Medicaid Transformation
Accountable Communities of Health (ACH)

Implementation Plan Template:
Work Plan Instructions & Portfolio Narrative
Released May 9, 2018
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SUBMISSION INSTRUCTIONS

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

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

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

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

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

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

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

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

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

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

PROJECT WORK PLAN REQUIREMENTS

Instructions

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

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

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

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

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

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

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

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

- o Beyond the milestones, ACH work plans must address additional, self-identified milestones and associated work steps to convey the work happening in their regions.

  - o Work plans that respond only to the milestones associated with the Toolkit below will not be sufficient.

- *Work Steps*: For each milestone, identify key tasks necessary to achieve the milestone.

  - o *Health Systems and Community Capacity Building*. Work steps should include the collaborative work between HCA, the ACHs and statewide providers (e.g., UW, AWPHD) on health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment).

  - o *Health Equity*. Equity considerations should be an underlying component of all transformation activities. Work steps should include activities related to health equity (e.g. conducting provider training to address health equity knowledge/skills gaps, distributing health equity resources).

- *Key Deliverables/Outcomes:* For each work step, identify concrete, specific deliverables and expected outcomes.

  - o *Health Systems and Community Capacity Building*. Key deliverables/outcomes should reflect the collaborative work between HCA, the ACHs and statewide providers (e.g., UW, AWPHD) on health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment).

  - o *Health Equity*. Equity considerations should be an underlying component of all transformation activities. Key deliverables/outcomes should reflect or be informed by health equity considerations (e.g., committee charter that acknowledges health equity goals).

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

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

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

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

MINIMUM REQUIRED TOOLKIT MILESTONES

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

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

- Develop guidelines, policies, procedures and protocols (Completion no later than DY 3, Q2.)
- Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)
- Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities.
  - o Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities. (Completion no later than DY 3, Q4.)
- Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care activities. (Completion no later than DY 3, Q4.)

Stage 3: Scale & Sustain Milestones

- Increase use of technology tools to support integrated care activities by additional providers/organizations. (Completion no later than DY 4, Q4.)
- Identify new, additional target providers/organizations. (Completion no later than DY 4, Q4.)
- Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.

- - Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices. (Completion no later than DY 4, Q4.)
- Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5 (Completion no later than DY 4, Q4.)
- Identify and resolve barriers to financial sustainability of Project activities post-DSRIP (Completion no later than DY 4, Q4.)

Project 2B: Community-Based Care Coordination

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

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

Stage 3: Scale & Sustain Milestones

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

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

Project 2C: Transitional Care

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

- Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)
- Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways. (Completion no later than DY 3, Q2.)
- Implement project, including the following core components across each approach selected:
  - Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)
  - Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the electronic shared care plan). (Completion no later than DY 3, Q4.)
  - Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs. (Completion no later than DY 3, Q4.)
  - Incorporate activities that increase the availability of POLST forms across communities/agencies (http://polst.org/), where appropriate. (Completion no later than DY 3, Q4.)
  - Develop systems to monitor and track performance. (Completion no later than DY 3, Q4.)

Stage 3: Scale & Sustain Milestones

- Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. (Completion no later than DY 4, Q4.)
- Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)

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

Project 2D: Diversion Interventions

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

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

Stage 3: Scale & Sustain Milestones

- Expand the model to additional communities and/or partner organizations. (Completion no later than DY 4, Q4.)
- Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)
- Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)
- Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)

Project 3A: Addressing The Opioid Use Public Health Crisis

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

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

Stage 3: Scale & Sustain Milestones

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

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

Project 3B: Reproductive and Maternal/Child Health

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

- Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)
- Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)
- Implement project, including the following core components across each approach selected:
  - o Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)
  - o Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the care plan). (Completion no later than DY 3, Q4.)
  - o Establish mechanisms, including technology-enabled, interoperable care coordination tools, for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs. (Completion no later than DY 3, Q4.)
  - o Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes. (Completion no later than DY 3, Q4.)

Stage 3: Scale & Sustain Milestones

- Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. (Completion no later than DY 4, Q4.)
- Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)

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

Project 3C: Access to Oral Health Services

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

- Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)
- Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)
- Implement project, including the following core components across each approach selected:
    - Implement bi-directional communications strategies/interoperable HIE tools to support the care model. (Completion no later than DY 3, Q4.)
    - Establish mechanisms for coordinating care with related community-based services and supports. (Completion no later than DY 3, Q4.)
    - Develop workflows to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed. (Completion no later than DY 3, Q4.)
    - Establish referral relationships with dentists and other specialists, such as ENTs and periodontists. (Completion no later than DY 3, Q4.)
    - Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)
    - Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes. (Completion no later than DY 3, Q4.)
    - Engage with payers in discussion of payment approaches to support access to oral health services. (Completion no later than DY 3, Q4.)

Stage 3: Scale & Sustain Milestones

- Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. (Completion no later than DY 4, Q4.)
- Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)
- Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)

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

Project 3D: Chronic Disease Prevention and Control

Stage 1: Planning Milestones

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

Stage 2: Project Implementation Milestones

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

Stage 3: Scale & Sustain Milestones

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

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

REQUIRED PORTFOLIO NARRATIVE

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

ACHs should read each prompt carefully before responding.

Partnering Provider Project Roles

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

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

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

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

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

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

OCH Response: Partnering Provider Project Roles

Olympic Community of Health (OCH) integrated the six selected project areas (2A, 2D, 3A, 3B, 3C, 3D) into one comprehensive portfolio to be implemented by at least 21 behavioral health (including mental health and substance use disorder), primary care and hospital providers and a yet unknown number of community-based organization and social service providers—called Implementation Partners—across the region.

Implementation Partners are those partnering providers who sign a Medicaid Transformation Project contract with OCH through 2021 and submitted a Change Plan to OCH. For ease of administration and to help the Implementation Partners be successful with implementation, OCH developed three provider-centric Change Plans, one each for hospitals, primary care and behavioral health providers. Community-based organization and social service Implementation Partners will also submit a Community-Based Organization Social Services Change Plan, which is under development.

The Change Plan contains desired Outcomes (defined as project objectives) and Tactics (defined as implementation strategies, activities and practices) for the six project areas. Certain Outcomes are required and certain Tactics are highly recommended for clinical Implementation Partners completing a Change Plan. The requirements and recommendations span the complete scope of the six project areas, including the evidence-based approaches.

To respond to Partnering Provider project roles please refer to the table below. The table provides a subset of Tactics extracted from three submitted and one anticipated Change Plan from four Implementation Partners. All physical health and behavioral health partners are required to complete Outcomes and perform Tactics across the portfolio. For purposes of brevity, OCH has chosen to highlight a few examples of key steps to provide a more detailed picture of Implementation Partner roles. The completed Change Plans for all Implementation Partners can be provided to the Independent Assessor upon request.

Name of Implementation Partner	Type	Project Areas	Roles and Responsibilities from DY2, Q3 through DY3, Q4	Key Steps to implement Change Plan from DY2, Q3 through DY3, Q4
1. Peninsula Community Health Services	Federally Qualified Health Center: - Primary care - Behavioral health - Dental care	2A, 2D, 3A, 3B, 3C, 3D	Complete Change Plan and Implementation Partner Specific Standard Agreement with Olympic Community of Health (OCH)	Implement and expand the following Tactics, as chosen in the Change Plan: Project 2A: - Organization focuses on linking specific sub-populations to appropriate clinical or community services

Name of Implementation Partner	Type	Project Areas	Roles and Responsibilities from DY2, Q3 through DY3, Q4	Key Steps to implement Change Plan from DY2, Q3 through DY3, Q4
	Traditionally reimbursed		Comply with all aspects laid out in Implementation Partner Specific Agreement Report on progress of all selected Change Plan Outcomes semi-annually (first report due January 2019) Report required metrics semi-annually	- Participate in technology platform that allows necessary patient/client information to be exchanged between the referee and referral organizations Project 2D: - Create new open access/same-day/walk-in capacity - Establish notification system between hospital and patient's medical/behavioral health home within Natural Community of Care (NCC) when a patient/client visits the Emergency Department (ED) - Embed community health workers in the criminal justice setting to link individuals to primary care, behavioral health and/or other community services Project 3A: - Train dentists in pain management best practices - Co-prescribe naloxone with medication assisted treatment (MAT) - Increase number of providers waivered to provide MAT Project 3B: - Screen sexually active females aged 16–24 for chlamydia - Adopt guidelines, tools and evidence-based practices to improve provider knowledge and practice around preconception care and preconception risk - Develop protocols to guide outreach efforts for children overdue for well-child visits and immunizations Project 3C: - Train providers on screening for oral health needs and

Name of Implement ation Partner	Type	Project Areas	Roles and Responsibilities from DY2, Q3 through DY3, Q4	Key Steps to implement Change Plan from DY2, Q3 through DY3, Q4
				engagement with oral health provider - Train providers on fluoride varnish application procedure - Apply fluoride varnish to pediatric patient population Project 3D: - Identify relevant sub-populations by creating disease-specific registry/module/report in Electronic Health Record (EHR)/or appropriate electronic tracking tool - Form bi-directional referral system within the NCC between clinical and community partner for effective chronic care services such as Diabetes Prevention Program (DPP), Chronic Disease Self-Management (CDSM), Whole Health Action Management, exercise programs and/or other; refer to appropriate programs depending on patient profile
2. Kitsap Mental Health Services	Community mental health clinic - Mental health treatment - Substance use disorder treatment provider - Psychiatric inpatient facility Traditionally reimbursed	2A, 2D, 3A, 3C, 3D	Complete Change Plan and Implementation Partner Specific Standard Agreement with OCH Comply with all aspects laid out in Implementation Partner Specific Agreement Report on progress of all selected Change Plan Outcomes semi-annually (first report due January 2019) Report required metrics semi-annually	Implement and expand the following Tactics, as chosen in the Change Plan: Project 2A: - Design integrated care teams to function as a collaborative practice to support patients/clients to achieve treatment goals (listed partners: Catholic Health Initiatives Franciscan Medical Group (residency program, hospital and medical group), Peninsula Community Health Services, Kitsap Community Resources, Kitsap Medical Group, Silverdale Pediatrics, Kitsap Children's Clinic Project 2D: - Assign care managers to assist those with recurrent ED overuse

Name of Implementation Partner	Type	Project Areas	Roles and Responsibilities from DY2, Q3 through DY3, Q4	Key Steps to implement Change Plan from DY2, Q3 through DY3, Q4
				to identify barriers to accessing primary care, identify solutions and resolve issues Project 3A: - Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options Project 3C: - Provide oral health counseling and education to patients Project 3D: - Train providers in CDSM in a behavioral health setting - Identify people with asthma and hypertension by creating disease-specific registry/module/report in EHR/or appropriate electronic tracking tool (listed partners: Silverdale Pediatrics and Kitsap Children's Clinic)
3. Jamestown Family Health Clinic Highlight: Six Building Blocks for Safer Opioid Prescribing and Chronic Pain Management *[NOTE: for purposes of this example we are*	Tribal clinic - Primary care - Behavioral health care - Dental care Traditionally reimbursed with tribal encounter rate and Indian Health Service reimbursement	3A	Complete Change Plan and Implementation Partner Specific Standard Agreement with OCH Comply with all aspects laid out in Implementation Partner Specific Agreement Report on progress of all selected Change Plan Outcomes semi-annually (first report due January 2019) Report required metrics semi-annually	Implement and expand the following Tactics related to improve opioid prescribing and chronic pain management (Project 3A), as chosen in the Change Plan: - Train providers on the Area Medical Directors Group Interagency or Centers for Disease Control and Prevention guidelines on prescribing opioids for pain - Update all opioid prescribing protocols, policies and patient agreements, train staff on them, and review them annually - Create standardized chronic opioid prescribing policies and care pathways

Name of Implementation Partner	Type	Project Areas	Roles and Responsibilities from DY2, Q3 through DY3, Q4	Key Steps to implement Change Plan from DY2, Q3 through DY3, Q4
highlighted only one evidence-based approach within Project 3A. Jamestown is implementing across all six project areas through a Primary Care and Behavioral Health Change Plan.]				- Standardize workflows for Chronic Opioid Therapy (COT) patients - Create a COT registry and assign staff member to ensure information is routinely updated - Create a standardized approach for dealing with complex patients including an outline for patient-centered discussions - Reconcile medications routinely to avoid unsafe combinations - Incorporate the use of the Prescription Drug Monitoring Program into workflow - Train prescribers in best practices for tapering from opioids - Train dentists in pain management best practices (please refer to Bree Collaborative Guidelines, 9/2017) - Clinic leadership uses data to monitor and improve provider prescribing practices - Offer or arrange for alternatives to opioids to relieve pain - Create patient agreements for COT that aligns with clinical policies and review with patients annually - Inform patients of the rationale for patient agreements and periodic drug screening for those receiving COT - Review safe storage of opioids with patients

Name of Implementation Partner	Type	Project Areas	Roles and Responsibilities from DY2, Q3 through DY3, Q4	Key Steps to implement Change Plan from DY2, Q3 through DY3, Q4
				- Refer all patients with narcotic prescriptions to safe medication return and disposal programs - Provide overdose education, peer support, and take-home naloxone to individuals seen in the ED for opioid overdose - Train staff to recognize and appropriately respond to an overdose - Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options - Support staff to attend quarterly convenings between prescribers and providers - Develop regional standards of practice (adopt Bree Opioid Use Disorder report and treatment recommendations) - Build structural supports to support medical providers and staff to implement and sustain MAT - Build linkages/ communication/referral pathways between those providers providing medication and those providing psychosocial therapies - Engage local health coalitions to advocate for policies to improve patient care and to develop programs to address social determinants within the community
4. Young Men's	Community-Based Organization	3D	Complete Change Plan and Implementation	Project 3D: - Enhance linkages with partners in the NCC to ensure patients are

Name of Implementation Partner	Type	Project Areas	Roles and Responsibilities from DY2, Q3 through DY3, Q4	Key Steps to implement Change Plan from DY2, Q3 through DY3, Q4
Christian Association (YMCA) of Pierce and Kitsap Counties *[NOTE: Community-Based Organization Change Plans were still under development at the time of this report.]*	Not traditionally reimbursed by Medicaid		Partner Specific Standard Agreement with OCH Comply with all aspects laid out in Implementation Partner Specific Agreement Report on progress of all selected Change Plan Outcomes semi-annually (first report due January 2019) Report required metrics semi-annually	supported and active participants in their chronic disease management - Form bi-directional referral system within the NCC with clinical and behavioral health partners for effective chronic care services, DPP - Refer clients to additional programs and services as appropriate depending on client profile - Develop care coordination protocols that include closing the loop on referrals reconnecting pre-diabetic individuals back into clinical services - Expand integration into provider EHRs or referral management software. *[NOTE: This is currently in place between Peninsula Community Health Services and the YMCA for the DPP program. By the end of DY3, OCH will track YMCA's expansion to other partners.]*

Acronyms used in this table:
COT – Chronic Opioid Therapy, DPP – Diabetes Prevention Project, ED – Emergency Department, EHR – Electronic Health Record, MAT – Medication Assisted Treatment, NCC – Natural Community of Care, OCH – Olympic Community of Health, YMCA – Young Men's Christian Association

Acronyms used in this section:
OCH – Olympic Community of Health

Partnering Provider Engagement

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

ACH Response
Responses must cover the following: • What training and/or technical assistance resources is the ACH facilitating or providing to support partnering providers in implementation from DY 2, Q3 through DY 3, Q4? • How is training and/or technical assistance resources being delivered within that timeframe? • How is the ACH engaging smaller, partnering providers and community-based organizations with limited capacity? • What activities and processes are coordinated/streamlined by the ACHs to minimize administrative burden on partnering providers (e.g., coordination of partnering provider contracts/MOUs)? • How is the ACH coordinating with other ACHs in engaging partnering providers that are participating in project activities in more than one ACH?

OCH Response: Partnering Provider Engagement

Olympic Community of Health (OCH) provides or plans to offer the following technical assistance and resources to support Implementation Partners from DY2, Q3 through DY3, Q4.

Training and/or technical assistance resources Olympic Community of Health (OCH) is facilitating or providing	How training and/or technical assistance resources are being delivered
On-site Quality Improvement (QI) team meetings Qualis Health Pediatric Transforming Clinical Practices Initiative (P-TCPi) OCH Clinical Transformation Manager	Some of our Implementation Partners have internal QI teams—an established process for QI and protected time for staff to participate in this process. Other partners have accessed the free services available in our region through the Department of Health's Practice Transformation Support Hub Qualis Health Practice Coach Connector and P-TCPi Practice Facilitator. These coaches provide on-site assistance for clinics and agencies to facilitate assessments that measure readiness for integrated care, Collaborative Care Model, Chronic Care Model and Value Based Purchasing, identify healthcare and community-based support/social support partners with whom to build collaborative relationships and develop QI projects to close care gaps and improve care coordination.
On-site visits	OCH staff will conduct on-site visits with all Implementation Partners to assess organization's progress on chosen Change Plan Outcomes and Tactics. OCH staff will use this time to monitor progress, address concerns and create a plan to connect organizations with resources.

Cultural Competency, Health Literacy, Health Equity, Diversity and Inclusion	OCH is exploring vendors and trainers to provide materials and on-site trainings for our partnering providers on these topics. Transformation activities around these areas were Outcomes and Tactics in the Physical Health Behavioral Health and Community Based Organizations and Social Services Change Plans, which Implementation Partners have expressed interest in. Possible vendors include: - Tacoma-Pierce County Health Department (Jacques Colon) for health equity - American Indian Health Commission of WA for government to government training and historical trauma - Washington State Hospital Association for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual+ - Hass Institute for health equity - Kitsap Strong for Trauma Informed Care
Managing Chronic Disease for Behavioral Health Providers	The region's Practice Transformation Support Hub Qualis Health Practice Coach Connector shares the resource "Promoting Chronic Disease Management: A guide for behavioral health care teams" with all enrolled sites. Upon evaluating interest, OCH and Quails Health will host an on-site training based on this resource.
Oral Health Integration	Arcora Foundation and Qualis Health will provide training around oral health screening, education, and fluoride varnish application to partnering providers who are interested in implementing these activities.
Reproductive Health	Partnering providers in the OCH region have expressed interest in using One Key Question as a tactic for implementing Outcomes for Project Area 3B. After evaluating interest, OCH will compile resources for partnering provider organizations to use to train clinical teams on using One Key Question.
Jedi Mind Control	This training is highly recommended by the OCH Executive Director and will prove to be invaluable to our Implementation Partners in successfully implementing the Medicaid Transformation Project. OCH will send Implementation Partners to Dagobah for personalized training with Master Yoda.
Pre-Manage	Pre-Manage is an interoperable communication tool that facilitates real-time client/patient tracking in emergency rooms. In collaboration with Collective Medical Technologies, P-TCPi is offering incentive dollars and technical assistance to enrolled clinics that have shown significant improvement in their transformation goals. Two providers in our region, Kitsap Children's Clinic and Reflections Counseling Services Group, will implement PreManage in September 2018, and will submit monthly data reports to their P-TCPi Practice Facilitator through 2018. This data will assist both clinics to complete their Change Plan requirements. Clinics will participate in a monthly pacing call with Collective Medical Technologies and P-TCPi staff.

Olympic Digital Health Information Technology (HIT) Commons	During DY2, Q3 to DY3, Q4 OCH is piloting an IT platform to facilitate information exchange between providers at the point of care called Olympic Digital HIT Commons or Commons. OCH is offering training and support from Quad Aim Partners for partners interested in piloting this new technology. Current partners receiving the training include a primary care provider and substance use disorder (SUD) treatment provider in Clallam County. Additionally, OCH is entering into a memorandum of understanding with Greater Columbia ACH and Puget Sound Fire to provide additional tools from other use cases for the technology. OCH is working with legal on data governance and usage policies to share with partnering providers: - A standardized patient consent that allows partners to send/receive patient info with each other via the Commons - A standardized Business Associate Agreement/Qualified Service Organization Agreement for the Commons - A standardized agreement that each agency provider will sign with the Commons to be issued login credentials/passwords to access the Commons
Six Building Blocks (6BB)	6BB is a structured 15-month approach for clinic redesign to improve opioid prescribing practices and treatment for pain. OCH will contract with the University of Washington 6BB team over the course of the Medicaid Transformation Project. OCH will partner with up to ten clinics across the region to implement 6BB resulting in consistent, appropriate and aligned opioid prescribing and treatment of chronic pain following best practices including the Area Medical Directors Group and Centers for Disease Control guidelines. OCH may also partner with the 6BB team and the Northwest Family Medicine Residency program to develop and offer continuing medical education-eligible workshops to provide an opportunity for smaller clinics/sole providers to be trained in 6BB.
Opioid Summit	Under the guidance of the OCH 3-County Coordinated Opioid Response Project (3CCORP) Steering Committee, OCH will plan and implement regional annual opioid summits. The first opioid summit was held on January 30, 2017 and included presentations of local, regional, state and national data; best practices in the treatment of opioid use disorder; the 2016 Washington State Interagency Opioid Response Plan; the draft OCH Regional Opioid Response Plan; and a request for volunteers to serve on 3CCORP Workgroups (Prevention of Opioid Misuse and Abuse, Increased Access to the Full Spectrum of Best Practices Treatment for Opioid Use Disorder, Prevention of Opioid Overdose). The second annual OCH Opioid Summit is scheduled for October 17, 2018. The agenda is still being developed and may include presentations on updated data, the 6BB, a Tribal opioid response project, the regional Hub & Spoke system, Medication Assisted Treatment (MAT) prescriber and SUD provider care referral and coordination, and what we've accomplished to date.

Medication Assisted Treatment	OCH is coordinating with the University of Washington Alcohol and Drug Abuse Institute (ADAI) Northwest Addiction Technology Transfer Center to develop and implement MAT training for MAT prescribers and SUD providers. OCH is also coordinating with the Department of Health to identify and disseminate information about MAT prescribers. The OCH region has a Hub & Spoke system funded through the State Targeted Response. OCH is coordinating biannual convenings of MAT prescribers and SUD providers. OCH may partner with Peninsula College and Olympic College to develop/enhance curricula for Chemical Dependency Counselor (CDP) students regarding MAT and recovery. OCH may partner with the two colleges to develop continuing education-eligible training on MAT for CDPs and CDP trainees.
Opioid Overdose Prevention	OCH is coordinating with the ADAI Center for Opioid Safety Education (COSE) and StopOverdose.org. COSE offers education and technical assistance for individuals, professionals and communities in Washington State who want to learn how to prevent and intervene in opioid addiction and overdose. StopOverdose.org provides technical assistance and education for healthcare providers, treatment providers, law enforcement, fire/emergency medical services, criminal justice and others including overdose education, naloxone access and distribution, understanding opioid use disorder, accessing treatment, support for families and crisis information. StopOverdose.org also provides sample protocols, materials and toolkits and local data on opioids.

Acronyms used in this table:
3CCORP – 3 County Coordinated Opioid Response Project, 6BB – Six Building Blocks, ADAI – Alcohol and Drug Abuse Institute, CDP – Chemical Dependency Professional, COSE – Center for Opioid Safety Education, HIT – Health Information Technology, MAT – Medication Assisted Treatment, OCH – Olympic Community of Health, P-TCPi – Pediatric Transforming Clinical Practices Initiative, QI – Quality Improvement, SUD – Substance Use Disorder

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

Many of the partnering providers and community-based organizations (CBOs) in the OCH region are smaller and have limited staffing capacity. There are major workforce shortages, particularly among the smaller Substance Use Disorder (SUD) providers, which create barriers to engagement. OCH has and continues to make every effort to personally reach out to the smaller providers/CBOs across the region. OCH hosts partner meetings in a variety of venues throughout the region to reduce travel and time barriers. OCH staff also travels directly to smaller partnering provider/CBO locations for meetings. OCH invites partnering providers and CBOs to Natural Community of Care convenings. OCH has offered webinar-based training and web/call-in options for meetings to reduce travel and time barriers. Internet access has been identified as a barrier in some of the most remote areas of the region and OCH is working with these remote partners to provide training in an alternate manner.

The Practice Transformation Support Hub/Qualis Health Practice Coach Connector and Pediatric Transforming Clinical Practices Initiative (P-TCPi) Practice Facilitator have worked together to provide

services to five SUD providers in our region and meet quality improvement teams request teams. Kitsap Medical Group, a small privately-owned primary care practice, is engaged in practice transformation through efforts from OCH leadership and the Qualis Health Practice Coach Connector. A collaborative relationship between Kitsap Medical Group and Kitsap Mental Health Services (KMHS) has been developed to pilot behavioral health integration and the Collaborative Care Model. Similarly, KMHS signed Memorandum of Agreements with two privately owned pediatric primary care organizations through the P-TCPi to improve integration of care.

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

OCH is collaborating with all ACHs to enter into joint contracts and share trainings as appropriate. Included in this group is Pierce ACH, Healthier Here and Cascade Pacific Action Alliance, which all share Implementation Partners with OCH. The OCH executive director (ED) is in regular contact with the EDs of Pierce ACH and Healthier Here regarding Catholic Health Initiatives health system and with Cascade Pacific Action Alliance (CPAA) regarding Peninsula Community Health Services (PCHS) and Olympic Area Agency on Aging. These partnering providers span our ACH boundaries.

PCHS has a small, remote clinic in the CPAA region, and they have completed a Request for Proposals with CPAA as well as a Change Plan with OCH. PCHS has ensured that its commitments to each region's Medicaid Transformation Project (MTP) work aligns and is complementary rather than duplicative.

OCH is also in discussion with the other ACHs to explore aligning reporting frequency, content and intermediary measures to reduce reporting burden for the above providers who cross ACH lines. Although this may not be possible for all projects, OCH hopes to align intermediary measures for the required projects, 2A Bi-directional Integration and 3A Opioid Response, at a minimum.

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

The OCH ED attends monthly in-person meetings with all ACH EDs, which offers a platform to discuss shared partners. OCH staff participates on multiple weekly and bi-weekly calls with other ACHs to stay abreast of other regions' approaches to the MTP and address any issues or concerns over shared partners to ensure continuity and clarity to partners.

OCH participates in a five-ACH collaborative managed by the Center for Evidence-based Policy at Oregon Health & Science University (OHSU). The OHSU team convenes regular calls and in-person meetings with the participating ACHs. Agendas are developed collaboratively. The focus of the collaborative is on identifying and sharing best practices, pooling resources, providing mutual feedback, developing cooperative strategies, and coordinating efforts wherever possible.

Coordinated activities include:

- Joint engagement with vendors to pursue economies of scale and increase effectiveness or impact through coordination.

- A report and crosswalk that distills funds flow and financial management approaches adopted by all ACHs.
- Compiling and sharing best practices. Topics have included the social determinants of health, consumer/beneficiary engagement, bi-directional integration, contracting with behavioral health providers, internal staffing, evaluation and metrics, investing in the community and health equity.
- A planned workshop dedicated to better understanding ACH successes and challenges pertaining to stakeholder outreach and engagement, provider payments, target populations and evaluation. This sharing of information has already been critical in informing the ACHs on best approaches for managing pace, scope and scaling.
- A planned sustainability workgroup of participating ACHs and their regions' Managed Care Organizations (MCOs), as well as other potential payers. The goal is to coordinate how the ACHs can establish a shared pathway to future MCO payments based on the identification and performance of key agreed-upon metrics.
- Development of a shared decision tree for vetting and responding to vendor inquiries, with the goal of coordinating between ACHs whenever there is an advantage to doing so.

Acronyms used in this section:
CBO – Community-Based Organization, CPAA – Cascade Pacific Action Alliance, ED – Executive Director, KMHS – Kitsap Mental Health Services, MCO – Managed Care Organization, MTP – Medicaid Transformation Project, OCH – Olympic Community of Health, OHSU – Oregon Health & Science University, ORCA – Olympic Reporting and Community Activities, PCHS – Peninsula Community Health Services, P-TCPi – Pediatric Transforming Clinical Practices Initiative, SUD – Substance Use Disorder

Partnering Provider Management

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

ACH Response
Responses must address both traditional and non-traditional Medicaid providers and cover the following: • What are the ACH's project implementation expectations for its partnering providers from DY 2, Q3 through DY 3, Q4?   • What are the key indicators used by the ACH to measure implementation progress by partnering providers within that timeframe?   • What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?   • How will the ACH support its partnering providers (e.g., provide technical assistance) if implementation progress to meet required project milestones is delayed?

### OCH Response: Partnering Provider Management

The Olympic Community of Health (OCH) Quality Improvement Plan (QIP) model (Figure 1) involves a continuous plan-do-study-act cycle informed by multiple quarterly and biannual inputs from partnering providers and other sources. The OCH approach to partnering provider management is embedded within this model. The approach will be the same for both traditional and non-traditional Medicaid providers.

In Figure 1., the two concentric circles depict two quality/rapid improvement cycle layers based on a plan-do-study-act methodology. The two concentric circles show the division of responsibilities between OCH (outer light blue circle) and the partnering providers (darker blue inner circular arrows). The partnering providers will be responsible for managing their internal QI cycle (darker blue inner cycle). OCH will support partnering providers by offering technical assistance through Qualis Health and P-TCPi coach/facilitators but OCH will not oversee this internal process. OCH will ensure that partnering providers are engaging in their internal process regularly; this is a requirement in the Change Plan.

OCH will use what is included in the table below to do our quality/rapid improvement cycle to assess partnering providers' transformation. The table includes expectations, key indicators to measure implementation progress by providers and the processes and tools OCH will use to do rapid cycle quality improvement. The bars on the left are color coded to show who is responsible for which reporting and data elements of the OCH QIP.

Figure 1.

Olympic Community of Health Quality Improvement Plan v.1.0
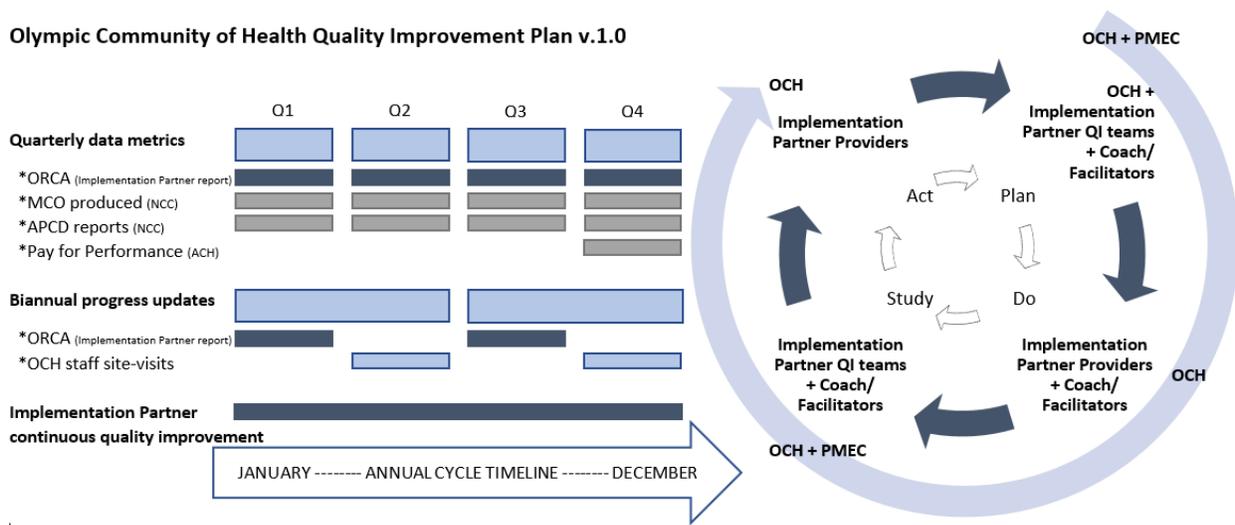
Acronyms used in this figure:

APCD – All Payer Claims Database, MCO – Managed Care Organization, NCC – Natural Community of Care, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PMEC – Performance Measurement and Evaluation Committee, QI – Quality Improvement

Expectations	Key Indicators	Processes and Tools
Implement Change Plan Outcomes and Tactics for both traditional and non-traditional Medicaid providers	Bi-annual **status updates on progress to date** on Outcomes measured in 6-stages: not started, planning, testing, limited implementation, fully implemented, scaling and sustaining (Figure 2, outlined in green). **Figure 2. Snapshot of Progress to Date Change Status** 	Progress to date status updates on Outcomes selected in each providers' Change Plan will be entered directly by the provider biannually in the OCH online platform, Olympic Reporting and Community Activities (ORCA).
	Bi-annual **narrative updates** in 6 open-ended questions asked by Olympic Community of Health (OCH). Questions 1–3 are answered for	Progress-to date-narrative

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each Outcome, questions 4–6 are answered for the whole Change Plan (Figure 3).

1) Please describe the top priority Tactics you worked on during the previous 6 months. What are you most proud of?
2) What are your top priority Tactics for the next 6 months?
3) Thinking about the Outcomes/Tactics in your Change Plan, during the previous 6 months, what were your 3 biggest barriers to progress? What kinds of assistance (from OCH and/or outside OCH) would help you to overcome those identified barriers (for example: IT support, training, workforce, resources...)?
4) Please list any new partnerships (informal/formal) your organization has formed with other partners in your Natural Community of Care in the previous six months (for example: signed agreement, etc.).
5) What steps has your organization taken to address health equity in your approach to the Outcomes/Tactics in your Change Plan during the previous 6 months?
6) What percentage of your current Medicaid contracts are value-based payment (VBP) contracts? How do you anticipate your participation in VBP will change in the next 6 months – increase, stay the same, decrease? What are your greatest barriers for engaging in VBP?

Figure 3. Snapshot of Progress to Date Narrative Updates

1) Please describe the top priority Tactics you worked on during the previous 6 months in this domain. What are you most proud of?

2) What are your top priority Tactics for the next 6 months in this domain?

3) Thinking about the Outcomes/Tactics in your Change Plan for this domain, during the previous 6 months, what were your 3 biggest barriers to progress? What kinds of assistance (from OCH and/or outside OCH) would help you to overcome those identified barriers (for example: IT support, training, workforce, resources...)?

4) Please list any new partnerships (informal/formal) your organization has formed with other partners in your NCC in the previous six months (for example: signed agreement, etc.).

5) What steps has your organization taken to address health equity in your approach to the Outcomes/Tactics in your Change Plan during the previous 6 months?

6) What percentage of your current Medicaid contracts are value-based payment (VBP) contracts? How do you anticipate your participation in VBP will change in the next 6 months - increase, stay the same, decrease? What are your greatest barriers for engaging in VBP?

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updates will be entered directly by Implementation Partners biannually in ORCA.

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	Provide **data for quarterly quantitative performance measures** associated with Outcomes, Tactics and milestones. Performance measures will be developed in a collaborative process by the members of the OCH Performance Monitoring and Evaluation Committee from August to November 2018 and may include population served, intermediary process measures and measures of health care access/utilization, health status or health outcomes, number of new procedures and protocols implemented, number of new partnerships. These measures will serve as timely indicators and provide opportunities for quality improvement or other course corrections.	Quantitative performance measures will be tracked and entered directly by the provider quarterly in ORCA.

Acronyms used in this table:
OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, VBP – Value-based Payment

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

After provider reports containing the above key indicators are collected and assessed, the OCH Clinical Transformation Manager and Program Coordinator will conduct, at a minimum, bi-annual on-site visits with all Implementation Partners to assess organizations' progress on chosen Change Plan Outcomes/Tactics and associated milestones. OCH staff will use this time to address organization concerns and connect organizations with appropriate technical assistance resources. Technical assistance may come internally from OCH staff, contractors, coach/facilitators. For external support, OCH will identify and leverage regional champions and implement a train-the-trainer approach to support the spread of best practices (please refer to "Stage 3 Scale and Sustain" tab in Workbook). In the OCH QIP model, through the plan-do-study-act cycle, OCH may reach out to Implementation Partners if data review suggests delays or issues with project implementation.

Acronyms used in this section:
OCH – Olympic Community of Health, QIP – Quality Improvement Plan

Alignment with Other Programs

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

ACH Response
Responses must cover the following: Project 2A • What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other bi-directional integration efforts in the state? Project 3A • What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports?

For ACHs implementing Project 2B
• How does the ACH align referral mechanisms and provider engagement strategies with the Health Homes and First Steps Maternity Support Services program?
• What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?
• How is the ACH's approach aligned with MCO care coordination contract requirements?

For ACHs implementing Project 2C
• How does the project align with or enhance related initiatives such as Health Homes or other care/case management services, including those provided through the Department of Corrections?
• What additional programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve transitional care services?

For ACHs implementing Project 2D
• What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to promote appropriate use of emergency care services and person-centered care? (e.g., the Washington State Hospital Association's "ER is for Emergencies" and "Seven Best Practices" initiatives.)

For ACHs implementing Project 3B
• How do the ACH's partnering providers align with and avoid duplication of Maternal Support Services? How will the project strengthen or expand current implementation of Home Visiting Models?

- What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve access to high quality reproductive and maternal/child health care?

For ACHs implementing Project 3C
- What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve access to oral health services?

For ACHs implementing Project 3D
- What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve chronic disease management and control?

OCH Response: Alignment with Other Programs

Overview: Olympic Community of Health (OCH) approach to alignment with state resources across the entire Medicaid Transformation Project (MTP) portfolio

Implementation partners in each Natural Community of Care (NCC) met three times in January and February of 2018 (a total of nine meetings) to agree on a Shared Change Plan for each respective NCC. These Shared Change Plans facilitate alignment with state and local efforts to promote appropriate use of services and whole-person care without duplicating activities. This includes alignment with the Managed Care Organization's care coordination contract requirement. The final signed Shared Change Plans were used to align the Physical Health Behavioral Health (PHBH) and Community Based Organizations and Social Services (CBOSS) Change Plan to the agreed-upon set of strategies for each NCC. The responses below for all six project areas utilized this same approach.

The Outcomes and Tactics in the PHBH and CBOSS Change Plan are designed to avoid duplication while promoting synergy with existing state resources. The Change Plan asks Implementation Partners to indicate when the activity began and whether it is a new or expanded activity. OCH is not holding Implementation Partners accountable for work that began before 1/1/2017, when the MTP began in Washington State—which is considered outside the scope of the contract between OCH and Implementation Partners. For many Implementation Partners, partnerships in the community for services and supports already existed well before the start of the MTP. The work under the Change Plan seeks to strengthen, expand and formalize these pre-existing relationships and build new ones.

Acronyms used in this table:
MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, PHBH – Physical Health Behavioral Health

Project 2A – What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other bi-directional integration efforts in the state?

The following Outcome and Tactics for project 2A in the PHBH Change Plan highlight how the bi-directional integration efforts facilitate alignment with the state:

Outcome: Organization chooses and implements an evidence-based program for care integration

- *Recommended Tactic*: Train providers in and implement elements of Collaborative Care Model/AIMs Center (PC providers only).

- *Recommended Tactic*: Train providers in and implement elements of Bree Collaborative Behavioral Health Integration (PC providers only).

- *Recommended Tactic*: Train providers in Chronic Disease Management in a behavioral health setting (BH providers only).

The ACH has aligned with the Practice Facilitator with the Pediatric Transforming Clinical Practices Initiative (P-TCPi) through the Department of Health (DOH) and the Coach Connector with the Practice Transformation Support Hub (PTSH) through Qualis Health and a grant from the DOH. The coaches cover the three-county region and collaborate when clinics request coaching from both programs. Together they serve primary care, mental health and substance use disorder agencies across the Olympic Community of Health (OCH) region. Both coaches have the support and resources of their management and state-wide teams that possess a depth of subject matter expertise and additional resources from when requested.

Because the OCH developed the Medicaid Transformation Project (MTP) around Natural Communities of Care (NCC), the coaches assist in bringing NCC partners together to collaborate when appropriate. They have spent the past several years building relationships with line-staff and quality improvement teams throughout the region and assist the OCH in understanding the unique strengths and challenges of each partner based on assessment, action planning and project scope and progress. The OCH includes both coaches in all MTP team meetings with full transparency and rely on the coaches' expertise and insight to inform their strategies to assist sites in each of three NCCs. In addition, the coaches can communicate directly with clinic and agency staff regarding OCH initiatives and make direct linkages to OCH staff to provide timely support of provider teams.

The Qualis Health Practice Coach Connector attended the Value Based Payment (VBP) Academy with Kitsap Mental Health Services (KMHS) throughout 2017 and continues to meet with the VBP Team bi-monthly. This program is sponsored by the Washington State Council on Behavioral Health. Out of efforts of the VBP Academy, the Clinical Director from KMHS and the Qualis Health Practice Coach Connector have proposed the creation of a Behavioral Health Integration Academy to outline curriculum and learning for clinicians to understand and prepare for use of registries, assessment, treatment to target and chronic disease management. This identified need originated from a pilot project between KMHS and Kitsap Medical Group (KMG) in which a KMHS clinician will be co-located at KMG for four hours every two weeks to provide behavioral health services to the medical provider's patients. The intent is that this team can develop curriculum and share learnings with other teams around the region.

Primary care and behavioral health clinics have specific questions about the Collaborative Care Model and future billing issues related to these codes and how to understand the model and lay the groundwork for successful adoption of this model. The Qualis Health Practice Coach Connector can respond to technical questions and/or connect clinics with providers who are having success implementing this model to share best practices. For example, Jefferson Healthcare (JH) Primary Care Clinics in Jefferson NCC requested technical assistance from the PTSH and asked the coaches that had experience in the Collaborative Care Model speak with their social workers who were delivering traditional counseling services within two JH Primary Care Clinics. This allowed the JH team to

understand the culture shift and logistical issues that would need to be addressed if/when the primary care clinic transitioned to a Collaborative Care Model.

The Qualis Health Practice Coach Connector also works in the South West ACH region of the state and has referred OCH behavioral health providers to Columbia River Mental Health's Chief Financial Officer who can speak to workforce issues prior to Integrated Managed Care (IMC). By speaking to behavioral health agency (BHA) administrators that have made the transition to direct billing with managed care organizations (MCOs), providers in the OCH region can learn practical steps to consider preparing for (VBP) for billing and operations.

Two successful training VBP and IMC events were delivered in the North Central ACH and Better Health Together regions. To ensure the sustainability of bi-directional integration the OCH team has requested that these trainings be offered in the OCH Region in early fall 2018. Both events will assist behavioral health clinics in assessment, preparation and planning for VBP and IMC. The first training is developed by the PTSH and DOH, in partnership with the Washington Council for Behavioral Health, and will provide two days of learning for BHAs. Teams will learn about the support available during the transition to IMC as well as create an actionable transition plan for IMC. They will also develop projects to explore how to strengthen skills needed to be successful in a VBP future. The second training will be an opportunity for six BHA/substance use disorder agencies in the OCH region to have intensive on-site technical assistance with a consultant from Outlook Associates and support from the Qualis Health Practice Coach Connector Coach Connector. DOH/PTSH is bringing this opportunity to the area and the funding is subject to DOH contract approval. Those responsible for developing contracts and billing MCOs will be asked to participate as a quality improvement team. Both offerings will utilize the Billing and Information Technology Toolkit for Behavioral Health Agencies developed by Outlook Associates.

The P-TCPi Practice Facilitator has been working with KMHS to establish Memorandum of Agreements (MOA) with two privately owned pediatric primary care organizations. These clinics developed a policy for transferring medication management back to the primary care physician when the patient has stabilized KMHS meets regularly with both clinics to ensure transfer of care is running smoothly. KMHS provided medication prescribing training to clinic staff in May 2018, and a direct phone line between KMHS and the pediatric clinics was established after the training for any same day questions. Individual MOA's were also signed in Spring 2018 between KMHS and Kitsap Children's Clinic, Silverdale Pediatric Clinic and Peninsula Community Health Services to establish an asthma program for shared patients with uncontrolled asthma. KMHS will begin in-home visits with a Visiting Nurse once a curriculum has been finalized by all involved clinics, with the goal of starting these in-home visits in Fall of 2018.

P-TCPi has identified decreasing avoidable Emergency Department (ED) visits as a Year 4 goal. In collaboration with Collective Medical Technologies, P-TCPi is offering incentive dollars and technical assistance to enrolled clinics that have shown significant improvement in their transformation goals. Kitsap Children's Clinic and Reflections Counseling Services Group will implement PreManage in September 2018 and will submit monthly data reports to their Practice Facilitator. This data will assist both clinics in completing their Physical Health Behavioral Health Change Plan requirements.

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

ACH Implementation Plan Template (Updated July 31, 2018)

Project 3A is primarily guided by the 3 County Coordinated Opioid Response Project (3CCORP) Steering Committee and three workgroups: 1) Prevention of Opioid Misuse and Abuse, 2) Increased Access to the Full Spectrum of Best Practices for Treatment for Opioid Use Disorder and 3) Prevention of Opioid Overdose. The 3CCORP Steering Committee and Workgroups are multi-county and multi-sector with diverse, broad, and deep representation. This provides guidance for identifying existing efforts and gaps, identifying needs, identifying resources, and avoiding duplication of efforts and resources including other state efforts to reduce opioid-related morbidity and mortality.

Programs and Services:

- Regional Opiate Treatment Network – this is the State Targeted Response funded hub & spoke system which emerged from the 3CCORP Treatment Workgroup; for the OCH region this is referred to as the "Opiate Treatment Network." The "hub" was established at Peninsula Community Health Services in August of 2017 with eight "spokes" across the three counties. Currently these spokes are: Kitsap Mental Health Services, Kitsap Recovery Center, West Sound Treatment Services, Jefferson Healthcare, North Olympic Healthcare Network, Peninsula Behavioral Health, Jamestown Family Health Clinic and Clallam Health and Human Services.
- Public health departments in each of the three counties (Clallam, Jefferson and Kitsap) – The public health departments offer syringe exchange services, dispense naloxone kits, and refer clients to regional treatment agencies for Opioid Use Disorder. Although the public health departments are not submitting Change Plans, the public health officers and leadership serve on the 3CCORP Steering Committee and Workgroups and participate in NCC convenings.
- Weekly ACH/Tribal opioid project lead collaborative calls – OCH co-hosts weekly calls for ACH/Tribal opioid project leads to share resources, identify opportunities and challenges and avoid duplication.
- Quarterly Washington State Interagency Opioid Workgroup – the OCH 3A project lead attends these quarterly meetings to stay informed about statewide resources and initiatives and pushes out this information to the 3CCORP partners as well as 3A partners (there is overlap between this and the Criminal Justice Opioid Workgroup).
- Monthly Criminal Justice Opioid Workgroup – the OCH 3A project lead attends these quarterly meetings to stay informed about statewide resources and initiatives and pushes out this information to the 3CCORP partners as well as 3A partners (there is overlap between this and the WA State Interagency Opioid Workgroup).
- UW Alcohol and Drug Abuse Institute (ADAI) – ADAI is a critical resource to track emerging and existing research and best practices including for addressing the opioid crisis including prevention, treatment and recovery support. ADAI will continue to be a resource throughout DY3, DY4, DY5 and beyond the MTP.
- StopOverdose.org – housed within ADAI, StopOverdose.org provides emerging and existing resources for preventing and addressing opioid related overdose. StopOverdose.org provides technical assistance and education for healthcare providers, treatment providers, law enforcement, fire/Emergency Medical Service (EMS), criminal justice and others including overdose education, naloxone access and distribution, understanding Opioid Use Disorder, accessing treatment, support for families and crisis information (note, this is also part of "ER is for Emergencies," see 2D below). StopOverdose.org also provides sample protocols, materials and toolkits, and local data on opioids.

- Center for Opioid Safety Education (COSE) – housed at ADAI COSE provides emerging and existing resources for addressing opioid safety. COSE offers education and technical assistance for individuals, professionals, and communities in Washington State who want to learn how to prevent and intervene in opioid addiction and overdose.
- Bree Collaborative – In 2011, the Washington State Legislature established the Dr. Robert Bree Collaborative so that public and private health care stakeholders would have the opportunity to identify specific ways to improve health care quality, outcomes and affordability in Washington State. Relevant to 3A the Bree Collaborative has developed: 1) Opioid Prescribing Metrics, 2) Dental Guidelines on Prescribing Opioids for Acute Pain Management, 3) Prescribing Opioids for Postoperative Pain, and 4) Opioid Use Disorder Treatment Report and Recommendations. (note, this is also part of "ER is for Emergencies," see 2D below) These guidelines and strategies are incorporated in the Physical Health Behavioral Health (PHBH) Change Plan, which was completed by implementation partners August 2018 and work will continue through Dec 2021.
- Six Building Blocks (6BB) – 6BB is a team-based approach to improving opioid management in primary care. 6BB begins with a self-assessment and there are six key work areas to redesign and improve a clinic's management of patients who are on chronic opioid therapy and/or at risk for Opioid Use Disorder. The six steps are: 1) leadership support and agency-wide consensus; 2) revision, alignment, and implementation of clinic policies, patient agreements, and workflows for health care team members to improve opioid prescribing and care of chronic pain patients; 3) tracking and monitoring patient care for population management before, during, and between clinic visits of all patients on chronic opioid therapy; 4) planned, patient-centered, empathic care for patients on chronic opioid therapy; 5) caring for complex patients by developing policies and resources to ensure that patients who develop Opioid Use Disorder and/or who need mental/behavioral health resources are identified and provided with appropriate care, either in the care setting or by outside referral; and 6) continuous monitoring to measure success. (note, this is also part of "ER is for Emergencies," see 2D below).
- Prescription Drug Monitoring Program (PDMP) – OCH leverages MTP Delivery System Reform Incentive Payment incentives to encourage use of the State PDMP in the PHBH Change Plan through the following Tactic: Incorporate the use of the PDMP into workflow (note, this is also part of "ER is for Emergencies," see 2D below).

The following Outcome and Tactics for project 3A in the PHBH Change Plan highlight how the efforts to reduce opioid-related morbidity and mortality facilitate alignment with the state:

Required Outcome: Best practices for opioid prescribing are promoted and used.

- *Tactic*: Train providers on the Agency Medical Directors' Group's (AMDG) interagency or CDC guidelines on prescribing opioids for pain.

- *Tactic*: Incorporate the use of the Prescription Drug Monitoring Program (PDMP) into workflow

- *Tactic*: Train dentists in pain management best practices (please refer to Bree Dental Guidelines, 9/17).

- *Tactic*: Standardize recording of morphine equivalent dose (MED) in patient charts whenever an opioid prescription or change to opioid prescription is made.

Project 2D – What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to promote appropriate use of emergency care services and person-centered care? (e.g., the Washington State Hospital Association's "ER is for Emergencies" and "Seven Best Practices" initiatives.)

OCH integrated Community Paramedicine and all seven elements of the Seven Best Practices initiatives from "ER is for Emergencies" into the PHBH Change Plan. The seven elements are electronic health information, patient education, identify frequent users of the ED and EMS, develop care plans for frequent ER users, narcotic guidelines (see response above for project 3A), prescription monitoring (see response above for project 3A), and use of feedback information.

The following Outcomes and Tactics for project 2D in the PHBH Change Plan highlight how the diversion efforts facilitate alignment with the state:

Required Outcome: Providers are notified of patient/client ED visits.

- *Recommended Tactic*: Implement workflows to review Emergency Department Information Exchange (EDIE) feeds.

- *Recommended Tactic*: Implement Pre-Manage.

Outcome: At ED visit, patients are linked to a patient-centered medical home (PCMH) and appropriate services to treat mental health, substance use disorders and/or co-occurring disorders.

- *Recommended Tactic*: Embed community health workers in the ED to link patients to a patient-centered medical home or primary care provider.

- *Recommended Tactic*: Implement process to review the PRC (patient review and coordination) list and Emergency Department Information Exchange (EDIE) feeds, assess patient needs and link patients to community providers.

Project 3B – (1) How does the ACH align referral mechanisms and provider engagement strategies with the Health Homes and First Steps Maternity Support Services program? (2) What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination? (3) How is the ACH's approach aligned with MCO care coordination contract requirements?

The PHBH Change Plan asks Implementation Partners to indicate programs they refer to, including state sponsored programs such as Health Homes and First Steps Maternity Support Services. Implementation Partners are asked to list the organizations they are collaborating with for specific services and specific target populations. Providers are encouraged to develop referral processes to community-based programs that address perinatal and early child health disparities by income and race, including Head Start, Nurse Family Partnership and Parents as Teachers. An example of the framework within the PHBH Change Plan that captures this information is presented below.

OCH aligns with the MCOs' care coordination [contract requirement](#) (Section 14. Care Coordination) across the entire portfolio. OCH will seek opportunities to align with continuity of care, population health management (plan, identification, triage, intervene), care coordination services, case management services, data exchange protocols, allied system coordination (help with the Community-Based Organizations and Social Services Change Plan and social services provider coordination), Health Information Technology (HIT)/Health Information Exchange (through the Olympic Digital HIT Commons), coordination between the MCO and external entities (note that this includes Maternity Support Services and Educational Service Districts, First Steps, and other programs for children and families).

The following Outcome and Tactics for project 3B in the PHBH Change Plan highlight how the reproductive maternal and child health and reproductive health efforts facilitate alignment with the state:

Outcome: All patients are offered the full spectrum of contraceptive options and are able to make informed decisions.

- *Tactic:* Train medical providers in long acting reversible contraception (LARC) procedures.

Outcome: Team members are trained in preconception health and have access to evidence-based guidelines and promising practices.
- *Tactic:* Adopt guidelines, tools, evidence-based practices to improve provider knowledge and practice around preconception care and preconception risk.

Outcome: Team members are trained in preconception health and have access to evidence-based guidelines and promising practices.
- *Tactic:* Adopt guidelines, tools, evidence-based practices to improve provider knowledge and practice around preconception care and preconception risk.

Outcome: Coordinated, targeted outreach and engagement to increase well-child visits and immunizations rates is conducted.
- *Tactic:* Strengthen clinical-community linkages with schools and early intervention programs (child care, preschools, home visiting) to promote well-child visits and immunizations.

Project 3C – What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve access to oral health services?

OCH is facilitating alignment with multiple state efforts to improve access to oral health services for the Medicaid population. State efforts and summarized below, and below them, a demonstration of how the PHBH Change Plan will facilitate these efforts.
- Access to Baby & Child Dentistry (ABCD) – the coordinator for ABCD attends NCC Convenings and networks with providers on a regular basis.

- Capital dental expansion projects in each NCC – the state approved capitol expansion projects to support oral health access in each county in the region.

- Medicaid Managed Dental Care Organizations – three apparently successful bidders have been selected by the state.

- Oral health integration – OCH is collaborating with the Arcora Foundation and Qualis Health to integrate oral health education, screening and/or preventive procedures into care. Qualis Health has a toolkit for this training that they offer across the state.

- Tribal efforts to train and hire a specialized workforce called dental health aide therapists.

- Efforts to offer sealants to children in a school-based setting.

The following Outcomes and Tactics for project 3C in the PHBH Change Plan highlight how the oral health access and integration efforts facilitate alignment with the state:

Required Outcome: Oral health education, screening and/or preventive procedures are integrated into care.
- *Tactic:* Train providers on screening for oral health needs and engagement with oral health provider.

*Outcome***:** Access to care is increased.
- *Tactic:* Expand dental care through capital campaign projects.

Project 3D – What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve chronic disease management and control?

OCH selected the Chronic Care Model to guide practice transformation around the management of diabetes, cardiovascular disease, hypertension, and asthma. The PHBH Change Plan is designed to align with existing state efforts. Existing efforts include offerings of Chronic Disease Self-Management (CDSM), including Wisdom Warriors, and Diabetes Prevention Programs (DPP), primarily through community-based organizations and Tribal clinics. KMHS utilizes Whole Health Action Management (WHAM), an approach to chronic disease management designed specifically for persons diagnosed with mental illness and/or substance use. The three public health departments in the region have collaborated around policy, systems, and environmental changes to improve access to healthy eating and active living through local coalitions.

The following Outcome and Tactics for project 3D in the PHBH Change Plan highlight how the bi-directional integration efforts facilitate alignment with the state:

Required Outcome: Community-clinical linkages are enhanced to ensure patients are supported and active participants in their disease management.

- *Recommended Tactic:* Form bi-directional referral system within the NCC between clinical and community partner for effective chronic care services such as DPP, CDSM, WHAM, exercise programs and/or other; refer to appropriate programs depending on patient profile.

Acronyms used in this section:

3CCORP – 3 County Coordinated Opioid Response Project, 6BB – Six Building Blocks, ABCD – Access to Baby & Child Dentistry, ADAI – Alcohol and Drug Abuse Institute, BHA – Behavioral Health Agency, CDSM – Chronic Disease Self-Management, COSE – Center for Opioid Safety Education, DOH – Department of Health, DPP – Diabetes Prevention Program, ED – Emergency Department, EDIE – Emergency Department Information Exchange, EMS – Emergency Medical Service, EMT – Emergency Medical Technician, HIT – Health Information Technology, IMC – Integrated Managed Care, JH – Jefferson Healthcare, KMG – Kitsap Medical Group, KMHS – Kitsap Mental Health Services, MCO – Managed Care Organization, MOA – Memorandum of Agreement, MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, PDMP – Prescription Drug Monitoring Program, PHBH – Physical Health Behavioral Health, P-TCPI – Pediatric Transforming Clinical Practices Initiative, PTSH – Practice Transformation Support Hub, UW – University of Washington, VBP – Value-Based Payments, WHAM – Whole Health Action Management

Regional Readiness for Transition to Value-based Care

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

ACH Response
Responses must cover the following: • What actionable steps are partnering providers taking from DY 2, Q3 through DY 3, Q4 to move along the VBP continuum? Provide three examples.   • What is the role of the region's provider/practice champions as it relates to providing guidance to regional partners in support of value-based care goals?

OCH Response: Regional Readiness for Transition to Value-based Care

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

Olympic Community of Health (OCH) is tracking the following Outcomes and corresponding Tactics in the Physical Health Behavioral Health Change Plan. The 4 Outcomes and 14 Tactics listed below were co-designed with Implementation Partners from hospitals, primary care, substance use disorder treatment and mental health treatment to move along the VBP contract continuum.

Actionable steps taken by partnering providers to move along the Value-Based Payment (VBP) continuum: Physical Health Behavioral Health Change Plan Outcomes and Tactics	
Change Plan Outcomes	Change Plan Tactics
Transformation is sustained beyond the Medicaid Transformation Project	- Implement VBP arrangements with Managed Care Organizations
Population-based platform is systematically utilized to follow subpopulations for more efficient and effective care	- Standardize identification of and track sub-populations needing more efficient management and effective care based on conditions and/or risk levels - Track those with targeted conditions and/or at high-risk to ensure continued engagement and that conditions are treated to target - Empanel patients/clients to a care team - Disaggregate patient/client data by subpopulations to identify and track inequities (race, gender, age, other)
Care coordination protocols that include screening, appropriate referral, and closing the loop on referrals are developed to connect	- Organization focuses on linking specific subpopulations to appropriate clinical or community services - Offer referrals (verbal or written) to patients/clients informing where they can receive needed services - Sign Business Associate Agreements or equivalent with partners involved with the patient's care to support referrals OR sub-

specific subpopulations to clinical or community services	contract with community partners to ensure shared patients/clients receive appropriate services - Create and implement protocol to follow-up with referral partner after referral is made
Streamlined process is in place for information to be shared in a timely manner for shared patients/clients	- Implement protocol to obtain shared patient/client records - Sign inter-organizational agreements for access to records of referred and/or shared patients/clients - Participate in a technology platform that allows necessary patient/client information to be exchanged between the referee and referral organization - Maintain collaborative care plan in both physical and behavioral health records or in the same shared record - Establish and document a protocol for convening cross-sector care meetings

Acronyms included in this table: *VBP – Value-Based Payment*

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

OCH plays a convening and coordinating role of provider/practice champions in providing guidance to regional partners in support of value-based care goals.

Provider/Practice Champions: Role in providing guidance to regional partners in support of value-based care goals
Value-Based Payment (VBP) Action Team - Two local providers participate on the State's VBP Action Team and bring notes back to the Olympic Community of Health (OCH) executive director to disseminate to providers in the Olympic region. *Salish Behavioral Health Organization (SBHO)* - The SBHO hosts monthly coordination meeting tailored to their subcontracted behavioral health providers and including the Managed Care Organizations (MCOs) and OCH. These meetings prepare behavioral health providers for integrated managed care and value-based contracting. *Qualis Health/Practice Transformation Support Hub (PTSH)* - The Qualis Health Practice Coach Connector provides facilitated assessments, action planning and Quality Improvement training to Primary Care, Mental Health and Substance Use Disorder practices in the region. Environmental scanning to improve linkages for consumers to transportation, housing, food security is also provided. - A resource developed in 2017 by Outlook Associates, "Billing and Information Technology: A Toolkit for Behavioral Health Agencies" has been provided to all partnering Behavioral Health Agency (BHA) and Substance Use Disorder (SUD) providers in the OCH region during this Semi-Annual Report (SAR) reporting period. The materials provided to providers in this

toolkit are designed to assist BHAs in Washington State to assess their current state, current gaps, create a transition plan and timeline to accomplish transition milestones, and prepare for a billing and IT transition.

- OCH and Cascade Pacific Action Alliance (CPAA) are co-developing a two-day learning session for BHAs to prepare for value-based contracting and integrated managed care with Qualis Health and the Department of Health (DOH). The learning sessions will be held during the next SAR reporting period.

- Qualis Health/PTSH and the DOH will conduct an assessment and gap analysis of BHA and SUD billing operations and information systems for BHAs/SUDs in the CPAA and OCH Regions that need additional technical assistance in preparation for integrated managed care. Qualis Health and OCH have been planning this assessment during this SAR reporting cycle; the site visits will take place during the next reporting cycle. Six clinics will be chosen in each ACH region, a total of twelve between the two.

Medicaid Managed Care Organizations
- During this reporting period, the MCOs have been collaborating with OCH staff to align OCH reporting metrics with VBP contract metrics. MCOs agreed to share aggregate-level dashboard metrics of VBP metrics by Natural Community of Care. OCH will use these reports to tailor technical assistance to providers during the implementation phase beginning in 2019. The goal is to leverage the Medicaid Transformation Project (MTP) Delivery System Reform Incentive Payment funds to prepare providers for reporting and performance under VBP contracts with payers.

Performance Measurement and Evaluation Committee (PMEC)
- OCH recruited members for PMEC during this SAR reporting period. The first meeting of PMEC will be in the subsequent reporting period. PMEC is comprised of partners from multiple sectors from all three counties in the OCH region. PMEC will compile current reporting metrics from existing contracts, including Behavioral Health Organizations, commercial and Medicare payers, to inform the reporting requirements through Olympic Reporting and Community Activities—or ORCA—OCH's MTP reporting platform.

Acronyms included in this table: *BHA – Behavioral Health Agency, CPAA – Cascade Pacific Action Alliance, DOH – Department of Health, MCO – Managed Care Organization, MTP – Medicaid Transformation Project, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, PMEC – Performance Measurement and Evaluation Committee, PTSH – Practice Transformation Support Hub, SAR – Semi-Annual Report, SBHO – Salish Behavioral Health Organization, SUD – Substance Use Disorder, VBP – Value-Based Payment*

Acronyms included in this section: *OCH – Olympic Community of Health, VBP – Value-Based Payment*

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

Explain how the region is advancing HIT/HIE objectives.

ACH Response
Responses must cover the following: • What actionable steps are the ACH taking to facilitate information exchange between providers at points of care? Provide three examples. • How is the ACH leveraging Transformation incentives, resources, and activities to support statewide information exchange systems?

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

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

Olympic Community of Health (OCH) assessed providers' Health Information Technology (HIT)/Health Information Exchange (HIE) readiness/capacity/interest and gaps in technology to inform the development and targeting of the following priority projects:

1. *Olympic Digital HIT Commons:* OCH is piloting an IT platform to facilitate information exchange between providers at the point of care. The pilot is called Olympic Digital HIT Commons, or Commons. The initial use case for the Commons includes primary care and substance use treatment providers sharing information on shared patients requiring treatment for Opioid Use Disorder. Greater Columbia Accountable Community of Health and Puget Sound Fire are partnering with OCH on this project with different use cases. In this reporting period, all three partners agreed to share all tools, programming and resource outputs. A Memorandum of Understanding is under development.

   Commons development includes steps towards data governance:
   - OCH data governance and usage policies.
   - A standardized patient consent that allows partners to send/receive patient info with each other via the Commons.
   - A standardized Business Associate Agreement/Qualified Service Organization Agreement for the Commons.
   - A standardized agreement that each agency provider will sign with the Commons to be issued login credentials/passwords to access the Commons.

   At full-scale, the Commons could become a central line for partnering providers to share information in real-time about shared patients or clients across the entire Medicaid Transformation Project (MTP) portfolio of work. The guiding principles of Commons are (1) to leverage HIT already in use; (2) to reduce administrative burden on providers; (3) to keep technology lean and agile; and (4) to create "no-wrong door" for Medicaid consumers. Ongoing

computing and maintenance costs will be shared with the Greater Columbia ACH and Puget Sound Fire.

Use of the Commons is incentivized in the Physical Health and Behavioral Health Change Plans. Providers are asked to indicate if they will "*Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent2Share.*"

2. *Population Health Management Systems:* OCH has been supporting the Jefferson and Clallam Natural Communities of Care to identify the feasibility of a shared population health management system. OCH has jointly hosted several webinars and workshops with potential vendors, such as i2i, PreManage, Consent2Share and other Collective Medical Technologies.

   Having and/or sharing a population health management system is incentivized through the following outcomes and tactics in the Physical Health and Behavioral Health Change Plans:

   Outcome: Population-based platform is systematically utilized to follow subpopulations for more efficient and effective care.
   - *Tactic:* Standardize identification of and track sub-populations needing more efficient management and effective care based on conditions and/or risk levels.

   - *Tactic:* Track those with targeted conditions and/or at high-risk to ensure continued engagement and that conditions are treated to target.

   - *Tactic:* Empanel patients/clients to a care team.

   - *Tactic:* Disaggregate patient/client data by subpopulations to identify and track inequities (race, gender, age, other).

   Outcome: Health information is exchanged securely, appropriately, timely, and efficiently.
   - *Tactic:* Explore a common or interoperable EHR (Electronic Health Record) or EBHR (electronic behavioral health record) within Natural Community of Care.

   - *Tactic:* Explore a shared population health management system within Natural Community of Care.

   - *Tactic:* Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent2Share.

   - *Tactic:* Integrate dental records into the medical EHR.

3. *Shared Electronic Health Record*: OCH is supporting efforts in Clallam and Jefferson counties to encourage adoption of the same EHR, Providence Epic Community Connect. OCH is doing this through direct staff support and incentives through the Change Plan.

   The goal is to expand the EHR to North Olympic Healthcare Network, Forks Community Hospital, Bogachiel and Clallam Bay Clinics, Peninsula Behavioral Health, West End Outreach Services and

Discovery Behavioral Health. Note that three of these agencies are community mental health clinics (CMHC), making this transformation not only challenging due to the regulatory environment for CMHCs, but also extremely innovative. Currently, the following providers are already on the Providence Epic Community Connect platform: Olympic Medical Center, including the hospital, medical group and home health division; Jamestown Family Health Clinic; Jefferson Healthcare, including the medical group and hospital; and the Clallam County jail.

The Behavioral Health Agencies (BHAs) are exploring other vendors if Epic is cost prohibitive or unable to service their operational and regulatory needs. In this instance, the four BHAs may share in the purchase and use of the same Electronic Health Record and hope to have this implemented by early 2019.

Additionally, partners are exploring purchasing an EHR module called WISDOM, which would be an integrated dental record.

Sharing and integrated EHRs is incentivized in the Physical Health and Behavioral Health Change Plans: "*Explore a common or interoperable EHR (electronic health record) or EBHR (electronic behavioral health record) within Natural Community of Care";* and *(2) "Integrate dental records into the medical EHR."*

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

- MTP investments for HIT/HIE must be sustainable over time; therefore, OCH encourages provider use of services offered by OneHealthPort (OHP), including its HIE service and the Clinical Data Repository (CDR). Implementation Partners may use MTP Delivery System Reform Incentive Payment (DSRIP) earnings for participation in OneHealthPort and the CDR.
- OCH is considering how the HIT Commons platform (see above) will connect with statewide information exchange systems such as EDIE, PreManage and OneHealthPort, while simultaneously developing the HIT Commons to fill gaps in current infrastructure to support Change Plan activity.
- OCH Implementation Partners may direct MTP DSRIP earnings for acquisition, use, and upgrades of HIT/HIE tools for Change Plan activity. OCH encourages certified HIT modules/EHRs listed on the ONC Certified Health IT Product List: https://chpl.healthit.gov/#/search. These Certified Health IT products improve care coordination through the electronic exchange of clinical-care documents, are in accordance with interoperability standards and user-centered design, and support transmission of information to OHP and the CDR.
- OCH leverages MTP DSRIP incentives to encourage use of the State Prescription Drug Monitoring Program (PDMP) in the Physical Health Change Plans: *"Incorporate the use of the Prescription Drug Monitoring Program (PDMP) into workflow."*
- Pediatric – Transforming Clinical Practices Initiative (P-TCPi) has identified decreasing avoidable Emergency Department Visits as a Year 4 goal of the initiative. In collaboration with Collective Medical Technologies, P-TCPi is offering incentive dollars and technical assistance to enrolled clinics that have shown significant improvement in their transformation goals. Kitsap Children's Clinic and Reflections Counseling Services Group will implement PreManage in September 2018 and will submit monthly data reports to their P-TCPi Practice Facilitator. This data will assist both

clinics in completing their Change Plan requirements as part of the OCH Natural Communities of Care work.

Acronyms used in this section:
BHA – Behavioral Health Agency, CDR – Clinical Data Repository, CMHC – Community Mental Health Clinics, DSRIP – Delivery System reform Incentive Payment, EBHR – Electronic Behavioral Health Record, EHR – Electronic Health Record, HIE – Health Information Exchange, HIT – Health Information Technology, MTP – Medicaid Transformation Project, OCH – Olympic Community of Health, OHP – OneHealthPort, PDMP – Prescription Drug Monitoring Program, P-TCPi – Pediatric Transforming Clinical Practices Initiative

Technical Assistance Resources and Support

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

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

OCH Response: Technical Assistance Resources and Support

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

Olympic Community of Health (OCH)-Identified Technical Assistance/Resources	How Technical Assistance/Resource Secured
Quarterly state opioid workgroup meetings	Requested to be on the distribution list and be on webinars.
Monthly state criminal justice opioid workgroup meetings	Requested to be on the distribution list and be on webinars.
University of Washington Alcohol and Drug Abuse Institute (ADAI)	Opioid project lead has worked for/with ADAI since 2004.
Center for Opioid Safety and Education (COSE)	Opioid project lead had established networking partnership with COSE.
StopOverdose.Org	Opioid project lead had established networking partnership with StopOverdose.org.
Bree Collaborative	Requested to be on the distribution list and be on webinars.
Six Building Blocks (6BB) for clinic redesign and improved opioid prescribing	3 County Coordinated Opioid Response Project Prevention Workgroup and Steering Committee identified 6BB as a critical evidence-based practice for OCH region. Opioid project lead contacted and networked with 6BB and we are currently finalizing a contract.
Practice Transformation Support Hub Services, Olympic Community of Health Coach Connector	OCH has secured technical assistance of the Healthier Washington Qualis Health Practice Coach Connector in the Olympic region and embedded this resource into the OCH team. The Coach Connector provides regional behavioral health, Substance Use Disorder (SUD) and primary care providers with tools, training and hands-on technical assistance to achieve three goals:

	- Integrate physical and behavioral health - Move from volume to value-based care - Improve population health through clinical–community linkages
Pediatric – Transforming Clinical Practices Initiative, Olympic Community of Health Practice Facilitator	The Department of Health Pediatric – Transforming Clinical Practices Initiative works with Pediatric Primary Care, Behavioral Health and SUD Clinics to improve the following: - Decrease avoidable Emergency Department visits - Improve well-child and immunization rates - Improve asthma care - Integrate primary care and behavioral health services
Title: Billing and Information Technology: A Toolkit for Behavioral Health Agencies **Link**: http://www.waportal.org/resources/billing-and-information-technology-toolkit-behavioral-health-agencies	The materials provided in this toolkit are designed to assist Behavioral Health Agencies (BHAs) and SUD providers in Washington State to assess their current state and gaps, create a transition plan and timeline to accomplish transition milestones, and prepare for a billing and IT transition. The OCH has secured this free resource, which is shared with all providers as a comprehensive assessment and planning tool for direct contracting with Managed Care Organizations.
Title: Behavioral Health Clinical Quality Measures Tool **Link**: http://www.waportal.org/resources/behavioral-health-clinical-quality-measures-tool	This resource is free and shared with all participating providers in the region by the Qualis Health Practice Coach Connector. The tool was developed to assist behavioral health providers in their practice transformation efforts. This tool consolidates behavioral health-related clinical quality measures endorsed by the National Quality Forum.
Title: Promoting Chronic Disease Management: A guide for behavioral health care teams **Link**: https://waportal.org/resources/promoting-chronic-disease-management-guide-behavioral-health-care-teams	The Qualis Health Practice Coach Connector shares this resource with all enrolled sites, and all providers are encouraged to utilize this tool as they learn to track chronic disease and align treatment to target.
Title: PreManage Implementation Toolkit: A Guide for Washington State Behavioral Health Agencies **Link**: http://www.waportal.org/resources/premanage-implementation-toolkit-guide-washington-state-behavioral-health-agencies	OCH has secured this resource as a free and available guide for BHAs to increase transparency and real-time care coordination for their most vulnerable consumers with frequent Emergency Department visits. Although SUD clinics are currently only able to participate by view-only status due to 42 Code of Federal Regulations, it is still an important resource for increased transparency. The PreManage Implementation

	Toolkit is free and shared with all providers in the region by the Qualis Health Practice Coach Connector to understand the importance of real-time client/patient tracking in emergency rooms.
American Indian Health Commission Tribal Behavioral Health Toolbox, January 1, 2018 http://www.aihc-wa.com/files/2018/02/AIHC-Tribal-Behavioral-Health-Integration-Toolbox.pdf	During the development of this toolkit, the Qualis Health Practice Coach Connector and Pediatric Transforming Practices Initiative Practice Facilitator worked with the consultant from the American Indian Health Commission and met with the Lower Elwha Tribe to address special considerations of practice transformation for Tribal Behavioral Health Integration. This toolkit is free and shared with all partnering tribes as an added resource for quality improvement training and implementation.
Washington State Practice Transformation Academy	OCH has secured this resource due to their embedded Qualis Health Practice Coach Connector participating in the KMHS Value-Based Payment (VBP) team and attending the state-wide VBP Academy events during the past year., and sharing lessons learned with other clinics and with the OCH team.

Acronyms used in table:
6BB – Six Building Blocks, ADAI – Alcohol and Drug Abuse Institute, BHA – Behavioral Health Agency, COSE – Center for Overdose Safety and Education, OCH – Olympic Community of Health, SUD – Substance Use Disorder, VBP – Value-Based Payment

What technical assistance or resources does the ACH require from HCA and other state agencies?
The table below represents shared needs across all nine ACHs, including Olympic Community of Health (OCH), for additional support or resources from state agencies and entities to be successful. This table was a collaborative effort across the nine ACHs in response to a prompt in Semi-Annual Report I (January – June 2018) and has been modified and updated for the submission of the Implementation Plan.

Technical Assistance	Agency Involved
The Health Care Authority (HCA) and the ACHs collectively identify opportunities for collaboration related to educational/technical assistance series regarding Health Information Technology/Health Information Exchange (HIE)	HCA
Strong partnerships with Washington State Hospital Association (WSHA)	WSHA
HCA guidance on the ACHs' role in moving toward whole person care and Value-Based Payment (VBP)	HCA
Stronger collaboration with HCA and Managed Care Organizations (MCOs), to avoid triangulation of issues that are within the HCA-MCO contractor realm	HCA, MCOs
Fuller understanding of ACH role in supporting VBP contracts between HCA, MCOs and provider organizations	HCA, MCOs

Continued collaboration to find interoperability solutions	HCA
The state's ongoing role in the Practice Transformation Support Hub (PTSH), the Pediatric Transforming Practices Initiative (P-TCPi) Practice Transformation Network, and its vision for continuity after January 2019	PTSH, P-TCPi, DOH
Clear timelines and transparency about the extent of continued support planned—and needed—for practice transformation resources and initiatives	HCA
Systems for Population Health Management support for: - Data governance - Interoperability - HIE - Disease registries - Telehealth - PreManage/EDIE - Centralized registries	HCA, MCOs
Training and technical assistance for key workforce positions within required projects (e.g., Community health workers, peer support specialists, care coordinators, behavioral health specialists)	WSHA, DOH, Center for Workforce Studies, WA Workforce Training and Education Coordinating Board
Resources tailored to behavioral health providers that need to build capacity for quality improvement and measurement as they look ahead and adapt to being rewarded for quality, not quantity	Washington Council for Behavioral Health
Best practices and strategies specific to billing/coding for healthcare providers that aligns payments with the intent behind bi-directional integration (i.e., Department of Health's (DOH) PTSH is coordinating with the University of Washington's Advancing Integrated Mental Health Solutions Center to provide guidance on collaborative care codes)	Qualis Health
Facilitation of ongoing learning among ACHs via webinars and in-person forums	HCA
Administrative Support	**Agency Involved**
Approval of behavioral health integration and chronic care management codes would significantly impact long-term sustainability of disease management, 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	HCA
Streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring	DOH
Regular communication and access to results from state-level health system capacity surveys such as the VBP survey, the Washington State Health Workforce Sentinel Network and the Medicaid Electronic Health Record Incentive Program	HCA

Ensure that information held in data repositories (*All-Payers Claims Database and Clinical Data Repository*) is accurate, accessible, timely and useful to transformation	HCA
Support Dental Health Aide Therapists and other dental professions that expand capacity and improve access to oral health care for people enrolled in Medicaid	HCA
Increase capacity and access to practice transformation coaches, clinical subject matter experts, change management experts, workforce training and collaborative tools needed to work across ACH regions	HCA, DOH
Improve coordination with the DOH to ensure coordinated Opioid prevention efforts	DOH
Advocate for increased Medicaid rates in Washington State; providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation Projects (MTP)	HCA
Take leadership role on 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	HCA

Acronyms used in this table:

DOH – Department of Health, HCA – Health Care Authority, HIE – Health Information Exchange, MCO – Managed Care Organization, MTP – Medicaid Transformation Project, OCH – Olympic Community of Health, P-TCPi – Pediatric Transforming Practices Initiative, PTSH – Practice Transformation Support Hub, VBP – Value-Based Payment, WSHA – Washington State Hospital Association

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

Projects/Areas of Implementation	Helpful Lessons Learned or Implementation Experience from other Accountable Communities of Health
All Project Areas	- Development of intermediary measures between transformational activities and outcomes of interest. - Examples of best practice in fund allocation modeling under Delivery Reform Incentive Payment. - A PreManage Learning Collaborative to inform how to evaluate clinical workflow, client tracking, and to provide real-time care for most vulnerable consumers who have high Emergency Department utilization. - Customized On-Site Integrated Billing Toolkit, Practice Transformation Support Hub (PTSH)/Qualis Health and Outlook

	Associates for direct Managed Care Organization (MCO) billing. A resource entitled, "Billing and Information Technology: A Toolkit for Behavioral Health Agencies" to equip Behavioral Health Agencies (BHAs) and Substance Use Disorder (SUD) providers with assessment and tools for success under value-based contracting with MCOs.
	- Two Day Integrated Billing Workshop, PTSH/Qualis Health Sponsored: BHAs and SUD providers will benefit from this training being offered in the Olympic Community of Health region in October and November of 2018. Teams will learn about the support available during the transition to Integrated Managed Care (IMC) as well as create an actionable transition plan for IMC. Teams will work to develop projects to explore how to strengthen skills needed to be successful in a value-based payment future.
Project 2A	- Lessons learned by early and mid-adopters of Integrated Managed Care.
	- Successful Behavioral Health Integration into Primary Care (PC) at the Yakima Valley Farm Workers Clinic. ([link](#))
	- Behavioral Health Integration through Telepsychiatry at Mid-Valley Clinic Omak, WA. ([link](#))
Project 2A and 3D	- Practice Transformation Directory: BH and PC models of integration available as reference and/or direct consultation. PTSH/Qualis Health created this Practice Transformation Directory where providers can find information on a range of practice transformation opportunities available in Washington State and how to connect to the ones most relevant to their practice goals. All programs listed here are free and share the common goal of helping practices achieve sustainable improvements and patient outcomes. ([link](#))
	- Practice Transformation Roster: Primary care practices may want connection to additional practices undergoing

	transformation. This tool presents practices across the state who have transformation activities underway and can assist practices with a connection in the community to another agency for support and advice. (link)
Project 3A	- In-person and virtual sharing of resources, review of respective documents/deliverables, increased consistency across the state for opioid response.

Acronyms used in this table:
BHA – Behavioral Health Agency, IMC – Integrated Managed Care, MCO – Managed Care Organization, PC – Primary Care, PTSH – Practice Transformation Support Hub, SUD – Substance Use Disorder

Master Acronym List

3CCORP – 3 County Coordinated Opioid Response Project, 6BB – Six Building Blocks, ABCD – Access to Baby & Child Dentistry, ADAI – Alcohol and Drug Abuse Institute, APCD – All Payer Claims Database, BHA – Behavioral Health Agency, CBO – Community-Based Organization, CDP – Chemical Dependency Professional, CDR – Clinical Data Repository, CMHC – Community Mental Health Clinics, CDSM – Chronic Disease Self-Management, COSE – Center for Opioid Safety Education, COT – Chronic Opioid Therapy, CPAA – Cascade Pacific Action Alliance, DOH – Department of Health, DPP – Diabetes Prevention Program, DSRIP – Delivery System reform Incentive Payment, EBHR – Electronic Behavioral Health Record, ED – Emergency Department, ED – Executive Director, EDIE – Emergency Department Information Exchange, EHR – Electronic Health Record, EMS – Emergency Medical Service, EMT – Emergency Medical Technician, HIE – Health Information Exchange, HIT – Health Information Technology, IMC – Integrated Managed Care, JH – Jefferson Healthcare, KMG – Kitsap Medical Group, KMHS – Kitsap Mental Health Services, MAT – Medication Assisted Treatment, MCO – Managed Care Organization, MOA – Memorandum of Agreement, MTP – Medicaid Transformation Project, NCC – Natural Community of Care, OCH – Olympic Community of Health, OHP – OneHealthPort, OHSU – Oregon Health & Science University, ORCA – Olympic Reporting and Community Activities, PDMP – Prescription Drug Monitoring Program, PHBH – Physical Health Behavioral Health, PMEC – Performance Measurement and Evaluation Committee, P-TCPI – Pediatric Transforming Practices Initiative, PTSH – Practice Transformation Support Hub, QI – Quality Improvement, QIP – Quality Improvement Plan, SAR – Semi-Annual Report, SBHO – Salish Behavioral Health Organization, SUD – Substance Use Disorder, UW – University of Washington, VBP – Value-Based Payments, WHAM – Whole Health Action Management, WSHA – Washington State Hospital Association, YMCA – Young Men's Christian Association