying degrees of partnership within many different sectors and non-typical referral sources. If your agency does not seem to be a good fit for becoming a Care Coordination Agency, the HUB model allows for other partnership opportunities such as:

- ❖ **Referral Partners:** The HUB network will rely on a group of agencies that serve as primary referral sources. Referral partners are agencies that interact with the HUB’s population of focus, and are seeking appropriate resources to help these individuals remove social barriers that may be keeping them from optimal health.

- ❖ **HUB Advisory Council:** The HUB will form an Advisory Council that will be made up of members who reflect the community and the North Sound region. This group will inform the direction of the HUB through data analysis, policy development and strategic guidance. Contracted CCA partners, additional community partners and referral sources will be invited to participate on the HUB Advisory Council.

Q: What is expected of the CCA in charge of employing a care coordinator?

A: The CCA will designate the staff person to be trained in the Pathways Community HUB model and electronic platform. This training will be provided at no cost to the CCA for the HUB pilot phase. Existing staff of CCAs are candidates to be designated and trained as care coordinators. The HUB model creates the potential for additional sources of reimbursement or funding for the work of existing care coordinators, as well as additional funds for adding care coordinator staff capacity as the HUB network of referrals is developed.

Q: What is the distinction between the eligibility criteria and the application of Pathways? For example, if a risk area is homelessness, are we then only working with clients to address homelessness?

A: The eligibility criteria is defining our initial population for the pilot. Once a client meets eligibility, a care coordinator can and should work through any of the Pathways that are creating barriers to health for the client. When reading the eligibility criteria, we recommend that you ask yourself: “Does my agency see a sizable number of folks with these conditions?” Even if this is not your primary service population, it might be possible that the population is presenting within your system and could therefore be brought into the HUB to work on any of their risk areas.

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Q: What does CCA capacity mean?

A: While the HUB will financially support Care Coordination Agencies in startup funding related to training, staffing, and development of work procedures, it is important that a CCA has other funding and/or funding strategies in mind for sustaining their involvement in the HUB network. The Pathways provide a tool for outcome-based payment directly to a CCA, and the HUB will lead all network sustainability work from the point of contracts with various payer sources for the creation of a robust braided funding model for the HUB. But it is important that the HUB is not viewed as the long term financial backer of the Care Coordination Agency.

Q: What are some of the reimbursement structures that this would entail? I'm concerned about the ROI for my agency and/ or staff to be involved.

A: Many agencies and their staff are already doing the work involved in Pathways, without a strong reimbursement model. As community-based organizations are called upon to tackle an increasing number of risk areas with their clients/patients, the HUB, and completion of Pathways, provides the opportunity to link mitigation of those risks directly to compensation from Medicaid payers and others. The Pathways Community HUB model is designed to be a lean overlay to current care coordination structures, and does not represent a large additional layer to the existing system.

The Medicaid Transformation funding available through the North Sound ACH provides a funding bridge that will allow CCA's to evaluate the future ROI of Pathways-driven care coordination.

Q: Why would Medicaid payers be motivated to contract/ pay for this when they all have other care coordination efforts or programs underway?

A: Pathways populations of focus are being selected based on data that identifies which populations are experiencing poor health outcomes, as well as qualitative feedback from key informants, community-based organizations, clinical providers, and payers serving the region. The pilot population will be one that has been identified by MCOs as one they would support expansion of additional services to. The Pathways HUB model is also based on the idea of leveraging and better coordinating the work of any agency, program or initiatives already providing care coordination services. With MCO leaders at the table in our HUB startup conversations, we are best able to identify those opportunities around overlapping care coordination efforts.

Q: What does it mean if the pilot population is not one my organization currently works with or provides services for?

A: The current best practice in HUB startup requires starting with a small focused population both demographically and geographically, then expanding out and scaling up once the HUB is operational and has worked out some operational and referral issues. If your population of service is not the pilot population we still very much need you as a partner to remain engaged and provide us important

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insight into continued areas of need. Recognizing that there are many different populations in the North Sound ACH region that could benefit from a Pathways Community HUB, we want to scope the startup in a way that is manageable to insure we're learning crucial lessons early on and optimizing HUB operations prior to bringing in additional populations.

NOTE: This application is supplemental to the [North Sound ACH Call for Partners](#). Any agency that is interested in becoming a Pathways Care Coordination Agency will **also need to complete the North Sound ACH Call for Partners**.

Appendix B: Getting to Pilot Population- Selection Process and Approach

Starting Point: Initial Considerations

Best Practice in Pilot Target Population Selection as Identified in the Agency For Healthcare Quality, *Pathways Community HUB Model*:

- ❖ Baseline data exists for the targeted population.
- ❖ Payers have expressed interest in this population and would consider paying for Pathways outcomes.
- ❖ Existing CCAs in the community or region have the capacity to serve this population.
- ❖ The HUB and CCAs have staff who can provide culturally and linguistically proficient services to the targeted population.

Additional Considerations:

- ❖ Desired initial pilot size of 250-600 patients.
- ❖ Qualitative validation that the population has unmet service needs.
- ❖ Diagnosis(es) that touch Pay for Reporting (P4R) metrics in Medicaid Transformation Project.
- ❖ Payor support and availability of additional funding sources for sustainability.

Key Stages in North Sound ACH Pathways Population Selection Process

- ❖ **Stage One: January - November, 2017: Information gathering for North Sound ACH Project Plan submission.**
 - Identification of ACH Project Plan partners and key informants.
 - Convening of regional stakeholders via topic specific workgroups, the North Sound ACH Program Council, and partner convenings.
 - Initial scan of relevant data sources illustrating health outcomes and disparities across various geographic and demographic elements.
 - Submission of [North Sound ACH final project plan](#), with high level identification of Pathways population selection criteria.
- ❖ **Stage Two: January - April, 2018: Pathways Specific Environmental Scanning**
 - Environmental scan and key informant interviews to build understanding of care coordination activities and populations served across North Sound region. Interviews include:
 - County Resource Centers in Island and San Juan Counties
 - Home Health Care Coordination Organizations
 - The North Sound Behavioral Health Organization

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- Community Based Organizations: Opportunity Council, Compass Health, Planned Parenthood.
 - North Sound ACH Leadership: Program Council
 - Medicaid Managed Care Plans
 - High Utilizer Group initiatives serving Skagit, Snohomish, Whatcom Counties.
 - Additional interviews ongoing.
- Partner convenings with opportunity to discuss populations of interest: such as the North Sound ACH Program Council, the North Sound ACH Convening of Community-Based Organizations.
 - Consultation, engagement, and strategic development input of state and national partners in Pathways HUB launch.

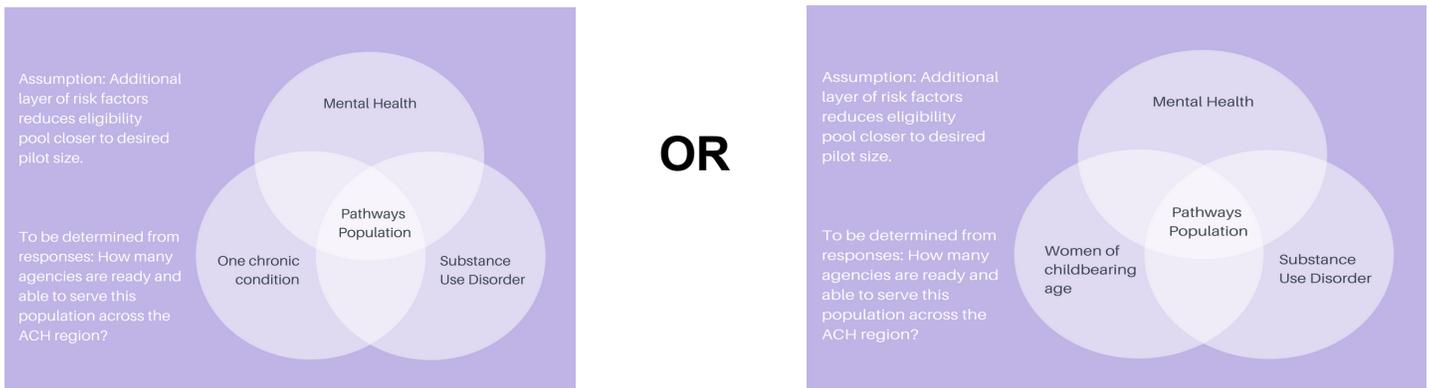
❖ **Stage Three: May 2018 until now**

- Consultation with [Foundation for Healthy Generations](#) in application of best practice to narrow scope of pilot populations.
- Development of criteria for Pathways care coordination agencies, including partner readiness assessment questions.
- Validation of which populations ring true for MCO payers (MCO Leadership meeting: May 10, 2018), North Sound ACH Program Council (Program Council meeting: May 17, 2018), and community-based organizations (CBO Convening: May 1 2018).

❖ **Stage Four: Final Decision points**

- Start with an anchor population, then apply additional layers of segmentation to get to manageable pilot population scope.
- The incoming CCA applications will help us refine our population, with final pilot population being determined by the service scope and geographic reach of those agencies that apply.
- The applicant’s readiness and capacity questions can be utilized to further refine eligible CCAs.
- Visual representation below.

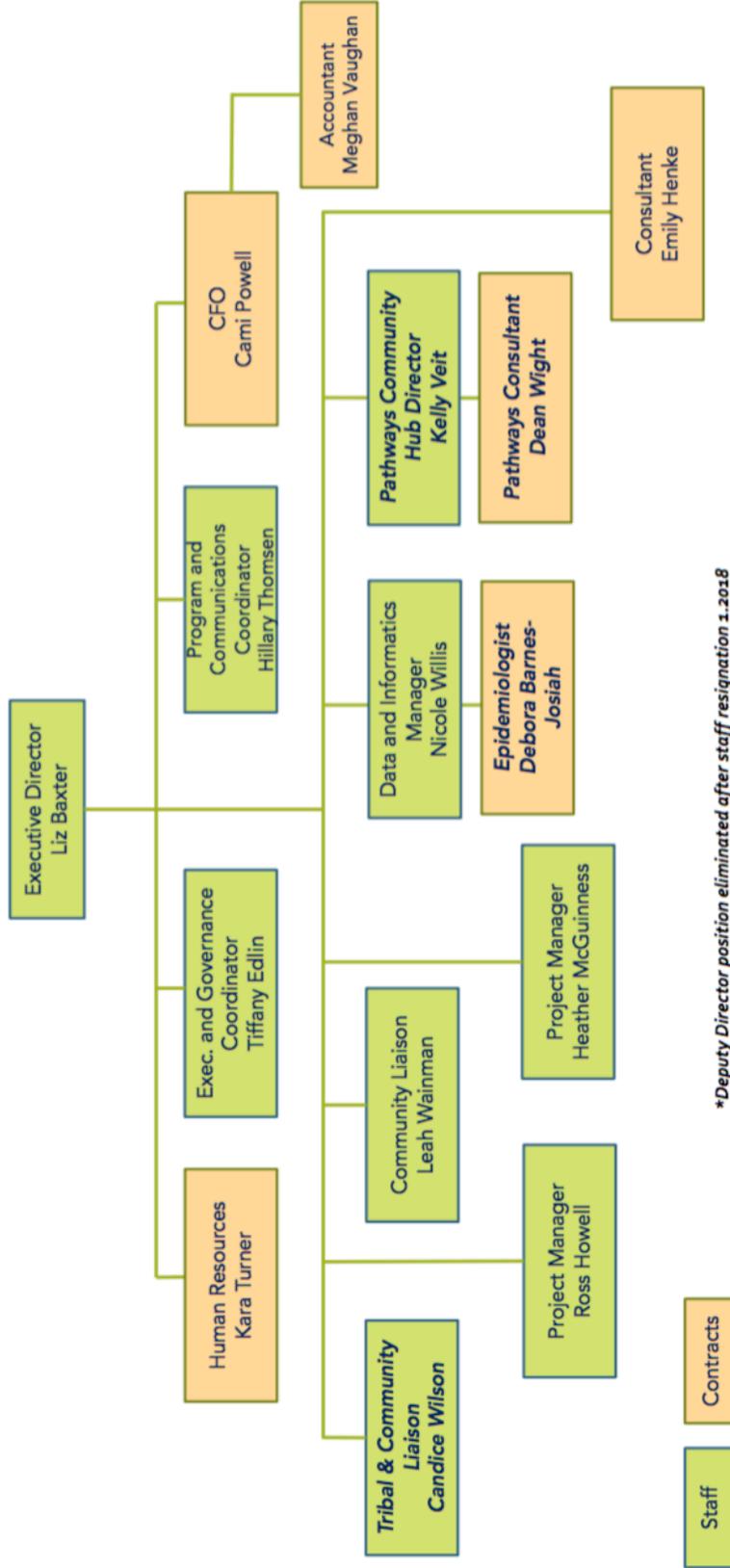
Image: A visual representation of Pathways population criteria, showing individuals with mental health and substance use disorder and EITHER 1 chronic disease OR be of childbearing age.



NOTE: This application is supplemental to the [North Sound ACH Call for Partners](#). Any agency that is interested in becoming a Pathways Care Coordination Agency will **also need to complete the North Sound ACH Call for Partners**.

ATTACHMENT D: North Sound ACH Organizational Chart

North Sound ACH Organization Chart, rev. July 2018



*Deputy Director position eliminated after staff resignation 1.2018

Contracts

Staff

ATTACHMENT E. Strategies Within Each North Sound ACH Initiative

	Care Coordination Initiative	Care Transformation Initiative	Care Integration Initiative	Capacity Building Initiative
Domain 1				<ul style="list-style-type: none"> • Distribute VBP readiness tools and resources • Connect providers to state VBP training and technical assistance • Improve partner readiness for MCO billing • Invest in billing support for MCO billing • Assess workforce readiness, capacity and needs • Assess population health management systems, including HIT/HIE status and interoperability capacity for community-based, integrated care
2A: Bi-directional Integration			<ul style="list-style-type: none"> • Screening (behavioral health/chronic disease) • Brief counseling interventions (behavioral health/chronic disease) • MAT for depression and opioids • Registry Development • Treat-to-Target • Consultation (medical/psychiatric) 	

	Care Coordination Initiative	Care Transformation Initiative	Care Integration Initiative	Capacity Building Initiative
2B: Care Coordination	<ul style="list-style-type: none"> • North Sound Community HUB • PreManage Integration • Health Home Coordination 			
2C: Transitional Care	<ul style="list-style-type: none"> • Enhanced Care Transitions Interventions (CTI) Model • Jail Transitions • Inpatient Mental Health Transitions 			
2D: Diversion Interventions	<ul style="list-style-type: none"> • Community Paramedicine • Care Coordination Collaboratives for Complex Cross-System Cases 			
3A: Addressing the Opioid Crisis		<ul style="list-style-type: none"> • Mobile opioid treatment and outreach • Scale up Medication Assisted Therapy (MAT) 	<ul style="list-style-type: none"> • Screening, Brief Intervention, and Referral to Treatment (SBIRT) • Enhance/expand community recovery services • Improve opioid prescribing practices 	
3B: Reproductive, Maternal & Child Health		<ul style="list-style-type: none"> • Increasing Long-Acting Reversible Contraception (LARC) access 	<ul style="list-style-type: none"> • One Key Question screening • HealthySteps specialists in pediatric practices 	

	Care Coordination Initiative	Care Transformation Initiative	Care Integration Initiative	Capacity Building Initiative
3C: Access to Oral Health Care		<ul style="list-style-type: none"> Dental Health Aide Therapists (DHAT) in Tribal Clinics ICD-10 coding in oral health Mobile Hygienists in Community Settings Silver Diamine Fluoride Dental Case Finding and Navigation 	<ul style="list-style-type: none"> Integrating Oral Health in primary care 	
3D: Chronic Disease Prevention & Control		<ul style="list-style-type: none"> Clinical transformation around chronic disease best practices Community-based Chronic Disease Prevention and Management Programs 		

Attachment F: Summary of Board Approved 2018 Fund Allocation Strategy

Key Elements of North Sound ACH Board Approved Fund Allocation Strategy (Approved at April 2018 Board meeting)

- All earned revenue will be considered available for allocation. In other words, we are not restricting any funds for a specific use due to the reason it was earned.
- The Interlocal Leadership Structure will recommend allocation for IMC and Bi-Directional Integration.
- Optimize use of funds for transformation activities through 2023 (instead of 2021)
- Optimize what we draw down (to move from non-interest-bearing FE account)
- Funds to ACH are limited to:
 - Admin at/below 10% of total earnings
 - 10% set aside for Community Resilience Fund; begin distribution in 2019 after Board sets goals and framework.
 - 2% set aside for contingency/reserve funds.
- Funds to 2018 Planning Partners will be based on a set of deliverables, in two parts:
 - A stipend in early summer 2018 (same to all partners who complete the required deliverables)
 - A payment in mid-fall 2018, variable to partners who complete the second set of deliverables based on:
 - Size, complexity of organization
 - Number of Medicaid lives reached
 - Workforce that will be engaged in implementation initiatives
 - Number of initiatives that organization commits resources to
 - Target populations that the organization commits to serve
 - Services that reach rural/remote populations
 - Organization's reach/commitment to underserved populations and/or those experiencing disparities
- While we anticipate receiving approximately \$32M in 2018, up to \$18.2M can be distributed in 2018 to assess and prepare partners for implementation in 2019.
- Fund Allocation Strategy for 2019 and beyond (Implementation Phase) will be put before Board for discussion and approval at August 2018 Board meeting.

Attachment G: List of Figures and Tables Contained in the Document

Title, with Page number in parentheses for reference)

Figure 1: North Sound ACH Medicaid Transformation Initiatives (5)

Figure 2: North Sound ACH Medicaid Transformation Initiatives and Project Plan Strategies (6)

Figure 3: Detailed Description of Initiatives and the 8 Project Areas (7)

Figure 4: Targeted Universalism (8)

Figure 5: North Sound ACH Planning Process (10)

Figure 6: Process to Further Refine North Sound HUB Populations of Focus (32)

Figure 7: Key Stages in North Sound HUB Population Selection Process (42)

Table 1: North Sound ACH 2018 CSA Activities and Processes (11)

Table 2: CSA Key Findings by Initiative (12)

Table 3: Summary from Partner Readiness Questions (20)

Table 4: Organization Assets that Support Work Toward Health Equity (23)

Table 5: Activities That Have Informed Domain 1 Strategies (26)

Table 6: Collaborative ACH Response to Needs from State Partners (28)

Table 7: Medicaid Transformation Evidence Based Approaches or Promising Strategies and Target Populations (34)

Table 8: Tribal Engagement and Collaboration Activities (72)

Table 9: Project Status Updates (85)

Table 10: North Sound HUB Strategic Partners (92)

Table 11: General Barriers to Participation (94)

Table 12: Community Engagement Activities (98)

Table 13: Engagement Challenges (108)

August 27, 2018

Dear Ms. Baxter:

Thank you for the submission of North Sound ACH's semi-annual report for the period January 1 – June 30, 2018. As the contracted Independent Assessor for the Washington Health Care Authority's Section 1115 Medicaid Transformation Project DSRIP program, Myers and Stauffer LC (Myers and Stauffer) has assessed the report.

Upon review of the documentation submitted, we have identified the below areas within your submission where we have requests for additional information. Please respond within the template provided. Updates to semi-annual reports are not required and will not be reviewed.

Please feel free to contact Myers and Stauffer at WADSRIP@mslc.com for additional information should you need clarification about the request. In your email, please specify your questions, or request a conference call if a discussion would be preferred. If requesting a conference call, please provide two or three available timeframes.

Please post your response in PDF or Word format to WA CPAS (<https://cpaswa.mslc.com/>) within the Request for Information folder (pathway is Semi-Annual Reports ➔ Semi-Annual Report 1 – ➔ July 31, 2018 Request for Information. **We ask for response no later than 5:00 p.m. PST, September 11, 2018.** Information received after this date will not be considered.

Thank you,
Myers and Stauffer LC

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

Request for Supplemental Information

Upon review of the ACH's semi-annual report, the Independent Assessor has identified the below areas where we have additional questions or requests for clarification. Please respond within this template. Updates to semi-annual reports are not required and will not be reviewed.

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

Milestone 1: Assessment of Current State Capacity. Item A.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.

- 1. Independent Assessor Question:** The response to Item A.3 is very detailed and highlights all required information with exception of mitigation strategies. Please re-review the response and provide applicable mitigation strategies for identified critical gaps.

North Sound ACH Response:

Throughout Table 2 (p. 12-10) and Table 3 (p. 20-21), critical gaps were identified, informing project portfolio refinement, future partner engagement strategies, selection criteria for target populations and populations of focus, and implementation plan requirements. The following describes these critical gaps and the mitigation strategies to address them.

- **Critical Gap:** Gaps in services for housing, food access, veteran services, and child care throughout the region.
 - **Mitigation Strategy:** Utilize early data from the Community Based Care Coordination strategy (the Community HUB), to illustrate which Pathways cannot be completed due to resource scarcity. Seek evidence from HUB's in Ohio, where such data has successfully been used to leverage for additional funding and/ or shifts in policy to address resource scarcity. Develop an action plan to replicate this process in our region and with our partners or identified champions.
- **Critical Gap:** Gap identified in relation to clearer messaging about health systems transformation



- **Mitigation Strategy:** North Sound ACH is recruiting a communications lead in Fall 2018. In addition, we intend to utilize the communication capabilities available through the online reporting portal to improve communication and increase collaboration with partnering providers.
- **Critical Gap:** Transportation can be a barrier to access. Service gaps in health-related transportation services.
 - **Mitigation Strategy:** North Sound ACH staff will continue to participate in the North Sound Transportation Alliance (NSTA) planning workshops that aim to developing better ways for people to travel within the region and prioritized needs based on community needs and identified solutions. Staff will continue to work with partners on assessing the impact of transportation gaps on people on Medicaid and others.
- **Critical Gap:** Perception that medication-assisted treatment (MAT) is not available for opioid treatment
 - **Mitigation Strategy:** Through a comprehensive partner self-assessment we will collect additional information to confirm the perceived gaps, assessment findings will then communicate results to partnering providers. Communications to provide clarity will be included in the regional implementation plan.
- **Critical Gap:** Need for more social services available to people with Substance Use Disorder (SUD)
 - **Mitigation Strategy:** advocacy by the ACH and its partners to increase services available to people with SUD at local, county and statewide level.
- **Critical Gap:** Shortage of behavioral health providers that accept Medicaid
 - **Mitigation Strategy:** Integration of behavioral health services in primary care settings will expand access to services for Medicaid enrolled people with mild and moderate behavioral health service needs. The ACH is working closely with the BHO and MCOs to ensure that the Integrated Managed Care transition in 2019 supports increased access to behavioral health services and that any risks of reduced provider networks are mitigated. Additionally, the ACH will work with BHO and BHAs to improve awareness and navigation of and
- **Critical Gap:** High need for oral health and SUD services, particularly in rural communities
 - **Mitigation Strategy:** Partner with Arcora Foundation to leverage foundation investments and relationships; pilot RHC-based dental clinics; partner with oral



health providers, SUD providers and the North Sound BHO to develop collaborative strategies.

- **Critical Gap:** Role of MCOs in sustainability is not clearly understood and must be explored in collaboration with the MCOs
 - **Mitigation Strategy:** Work with HCA and MCOs to educate providers in physical, behavioral and oral health around role of MCOs in relation to sustainability
- **Critical Gap:** Lack of cohesion and "collective voice" among CHW workforce
 - **Mitigation Strategy:** Dedicate ACH staff to foster development of a regional coalition of Community Health Workers.
- **Critical Gap:** There is no consistent electronic health record platform being used across the region and limited interoperability may inhibit the ability to share needed information across systems. 43% (32) of partnering providers have an EHR which all charts are electronic; no paper charts
 - **Mitigation Strategy:** Work with other ACHs to develop statewide HIE/HIT strategies; focus regional HIE/HIT efforts and investments on interoperability. Support usage of Collective Medical Technology's EDIE and PreManage platforms for shared care planning, as well as other tools for cross-EHR interoperability. Provide and support technical assistance to partners in improving workflows and HIT processes that solve cross-system communication and care planning barriers.
- **Critical Gap:** The partners readiness assessment identified lower rates than expected in the participation of state systems, 26% (19) report to WA's immunization registry and 16% (12) enter data into/use WA's prescription monitoring program.
 - **Mitigation Strategy:** Emphasize importance to providers, include participation as a measure in their MOUs. Support practices in connecting to and actively using WAIS and PMP through their electronic health records through technical assistance and capacity building for their HIT infrastructure and workforce skills in using these and other statewide or national registries.

As the North Sound ACH attested to completing Current State Assessment activities, we recognize the need for continuing assessment work as partnering providers are selected and the process of creating a regional implementation plan begins. In July 2018, a comprehensive partnering provider self-assessment will be launched to identify critical gaps within evidence-based practice, HIT/HIE capacity, health equity knowledge/skills and availability of culturally and linguistically proficient services for target populations.

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

- 2. Independent Assessor Question:** The response to Item B.3 is very informative as to processes to identify potential strategies for Domain 1 focus areas, and notes the continuing process of identifying Domain 1 strategies with partners and further refining strategies. However, the response does not detail progress in identifying potential strategies. The response to Item B.4 provides some insights into progress. Please elaborate on potential strategies or identified strategies that have been further refined

North Sound ACH Response:

In the November 2017 Project Plan, the North Sound ACH described the approach to identifying Domain 1 strategies and preliminary strategies. Because these foundational health system capacity development strategies cut across all the project areas, much of the identification and strategy development process has overlapped with ongoing project planning. Strategy development is also in discussion with other ACHs, and with IGT contributors (University of Washington and Association of WA Public Hospital Districts) as part of a shared Domain 1 strategy.

During the reporting period (January - June 2018), significant progress was made in identifying potential Domain 1 strategies. This reporting period falls during the Planning phase; therefore, most of the progress made in refining identified and potential Domain 1 strategies was focused on coming to agreement with other ACHs on common processes. Coming to these agreements where ACHs can see the overlaps and dependencies across the state marks significant progress from a year ago when each ACH was considering Domain 1 strategies separately and distinctly from each other.

Specific activities that have helped the North Sound ACH progress in identifying and developing Domain 1 strategies are shown in Table 5 on p. 26-27.

In addition to the Domain 1 strategies described in the project plan, the North Sound ACH has participated in ongoing discussions with the University of Washington, the Association of Washington Public Hospital Districts, and other statewide partners about the opportunity to leverage resources and strategies to support statewide health care workforce development and population health management strategies. The region's approaches have evolved as the HCA has refined its expectations of the ACHs and fostered regional and cross-sector discussions.



Across all clinical transformation strategies, partners will be required to describe in their individual implementation plans how they will be aligning their goals of VBP contracts with the goal of improving internal systems to prepare for further contracts that are outcomes-based. As these processes continue during the partner selection process and the North Sound ACH Implementation Plan development continues, Domain 1 strategies will be further developed.

Although the Current State Assessment (CSA) provided insights into Domain 1 capacity and needs (see CSA findings in Section 1 of the 2018 Semi-Annual Report), North Sound has not made significant changes to the Domain 1 activities listed in the Project Plan. Domain 1 investments are foundational across all of the initiatives, and readiness to take on VBP contracts is a core goal for clinical partners, who recognize the importance of Domain 1 assessment work to continue. As planned, North Sound will administer Part 2 of the Partnering Providers Readiness Survey in July 2018 that will collect specific information on capacity and needs for financial sustainability through (VBP) and on workforce and systems for population health management.

Milestone 3: Define Medicaid Transformation Evidence-based Approaches, Promising Practices, Strategies, and Target Populations. Provide a detailed description of population(s) that transformation strategies and approaches are intended to impact.

3. *Independent Assessor Question:* The descriptions for target populations are unclear. Page 32 indicates the ACH has "carried forward appropriate population segments within each initiative that were identified in the original eight target populations." Within project descriptions, the following are indicated:

- Target Populations Described in Project Plan
- 2018 Initiative Target Populations and Strategy Populations of Focus
- (*Specific to some projects*) Strategy Populations of Focus (to be finalized with partnering providers)

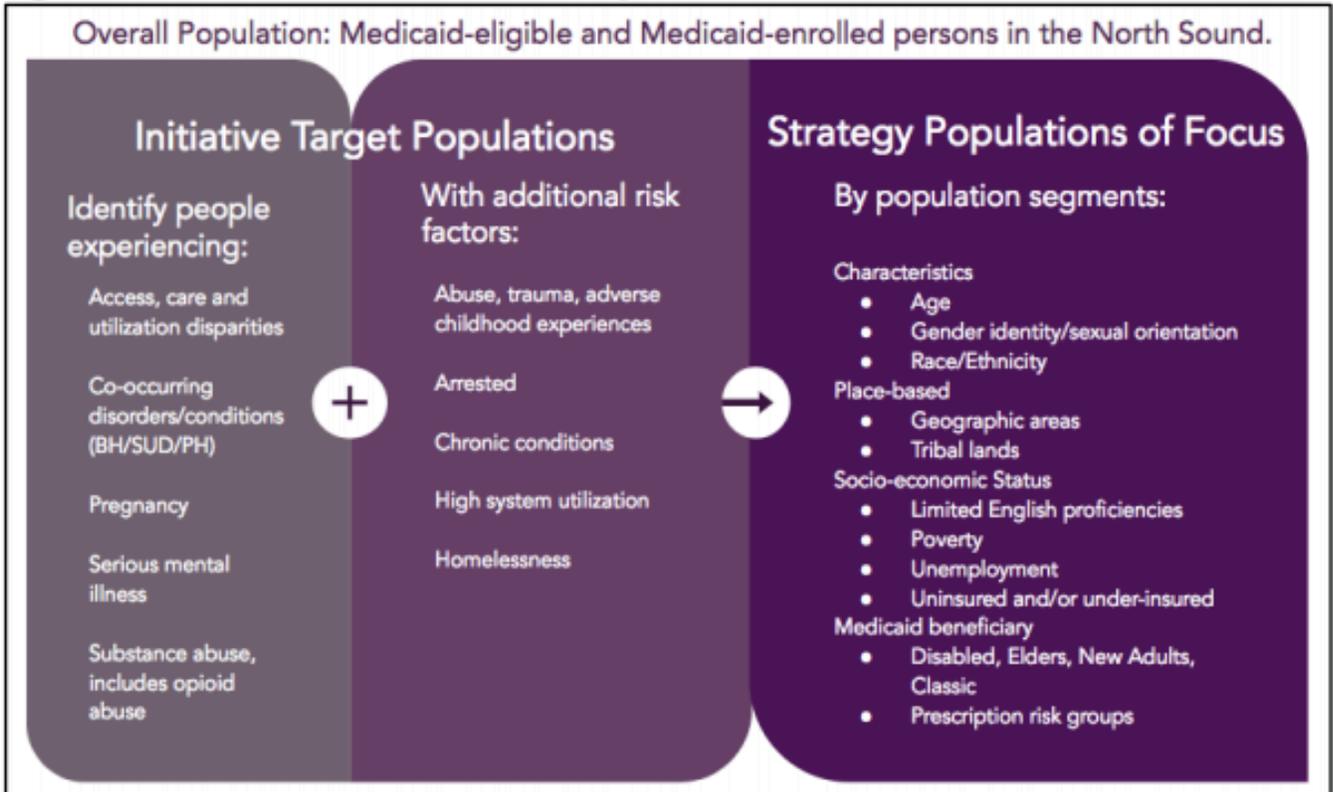
Please clarify the descriptions of each and how they relate. For example, are the Target Populations still those from the Project Plan, but within those populations, the ACH is focusing on the people and risk factors noted in the other bullets?

North Sound ACH Response:

Since the writing of the 2017 Project Plan, the North Sound ACH has selected a framework (below) to further refine populations of focus. Figure 6 from the Jan-Jun 2018 semi-annual report is included here for reference.



Figure 6. Process to Further Refine Populations of Focus



This framework has expanded what we felt were silos of target populations (by project areas) to **initiative** target populations and **strategy** populations of focus. This expansion has introduced new terminology that can be found in Figure 6 on page 32 (and shown above) and throughout each project area of Table 7 of pages 34-64 of the SAR.

Our shift from the eight project areas to four initiatives resulted in a refinement of our thinking about the use of the term “target population” so we created a crosswalk from those broad definitions to language that aligns with language for partnering providers that is more specific. The following describes the new terminology and how terms relate to one another:

- Information provided under the **Target Populations Described in Project Plan** header are the original target populations stated in the project plan for each project area as indicated and remain so until we finalize initiative target populations and strategy populations of focus in collaboration with partnering providers in late 2018 and early 2019.



Project Area	Target Population (7/31/18)
2A: Bi-directional Integration of Care and Primary Care Transformation	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or SUD.
2B: Community-Based Care Coordination	Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (e.g., arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe SUD and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).
2C: Transitional Care	Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with serious mental illness discharged from inpatient care, and clients returning to the community from prison or jail.
2D: Diversion Interventions	Medicaid beneficiaries presenting at the emergency department for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.
3A: Addressing the Opioid Use Public Health Crisis	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.
3B: Reproductive and Maternal/Child Health	Medicaid beneficiaries who are of reproductive age, pregnant, parents of children ages 0–3, and children ages 0–17.
3C: Access to Oral Health Services	All Medicaid beneficiaries, especially adults.
3D: Chronic Disease Prevention and Control	Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity, and stroke, with a focus on populations experiencing the greatest burden of chronic disease(s) in the region.

- Information provided under **2018 Initiative Target Populations and Strategy Populations of Focus** header first describes the proposed initiative target populations by listing which outcomes/conditions individuals are experiencing and additional risk factors. Project areas



within each initiative (Care Coordination-2B, 2C, 2D, Care Integration-2A, and Care Transformation-3A, 3B, 3C, 3D) will share target populations.

- **Strategy Populations of Focus**, describes the further refinement of the initiative target populations by population segments. As described in the SAR, this last step is modeled after Targeted Universalism, in which targeted strategies are informed by data and best-practice research and crafted targeted processes to each selected population of focus to reach universal goals.

Section 2: Standard Reporting Requirements

Item B.1: Provide completed table listing 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.

- 1. Independent Assessor Question:** It is unclear in some instances within the listing which activities the ACH conducted, the ACH’s role, or how some are relevant to ACH activities specific to tribal engagement and collaboration. For example, the Girl Scouts Western Washington Annual Lunch is listed. Additional information provided does not give context for the ACH’s role or relationship of the activity to tribal engagement and collaboration. Please review the full listing provided and clarify those activities where ACH role and relationship to tribal engagement and collaboration is not provided.

North Sound ACH Response:

For this table, which is on Page 72 of the Semi-Annual Report, the North Sound ACH’s Tribal and Community Liaison compiled tribal-specific engagement activities over the 6-month reporting period. This position was added specifically to have the ACH build relationships with tribal organizations and tribal leaders through the North Sound region and across the state. This relationship building takes time and in-person meetings in many diverse settings.

Please note, in the table:

- We have **bolded** those meetings that were convened by the North Sound ACH.
- We have ~~struck through~~ those meetings where the Tribal and Community Liaison was playing a bridging role between tribal partners and general meetings in the region.

Table 8: Tribal Engagement and Collaboration Activities for the Reporting Period				
Activity Description	Date	Attendees	Objective	Brief Description of Outcome/Next Steps
Department of Social and Health Services - Regional Tribal Coordinating Council Meeting	3/13	Tribal representatives and state agency representatives	Ongoing collaboration between tribes and DSHS services.	Introduction to DSHS RTCC members and tribal representatives. Bimonthly meetings.



Since Time Immemorial Lummi Advisory Committee	3/15	Lummi leaders, school administrators, and FSD board member	Introductory meeting with educational and cultural representatives. Collaborate on resources available for the Since Time Immemorial curriculum.	Introduction made with educational and cultural representatives. Schedule next meeting—2 weeks.
Lummi Nation School Board & Ferndale School Board	3/19	Superintendent, Education Director, School Board reps and admin team	Collaboration on Native student education and health services	Introduction made with School Board Members. Ongoing monthly meeting.
Stillaguamish Health Facility Open House	3/20	Stillaguamish community and public	Grand opening of new health facility - celebrating progress and relationship building.	Connection made with Stillaguamish representatives, learned about new services available. Connect with new contacts met at Open House to discuss ACH opportunities.
North Sound ACH Tribal Alignment Committee	3/20	Tribal Alignment Committee members, ACH staff, guests	Coordinate & provide updates for the North Sound ACH eight tribes.	Introduction made to Tribal Alignment Committee. Bimonthly meeting.
Washington State Indian Education Committee	3/21	Committee members	Native education annual conference planning.	Participated in Native education conference planning, connected with keynote & breakout session presenters. Monthly meeting.
Northwest Indian College Community Action Board (CAB)	3/22	CAB members	Learn about Native Transformations Project and relationship to ACH work.	Learned about NTP, Tribal communities' wellness model. Monthly meeting.
Whatcom Family & Community Network (WFCN) Coalition Meeting	3/22	Coalition members	Introduction to Coalition members, learn about services available in county, community capacity building.	Introduction made, discussed possible ACH collaboration. Monthly meeting.



Since Time Immemorial Lummi Advisory Committee	3/22	Lummi Indian Business Council (LIBC) Vice Chairman, Advisory Committee members	Continued collaboration on resources available to students for the Since Time Immemorial curriculum.	Designed project plan and assigned tasks. Next meeting TBD.
Lummi Indian Business Council (LIBC)	3/23	Board members, Secretary of Interior	Tribal relationship building, Meet & greet with Secretary of Interior.	Discussion included opioid epidemic in Indian country, natural resources, and tribal relations. One-time visit/meeting.
Ferndale School District Student Services (Native American Student Services)	3/23	Student Services Director & Ferndale School Board member	Discuss programs and services for Native students.	Discussed successes, challenges, and future opportunities for ACH collaboration. Meeting upon request.
State Epidemiological Outcomes Workgroup (SEOW)	3/28	SEOW members and presenters	Learn about outcomes relevant to tribal communities, and hear research presentations	Participated in presentation of the Native Transformations Program. One time meeting.
Meeting with HCA ACH Tribal Liaison	3/30	HCA Tribal Liaison	Introduction, relationship building, learning about HCA Tribal relations	Tribal liaison updated by the HCA with ACH Tribal Liaisons. Ongoing meetings.
Washington State Indian Education Conference	4/4-4/6	Native elders, students, teachers, education representatives	Collaborate on meeting Native student needs.	Learned about needs across the state, met with keynote & breakout session presenters. Follow up with new contacts.
Northwest Indian College Community Action Board	4/9	CAB members	Learn more about Native Transformations Project.	Learned more about Tribal communities' wellness model. Monthly meeting.



Indian Policy Advisory Commission/Governor's Office of Indian Affairs	4/11-4/12	Tribal leaders, State agency representatives	To provide policy updates to tribal leaders	IPAC policy review & updates for tribal leaders. Ongoing meetings.
Since Time Immemorial Lummi Advisory Committee	4/13	Lummi Indian Business Council (LIBC) Vice Chairman, Advisory Committee members	Collaborate on resources available for the Since Time Immemorial curriculum	Updated project plan and assigned new tasks. Next meeting TBD.
Northwest Indian College Community Action Board	4/16	CAB members	Hear updates on Native Transformations Project.	Learned more about Native Transformations Project specific to opioids. Ongoing meetings.
Washington Indian Education Association Conference Planning	4/18	Tribal leaders, tribal representatives	Collaborate on Native education conference planning.	Participated in native education conference planning, discussed with keynote & breakout session presenters. Monthly meeting.
Lummi Indian Child Welfare meeting	4/19	Native grandparents, former foster care children, committee members, tribal judges	Review children in care/foster care, propose code/policy amendments	Tribal code & policy review by tribal elders & community leaders for children in care Title IV-E. Develop working group TBD.
Lummi Nation School Board & Ferndale School Board	4/20	Superintendent, Education Director, School Board reps and admin team	Collaboration on Native student education and services	Discussed Indian Education for Native students. Ongoing monthly meeting.
Western Washington University Multicultural Center Groundbreaking	4/20	Ethnic student associations, campus diversity groups, alumni, students, staff, community and public	Celebrate groundbreaking and learn about resources available to native WWU students, relationship building	Connected with community members, shared about tribal needs and ACH work with WWU staff/students. One-time event.



Northwest Washington Indian Health Board (NWWIHB)	4/25	NWWIHB Executive Director, Nooksack leadership	Learn about and discuss native health care needs and services	Identified public health services and advocated for improvements in Native health for tribes in Northwest Washington. Next meeting TBD
HCA Tribal Consultation	4/30	Tribal leaders, HCA staff, administrators	Participate in Tribal consultation, Government to government relations with tribal leaders.	Strengthened relationships, discussed next steps for ACH work with tribal nations.
Health & Human Service Tribal Consultation	5/2	Tribal leaders, HHS staff, administrators	Participate in Tribal consultation, Government to government relations with tribal leaders.	Strengthened relationships, discussed next steps for ACH work with tribal nations.
Ferndale School District Student Services (Native American Student Services)	5/4	Student Services Director & Ferndale School Board member	Discuss Native American student needs and services	Discussed programs and services for Native students, including successes, challenges, and future opportunities. Next meeting upon request.
Meeting with john a. powell (Haas institute) author of targeted universalism	5/15	john powell, North Sound ACH team	Discuss how targeted universalism and health equity will be centered in the ACH work, provide perspective on tribal health needs	Schedule meeting with john powell for next steps in tribal approach to equity
North Sound Behavioral Health Organization (BHO) Tribal Mental Health Conference	5/16-5/17	Tribal leaders, elders, communities, North Sound BHO staff and leadership, health care providers & professionals	Represent North Sound ACH at annual conference, relationship building	Learned about needs and ongoing work related to tribal behavioral health in our region, made new contacts. Follow up on contacts, participate in planning for next year's conference.



Vine Deloria, Jr. Indigenous Studies Symposium	5/18-5/19	Tribal College University students, scholars, tribal and public community members	Learn about engaging indigenous knowledge to transform community health and well-being, relationship building	Represented North Sound ACH at tribal self-governance & indigenous studies symposium. Follow up on new contacts, participate in planning for next year's conference.
Lummi Nation School Board & Ferndale School Board	5/18	Superintendent, Education Director, School Board reps and admin team	Collaborate on Native student education and services	Discussed updates, ongoing Native student needs, represented ACH.
Ferndale School District Culture Fair	5/18	Diverse community members participating, presenting and performing at cultural event	Represent ACH, celebrate tribal communities, relationship building	Made new contacts, discussed extracurricular activities relevant to native students' health and well-being. Participate in planning for next year's conference.
Tribal Culture Curriculum meeting w/ Michelle Vendiola	5/21	Michelle Vendiola, consultant	Discuss opportunities for training on tribal curriculum	Identified goals and training plan for tribal curriculum. Next meeting TBD.
Girl Scouts Western Washington Annual Luncheon	5/22	Participants, supporters, funders and media relations.	Annual campaign to celebrate honorees and to share the mission of Girl Scouts of America.	Celebration and promotion of success of Girl Scout honorees and special recognition of alumni. Collaborate with networks.
Lummi Community Development Financial Institute	5/23	LCDFI Executive Director, and Executive Assistant.	Communicate & collaborate on Medicaid transformation with tribal partner. Learn about economic & human development in tribal communities. Relationship Building	Discussed ACH work, strengthened relationships. Next meeting TBD.



Johnson O'Malley, Native Student Recognition	5/23	Native communities, students, parents, guardians, grandparents, family & friends. Educational professionals.	Recognition & celebration of Native student accomplishments. Relationship building.	Participated in community celebration of Native student success & accomplishments. Learned more about Bureau of Indian Education subsidizing education, medical attention, and other services provided by states to Native Americans. Participate in planning for annual event.
Meeting with HCA ACH Tribal Liaison	5/24	ACH tribal liaisons, HCA staff	Communicate and collaborate with ACH tribal liaison, share updates, discuss needs.	Discussed ACH updates & needs around HCA support. Next meeting TBD.
Sauk Suiattle tribal visit	5/29	Tribal leaders, HCA Tribal Administrator & North Sound ACH Tribal Liaison	Discuss Medicaid transformation project with tribal government, relationship building	Discussed tribal needs, opportunities for collaboration. Next meeting TBD.
Northwest Washington Indian Health Board Meeting	5/30	Board Members	Discuss Medicaid Transformation Project	Discussed opportunities for collaboration.
Lhaq'temish Foundation Board Meeting	5/31	Tribal board members and staff. Tribal community members.	Learned about funds distribution for promotion of health & wellness activities.	Discussed opportunities for collaboration, made new contacts. Quarterly meeting.
HCA/DOH Monthly Tribal Meeting	6/6	HCA & DOH executive staff, tribal leaders/representatives	Hear HCA & DOH Healthier Washington Initiative tribal updates	Participate in monthly meetings.



Lummi Community Development Financial Institute Meeting	6/7	LCDFI Executive Director, and Executive Assistant.	Communicate & collaborate on Medicaid transformation with tribal partner. Economic & human development in tribal communities.	Shared updates about ACH work, learned about tribal efforts on poverty reduction, financial literacy. Next meeting TBD.
North Whatcom Health Center	6/7	Ferndale community, health care professionals, Ferndale Chamber of Commerce community, Ferndale City Council, Ferndale School Board, public	Groundbreaking Ceremony at North Whatcom Health Center	Groundbreaking Ceremony at North Whatcom Health Center. Celebrate future project. Grand opening TBD.
Lummi High School Graduation	6/7	Native students, parents, guardians, grandparents, families and communities	Traditional student recognition and celebration of high school diplomas - Relationship building, ACH support	Relationship building. One time event.
North Sound Interlocal Leadership Structure Meeting	6/8	Behavioral health care professionals and administrative support	Provide update on tribal health needs around behavioral health integration	Provided update. Participate in future meetings.
Whatcom County Sheriff & Lummi Island Community Leadership Meeting	6/8	Whatcom County Sheriff & Lummi Island Community Leadership	Introduction to Sheriff, represent ACH, discussed diversion and transitions work related to tribal needs	Discussed jail inmate reentry into communities with life skills and vocational access.
Ferndale High School Graduation	6/9	Ferndale students, parents, guardians, grandparents, families and communities	Student recognition of high school diploma for tribal students, celebration of tribal communities	Strengthened relationships, represented ACH. One time event.
Ferndale/Lummi Emergency Communications Committee Meeting	6/11	Lummi Chief of Police, Ferndale Communication Volunteer, Tribal & Community Liaison	Communicate and collaborate on emergency communications system, represent ACH, build relationships	Provided information on ACH work, discussed setup testing and trial system. Next meeting TBD



Lummi Indian Business Council Meeting	6/11	Tribal council leadership, administration and tribal & community liaison	Communicate and collaborate on tribal policy and relations with local and state agencies	Represented ACH. Next meeting TBD.
North Sound Behavioral Health Organization Meeting	6/11	Regional behavioral health care professionals (public and tribal organizations).	Collaborate on behavioral health care services in region for tribal communities	Participate in ongoing meetings and discussions.
Whatcom Parkscriptions Advisory Team Meeting	6/12	Medical, health care, and fitness professionals	Parkscriptions connects patients with positive outdoor experiences for healthier lifestyles and improved mental and physical health	Parkscriptions collaboration for patients with positive outdoor experiences for healthier lifestyles and improved mental and physical health. Ongoing.
Department of Social and Health Services Regional Tribal Coordinating Council Meeting	6/12	Tribal representatives and state agency representatives	Introductions, provide ACH updates	Discussed ongoing collaboration between tribes and DSHS services and ACH. Bimonthly meetings.
Windward High School Graduation	6/15	Ferndale students, parents, guardians, grandparents, families and communities	Student recognition of high school diploma for tribal students - celebrate tribal communities, relationship building.	one time event.
Northwest Washington Indian Health Board	6/13	Executive Director and Tribal & Community Liaison	Discuss collaboration on native health care policies and services	Identified opportunities around public health services and advocated for improvements in Native health for tribes in Northwest Washington.



Northwest Indian College Dean of Curriculum	6/14	Dean of Curriculum, Northwest Washington Indian Health Board Executive Director, and Tribal & Community Liaison	Discuss opportunities to provide training for tribal Dental Health Therapy (DHAT), behavioral health aides, Community Health Aide Program (CHAPs)	Discussed ACH and Northwest Indian College collaboration. Next meeting TBD.
Northwest Washington Indian Health Board	6/14	Executive Director and Tribal & Community Liaison	Follow-up meeting with NWIC DHAT/BHA/CHAPs collaborate native health care policies and services	Public health services and advocates for improvements in Native health for Tribes in Northwest Washington.
Community Forum on Medicaid (Healthier Washington Initiatives)	6/14	Community members	Discus MTP, represented Tribal Alignment Committee and provided introduction/Land Acknowledgement statement. Relationship building.	Made new contacts. Next event TBD.
Lummi Nation School Board & Ferndale School Board	6/15	Superintendent, Education Director, School Board reps and admin team	Collaboration of Native student education and services	Collaboration of Indian Education for Native students. Ongoing monthly meeting.
Meeting with HCA ACH Tribal Liaison	6/15	HCA Tribal Liaison & North Sound ACH Tribal & Community Liaison	HCA Tribal relations	Tribal liaison updated by the HCA with ACH Tribal Liaisons. Ongoing.
Northwest Indian College Graduation	6/15	Native students, parents, guardians, grandparents, families and communities	Student recognition of high school diploma	Traditional student recognition and celebration of high school diploma.



North Sound ACH Community Leadership Council (CLC)	6/18	Community members and representatives of CBOs	To help CLC members and CBO representatives understand the needs, strengths, and challenges that tribal members face each day in trying to move toward better health	Presented to CLC, answered questions. Participation in future meetings TBD.
RE Sources Sustainable Communities Meeting	6/19	Board members, staff and open to public	Promote and protect healthy environment for healthy communities by policy and leadership	Promote and protect healthy environment for healthy communities by policy and leadership. Stewards. Monthly meeting.
Department of Social and Health Services, Office of Indian Policy	6/20	DSHS Tribal Administrator, DSHS Tribal Liaison, and Tribal & Community Liaison	Strengthen tribal relations around DSHS services, discuss ACH collaboration	Identified opportunities for collaboration. Follow-up at next Indian Policy Advisory Council meeting.
RE Sources Sustainable Communities Meeting	6/20	Board Chair, Executive Director and Tribal & Community Liaison	Follow-up meeting for healthy environment for healthy communities by policy and leadership	Share community relations for healthy environment for healthy communities by policy and leadership. TBD.
Washington State Indian Education Committee	6/20	Committee members	Represented North Sound ACH, provide updates	Native education conference planning, discussed keynote & breakout session presenters. Participate in monthly meeting.



Children of the Setting Sun Productions	6/20	Tribal and community members	Discuss ACH collaboration with Children of the Setting Sun around tribal learning series for ACH partners.	Communicate and collaborate on tribal traditions and teachings with community. Promote culture and story with community. Next meeting TBD.
Northwest Washington Indian Health Board	6/21	Tribal Leader, Executive Director and Tribal & Community Liaison	Update meeting with NWIC DHAT/BHA/CHAPs collaborate native health care policies and services	Public health services and advocates for improvements in Native health for Tribes in Northwest Washington.
HCA Accountable Communities of Health Tribal Liaison	6/22	HCA Tribal Liaison & North Sound ACH Tribal & Community Liaison	HCA Tribal relations	Tribal liaison updated by the HCA with ACH Tribal Liaisons. Ongoing.
Department of Social and Health Services Region 2 Meeting	6/25	Tribal and community representatives, North Sound Behavioral Health Organization, and DSHS staff	Update of Division of Behavioral Health and Recovery	Transition of Division of Behavior Health and Recovery from DSHS to HCA
HCA American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Swinomish Indian Tribal Community	6/26	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Executive Director and Tribal & Community Liaison, with Swinomish representative	Medicaid Transformation communication and collaboration, relationship building	Communication and collaboration on tribal funds and tribal ACH planning. Next meeting TBD.



HCA American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Upper Skagit Indian Tribe	6/26	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Executive Director and Tribal & Community Liaison, with Upper Skagit Tribal Council and administrative staff	Medicaid Transformation communication and collaboration, relationship building	Communication and collaboration on tribal funds and tribal ACH planning. Next meeting TBD.
Ferndale School Board Meeting	6/26	School board members, Ferndale School District Executive Administration, and community members	Review board policies and updates by administration	Action of board policies and discuss student education updates by administration.
HCA, American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit--Samish Indian Nation	6/27	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Executive Director and Tribal & Community Liaison, with Samish tribal council and administration	Medicaid Transformation communication and collaboration, relationship building	Communication and collaboration on tribal funds and tribal ACH planning. Next meeting TBD.
HCA, American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Tulalip Tribes	6/27	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Executive Director and Tribal & Community Liaison, Tulalip tribal leaders and members of Tribal Clinic staff	Medicaid Transformation communication and collaboration, relationship building	Communication and collaboration on tribal funds and tribal ACH planning. Next meeting TBD.



Ferndale School Board Study Session	6/27	School board members, Ferndale School District Executive Administration, and community members	Review board policies and updates by administration	Discuss board policies and student education updates by administration.
HCA, American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Lummi Indian Business Council	6/28	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Tribal & Community Liaison, with tribal council and administration	Medicaid Transformation communication and collaboration, relationship building	Communication and collaboration on tribal funds and tribal ACH planning. Next meeting TBD.
Whatcom Family & Community Network Meeting	6/28	Board members, staff and community	Review and discuss board policy building capacity through health and wellness in communities with partners	Discuss board policy building capacity in communities with partners and networks. Promote health and wellness. Monthly meeting.
HCA, American Indian Health Commission and North Sound Accountable Community of Health Tribal Visit with Stillaguamish Tribe of Indians	6/29	HCA Tribal Administrator & Medicaid Transformation Representative, AIHC Executive Director, North Sound ACH Tribal & Community Liaison, with tribal representative and administration	Medicaid Transformation communication and collaboration, relationship building	Communication and collaboration on tribal funds and tribal ACH planning. Next meeting TBD.

Item D.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?

2. Independent Assessor Question: The information provided more describes planning meetings between the ACHs than coordinated engagement of partnering providers that has occurred. Were any coordinated partnering provider engagement activities conducted during the reporting period? If so, please describe. Otherwise, are there examples the ACH can provide of coordinated engagement activities that the ACHs have discussed and/or plan to conduct? Also, are cross-collaboration opportunities discussed in all meetings described? If not, please indicate which are relevant to this question.

North Sound ACH Response:

During the reporting period, coordinated partnering provider engagement activities that happened across ACHs focused largely on implementation planning and how to successfully engage larger providers that are working across ACHs. ACH staff discussed barriers to participation for shared providers, as well as shared information about the ways in which each ACH was including these shared providers in planning activities to identify successes and challenges and ensure that each ACH was on the same page. Not all of the cross-ACH activities included on p. 89 of the Semi-Annual Report were focused on cross-collaboration opportunities with shared partnering providers. However, cross collaboration opportunities were regularly discussed on weekly cross-ACH huddle phone calls with Directors, and in monthly in-person ACH leadership meetings.

The shared partnering providers (i.e. providers who are active in more than one ACH) that were the focus of these cross-ACH collaborative discussions are listed on page 89 of the 2018 Semi-Annual Report. ACH Directors **and** these shared partnering providers have participated in our cross-ACH discussions and strategizing meetings. These shared partners include:

- Providence Health System
- Collective Medical Technologies
- Care Coordination Systems
- Foundation for Healthy Generations
- Washington State Hospital Association (WSHA)
- University of Washington
- Association of Washington Public Hospital Districts
- Healthier Washington Practice Transformation Support Hub (Washington Department of Health and Qualis Health)

Future cross-ACH coordination will include other partners who cross ACH boundaries, including PeaceHealth (health system), SeaMar (FQHC), and Compass Health (BH).



Item G.2, Table B. If the ACH has not expended the full amount of earned Design Funds, describe the planned use for these funds.

- 3. Independent Assessor Question:** The response provided is focused on the internal process for deciding how to use design funds, whereas the question asks for information about planned use of the funds. Please elaborate on how the ACH is considering using the funds.

North Sound ACH Response:

The North Sound ACH did not separate the Design Funds into a separate category (cost center) for expenditure purposes uniquely from other earned funds. We clarified and confirmed with the Health Care Authority multiple times in 2017 that this was not required. From an accounting standpoint, because we can define the point in time of receipt, our accountant can determine the remaining balance of those funds received as Design Funds. Any balance remains in savings until the Board approves distribution of those funds.

In the Excel spreadsheet on Tab G2 we noted that “The North Sound Accountability Community of Health has not expended the full amount of earned Design Funds as of this reporting period. The North Sound Accountable Community of Health will approve a budget for allocation of available funds, which will guide strategic use of these funds appropriately in subsequent years.”

On page 112 of the narrative we noted that “the North Sound ACH board of directors, in approving the 2018 Fund Allocation strategy, agreed that after funds are earned by the region they are considered **all one fund**,” therefore no earned funds are ‘earmarked’ for any specific purposes. The North Sound Board came to this decision after the Executive Director and CFO had multiple discussion with the Health Care Authority, the Independent Assessor, and within our own strategic planning discussions. As such, the Design Funds earned after completion of the Certification submissions are earnings for which the North Sound ACH Board of Directors will annually determine the specific focus and use.

The North Sound ACH Board will be using the FE Portal Use Categories to allocate earned funds, including the balance remaining from prior earnings such as the Design Funds, on an annual basis. The balance of the Design Funds, like all of our earnings, are available for the Board to decide to approve for allocation.

A full description of the Board decision around allocation of earned funds can be found in Attachment F in the Semi Annual Report. It lists the limitations of use of funds such as no more than 10% for Administration, an allocation toward the Community Resilience Fund, a percentage toward reserves. Any balance remaining will be held in savings until the Board approves an allocation strategy for those dollars.

Item G.4.a: Describe how the ACH has prioritized, or will prioritize, integration incentives to assist Medicaid behavioral health providers transitioning to fully integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have or will participate in discussions on the prioritization of these incentives.

- 4. Independent Assessor Question:** The response does not include details on how Medicaid behavioral health providers and county government(s) have or will participate in discussions on the prioritization of these incentives. Please elaborate (e.g., are there members of each that sit on the Interlocal Leadership Structure group)?

North Sound ACH Response:

The North Sound ACH Board of Directors approved its 2018 Fund Allocation Strategy with an understanding that the Executive Director would look to the Interlocal Leadership structure (ILS) for guidance and recommendations about needed funds to support the Integrated Managed Care work plan.

All five county governments in the North Sound Region (Island, San Juan, Snohomish, Skagit and Whatcom) have representatives on the ILS, and all five counties have seats on the North Sound ACH Board of Directors. They have fully participated in the planning and prioritization process for the 2019 transition to fully integrated managed care. In addition, the North Sound ACH and the North Sound BHO have jointly hosted meetings with behavioral health providers and physical health providers to gain insight into what is needed to support IMC and the bi-directional integration efforts. Medicaid behavioral health and physical health providers have sought input from regional leaders and providers in behavioral health as the Fund Allocation strategy was discussed at the Board.

The North Sound ACH is also finalizing a contract with the North Sound BHO, because of their close relationship with regional BHAs, to collaborate in project management.