



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

June 26, 2018

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Attachment: Semi-Annual Report Workbook

Semi-Annual Report Information and Submission Instructions

Purpose and Objectives of ACH Semi-Annual Reporting

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

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

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

Reporting Requirements

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

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

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

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

ACH Semi-Annual Report 1 – Reporting Period: January 1 through June 30, 2018	
Section	Sub-Section Description
Section 1. Required Toolkit Milestones (DY 2, Q2)	Milestone 1: Assessment of Current State Capacity
	Milestone 2: Strategy Development for Domain I Focus Areas (Systems for Population Health Management, Workforce, Value-based Payment)

ACH Semi-Annual Report 1 – Reporting Period: January 1 through June 30, 2018	
Section	Sub-Section Description
	Milestone 3: Define Medicaid Transformation Evidence-based Approaches or Promising Practices, Strategies, and Target Populations
	Milestone 4: Identification of Partnering Providers
Section 2. Standard Reporting Requirements	ACH Organizational Updates
	Tribal Engagement and Collaboration
	Project Status Update
	Partnering Provider Engagement
	Community Engagement
	Health Equity Activities
	Budget and Funds Flow

Key Terms

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

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

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

Semi-Annual Report Submission Instructions

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

File Format

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

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

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

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

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

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

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

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

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

Semi-Annual Report Submission and Assessment Timeline

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

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

Contact Information

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

ACH Contact Information

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

ACH Name:	Olympic Community of Health (OCH)
Primary Contact Name	Elya Prystowsky
Phone Number	(360) 633-9241
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Secondary Contact Name	Margaret Hilliard
Phone Number	(360) 689-2345
E-mail Address	margaret@olympicch.org

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

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

A. Milestone 1: Assessment of Current State Capacity

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

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

Yes	No
X	

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

ACH Response:

Not Applicable.

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

ACH Response:

Current State Assessment

Olympic Community of Health (OCH) conducted current state assessment activities during January-April 2018. OCH is comprised of three counties, which each have their own sub-regional groups of traditional and non-traditional Medicaid service providers referred to as Natural Communities of Care (NCCs). OCH held three meetings for each NCC; a total of nine meetings. Between the first and second NCC meetings, partners were asked to complete an online assessment for their respective organizations. The assessment consisted of 73 questions with subsets determined by partner type — physical health provider, behavioral health (BH) care provider (Substance Use Disorder (SUD) treatment or mental health (MH) treatment), community-based organization,

payer or state partner. OCH held a Regional Convening of all three NCCs in April 2018 to review regional Assessment results.

Key Definitions:

- *Implementation Partners:* Partnering providers that serve Medicaid beneficiaries within the three-county region with a completed Change Plan, signed Shared Change Plan and signed Implementation Partner-Specific Agreement.
- *Change Plan:* A detailed description of an Implementation Partner’s Outcomes and Tactics to meet the Board’s vision of the Medicaid Transformation Project (MTP). Change Plans form the scope of work for the Implementation Partner-Specific Agreement between OCH and the implementation partner. There are four versions of the Change Plan, each tailored to the type of Implementation Partner: (1) Hospital; (2) Primary Care; (3) Behavioral Health; and (4) Community-Based Organization.
 - *Outcome:* Desired sustainable result at the end of the MTP
 - *Tactic:* Strategy, workflow or and transformation activity for Implementation Partners to achieve the Outcome.
- *Shared Change Plan:* An agreement between partners within the NCC to cooperate to implement shared activities, share lessons learned and best practices, and participate with a sincere spirit of collaboration, an open mind, willingness to listen, mutual respect, and a commitment to doing the right work.
- *Implementation Partner-Specific Agreement:* A contract through 2021, possibly extended to 2023, between each Implementation Partner and OCH outlining mutual expectations between parties.



For a full list of the acronyms in use throughout this document, please refer to Attachment D: Glossary of Acronyms.

Summary of assessment respondents by type:

- 13 physical health providers (primary care, hospital, emergency department, specialty, pediatric)
- 10 BH care providers (SUD treatment and MH treatment)
- 3 payers (managed care or BH organization)
- 3 public health agencies
- 2 state agencies or associations

- 2 fire and rescue or emergency medical system agencies
- 1 of each of the following: tribal health clinic, law enforcement, education organization, community action agency, area agency on aging, community coalition, MH and family support, early learning regional coalition, housing authority.

Assessment questions were grouped into five sections, three at the NCC Shared Change Plan level and two at the partner Change Plan level.

Assessment Survey Results: NCC Shared Change Plan-Level

Table 1 identifies the top three transformation activities that each region is most interested in addressing through the MTP. The color-coding in the table indicates where there is alignment among the counties in regard to top activities.

Table 1. Top 3 Transformation Activities Identified by Region			
	Clallam NCC	Jefferson NCC	Kitsap NCC
1	<i>Opioid use disorder (OUD) treatment: regional standards of practice coordinating care and implementing the full spectrum of best practice treatment for opioid use disorder including primary care, BH, housing, and criminal justice (project 3A)</i>		
2	<i>Chronic disease prevention and control: referral processes between clinical and community settings to support disease self-management (project 3D)</i>	<i>Care coordination for emergency department and jail utilization: community health workers or equivalent workforce from the patient-centered medical home embedded in the emergency department and/or jail (project 2D)</i>	<i>Chronic disease prevention and control: referral processes between clinical and community settings to support disease self-management (project 3D)</i>
3	<i>Care coordination for emergency department and jail utilization: community health workers or equivalent workforce from a patient-centered medical home embedded in the emergency department and/or jail (project 2D)</i>	<i>Chronic disease prevention and control: referral processes between clinical and community settings to support disease self-management (project 3D)</i>	<i>Case management for emergency department utilization: intensive, cross-sector case management for frequent users of the ED and/or jail (project 2D)</i>

- Care Integration Key Findings (primary care & BH care providers only) (Project 2A)
 - Collaboration: current Substance Abuse and Mental Health Services Administration (SAMSHA) level of integration and additional interests; overall regional score = 2.6 which is between Level 2 – Basic collaboration at a distance and Level 3 – Basic collaboration onsite.
 - Integration interests (top 3): (1) bi-directional referrals, (2) data sharing agreements (DSA) across sectors, (3 tie) integrated care teams, (3 tie) co-location of BH and medical providers in the same facility

- Technical assistance (TA): current vendors and additional interests (top 3)
 - Current TA vendors: (1) Practice Transformation Support Hub (PTSH)/Qualis, (2) Pediatric-Transforming Clinical Practices Initiative (P-TCPI), (3) Advancing Integrated Mental Health Solutions (AIMS) Center
 - Additional TA vendor interest: (1) SAMHSA, (1) PTSH/Qualis, (3 tie) Bree Collaborative, (3 tie) AIMS Center
- Resources to share with partners (top 3): (1) Subject matter expertise, (2) Facilities, (3) Workforce
- Care Infrastructure Key Findings (all projects)
 - Shared workforce investment/training opportunity interests (top 3)
 - *Clallam NCC*: (1) Medication Assisted Treatment (MAT), (2) Placing nursing students and residents from local community colleges in internships and practicums, (3) Population health management (PHM): training in how to make a referral, use a registry, track patients, and other similar activities
 - *Jefferson NCC*: (1) chronic disease self-management support, (2) trauma-informed care training, (3) shared recruitment and retention tools, (3) mobile workforce (e.g., mobile dental van (project 3C))
 - *Kitsap NCC*: (1) Advocating for scope of practice changes, (2) shared recruitment and retention tools, (3) shared workforce (e.g., specialists)
 - Health Information Exchange (HIE)/Health Information Technology (HIT): level of interest in shared PHM strategy and/or compatible electronic (behavioral) health record (EHR/EBHR)
 - Shared PHM Strategy: Yes- 76%, Maybe- 24%, No- 0%
 - Compatible EHR/EBHR: Yes- 34%, Maybe- 58%, No- 8%
 - Community empowerment and education campaign interests (top 3): (1 tie) opioid misuse/abuse/fatal overdose prevention, (1 tie) opioid use disorder (OUD) treatment, (2 tie) MH stigma reduction, (2 tie) healthy eating and active living; (3) chronic disease prevention

Assessment Survey Results: Partner Change Plan-Level

Table 2 indicates the top 3 transformation activities clinical partners are most willing to perform within their clinics. The color-coding in the table indicates where there is alignment among the counties.

Table 2. Top 3 Clinical Partner Transformation Activity: Willingness			
	Clallam NCC Partners	Jefferson NCC Partners	Kitsap NCC Partners
1	<i>Mental Health Care (lite)</i> : Depression and anxiety screening (project 2A)		
2	<i>Prevention of Fatal Opioid Overdose</i> : Co-prescribing naloxone with safe opioid prescribing practices (project 3A)	<i>Opioid Use Disorder (OUD) Treatment</i> : Increase the number of providers waived to prescribe/provide medication assisted	<i>Opioid Misuse and Abuse Prevention</i> : Clinic redesign for safer opioid prescribing practices (project 3A)

		treatment (MAT) (project 3A)	
3	<i>Chronic Disease Prevention and Control: Medication management and education (project 3D)</i>	<i>Reproductive Health: Screening for sexually transmitted infections (project 3B)</i>	<i>Chronic Disease Prevention and Control: Medication management and education (project 3D)</i>
3	*	<i>Mental Health Care (lite): Depression medication management (project 2A)</i>	
3	*	<i>Reproductive Health: Contraceptive education (project 3B)</i>	*

* indicates no clear, similar leading activities among respondents

- Workforce investment/training opportunity interests (top 3): (1) retention, (2) recruitment, (3) cross training/retraining/certification/up-training
- Value-based payment (VBP) readiness: current participation, experience, enabling factors, barriers, anticipated future participation
 - Current participation: 45% limited experience feedback, 86% anticipated future participation increase
 - Enabling factors (top 3): (1 tie) Aligned quality measurements and definitions, (1 tie) Aligned incentives and/or contract requirements, (2) State-based initiatives (e.g., State Innovation Model grant, Healthier Washington, MTP)
 - Barriers (top 3): (1 tie) Lack of interoperable data systems, (1 tie) Lack of availability of timely patient/population cost data to assist with financial management, (2) Lack of access to comprehensive data on patient populations (e.g., demographics, morbidity data)
- HIE/HIT: current inter-agency Data Sharing Agreements (DSAs), EHR/EBHRs, PHM system, interest in multi-disciplinary system
 - Agencies with DSAs with partners within the NCC: 69%. Note: 87% without DSAs are willing to put a DSA in place
 - Most common EHR: EPIC; EBHRs: Profiler, Valent
 - Most common PHM systems: Healthy Planet, i2i
 - Multi-Disciplinary System: Yes- 72%, Maybe- 23%, No- 4%
- Reporting Infrastructure: reporting and communication portal experience & input for future design
 - Currently using a portal: Yes – 37%, Maybe – 17%, No- 46%
 - Input: simple, easy to use, compliant, secure, web-based

General Assessment Survey Results

- Organizations serving partners: resources to share with partners and desired involvement
 - Resources to share (top 2): (1) data & analytics, (2) administrative support for the transition to integrated managed care
 - Desired involvement: meet regularly- 75%
- Partner hesitations (top 3): (1) time, (2) limited staff capacity to participate on various committees and QI projects, (3) not enough money
- Excitement and feedback (top 3): (1) working with partners in my community, (2) providing better care, (3) being able to succeed in a value-based, financially integrated health care delivery payment model

Practice Transformation Assessments

The PTSH/Qualis Health Coach-Connector and P-TCPI Practice Facilitator assigned to the Olympic region engaged eleven BH practices and eleven physical health practices for assessment of current state, quality improvement activities, technical assistance and action planning for integrated care. Through their efforts, OCH identified regional and specific sub-group themes of quality improvement (QI) areas. The included PTSH/Qualis and P-TCPI Aggregated Report summarizes the Olympic region's current practice transformation assessment utilizing the Patient Centered Medical Home Assessment (PCMH-A), the Maine Health Access Foundation (MeHAF) Site Self-Assessment and Practice Assessment Tool (PAT), action planning process with each partnering clinic/agency (Attachment A and B: PTSH and P-TCPI Aggregated Report).

Key practice transformation assessment findings are presented by subcategory below.

Practice Transformation Assessment General Results: Olympic Region

- Optimize and/or finance new EHRs
- Leadership buy-in of whole person care and development of QI teams to begin the process of planned transformation
- QI projects to build registries to track chronic disease and BH treatment to target
- Systematic assessment of health literacy, social determinants of health (SDoH)
- Linkage to community-based services
- Designing and building new systems within each NCC to deliver whole-person care and prepare for VBP contracting

Practice Transformation Assessment Results: Behavioral Health Providers

- Improve referrals and care coordination for engaged clients by building relationships with primary care partners
- Assistance in administering and managing contracts with Medicaid Managed Care Organizations (MCOs)
- Salish Behavioral Health Organization (SBHO), the single payer for BH services in the region, to serve as intermediary between SUD clinics and MCOs

Practice Transformation Assessment Results: Primary Care Providers

- Optimize EHRs
- Build PHM tools such as registries for chronic disease and BH tracking treatment to target
- Transition to the Collaborative Care Model (project 2A) and set up workforce and billing systems to utilize new Collaborative Care billing codes. Workforce developments include new positions such as health navigators and/or care coordinators

Practice Transformation Assessment Results: Implementation Partner and Tribe-Specific Updates

Key practice transformation assessment findings by Implementation Partner:

- Kitsap Mental Health Services (KMHS), a MH treatment provider, and Kitsap Medical Group, a primary care provider, in partnership with Harrison Heath Partners Catholic Health Initiatives Franciscan/Northwest Washington Family Medicine Residency, a hospital-medical group provider, are developing a pilot program in Bremerton for an eight-hour-per-month Collaborative Care Model (project 2A)
- Harrison Health Partners is hiring three social workers to be employed by KMHS and embedded in the multiple clinics throughout the Kitsap NCC (project 2A & 3A)
- KMHS has partnered with Kitsap Children’s Medical, Silverdale Pediatrics, and Peninsula Community Health Services on a chronic asthma population health project (project 3D) targeting patients with asthma and high emergency department (ED) utilization for a curriculum to conduct in-home assessments and patient education visits
- Lower Elwha Klallam Tribe (LEKT) and Port Gamble S’Klallam Tribe (PGST) formed integrated QI teams and prioritized EHR capability for full transparency between oral, physical, mental and SUD treatment services (all projects)

Practice Transformation Assessment Results: Tools for Integration

The PTSH/Qualis Health Coach Connector shared the tools listed below with QI teams at each Olympic partnering site to assist practices with integration:

- *Billing and Information Technology: A Toolkit for Behavioral Health Agencies* - Designed to assist MH and SUD providers in Washington State to assess current state and gaps, create a transition plan and timeline to accomplish transition milestones, and prepare for a billing and IT transition (project 2A & 3A)
- *PreManage Implementation Toolkit: A Guide for Washington State Behavioral Health Agencies* - A care management tool that combines and synthesizes information from participating healthcare partners, including hospitals and EDs, primary care practices and BH agencies into brief, actionable information about individual clients; designed to walk a BH agency through the process of preparing for and implementing PreManage (all projects)
- *Promoting Chronic Disease Management: A Guide for Behavioral Healthcare Teams* - This tool describes steps BH practitioners can take to assist clients in addressing chronic disease and includes an extensive list of physical health resources, that can help increase the care team’s knowledge and confidence in discussing all aspects of a clients’ care from understanding a diagnosis to discussing medication adherence (project 3D)

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

ACH Response:

Since submitting the Project Plan, OCH has continued to explore available data to inform the project planning and implementation. OCH administered a customized current state assessment and held subsequent discussions with NCC partners to adjust proposed projects so they are meaningful to Medicaid consumers and providers.

OCH presented evidence-based practices (EBPs) in the Project Plan however they will be operationalized by Implementation Partners as workflow redesigns in the Change

Plan. The Change Plan is the linchpin for OCH's MTP implementation approach. The Change Plan approach offers Implementation Partners a realistic understanding of the effort it will take for their organizations to operationalize the EBPs. OCH integrated Implementation Partner input to prioritize EBP workflows, develop activities for each workflow, and align activities with desired outcomes in the Change Plan. For purposes of this report, OCH staff cross-walked each activity by project area to illustrate the comprehensive nature of this approach in achieving the goals of the MTP. (Attachment C: Physical Health/Behavioral Health Change Plan).

The bulleted findings below are from the OCH current state assessment and analysis of other data sources. Grey highlighted text is examples that crosswalk the Change Plan to assessment findings. Findings were presented for discussion at NCC meetings to help partners come to agreement on the content of the Shared Change Plan for each NCC and the Change Plans for Implementation Partners.

Current State Assessment: Opportunities for Improvement - Key Themes (Sample of corresponding Outcomes and Tactics in the Change Plan)

- Major workforce shortages, particularly in opioid use disorder treatment such as waiver MAT providers (Change Plan includes the following Tactics: Increase the number of providers waived to provide MAT; Offer patients MAT)
- Major barriers to bi-directional physical health and BH integration, such as barriers to making referrals between primary care and BH care (Change Plan includes the following Outcome: Health information is exchanged securely, appropriately, timely, and efficiently; and Tactic: Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share)

Geographic Data Highlights

- *Clallam NCC:*
 - Rate of ED utilization 16% higher than WA average (Change Plan includes the following Outcomes: (1) At ED visit, patients are linked to a patient-centered medical home (PCMH) and appropriate services to treat MH, SUD and/or co-occurring disorders; (2) Organization develops or enhances services to help keep patients/clients out of ED; (3) Patients/clients are assisted to understand appropriate settings for receiving health care services including ED utilization; (4) Providers are notified of patient/client ED visits)
 - 3 in 10 beneficiaries used dental services, below WA average; 4 in 10 children, 15% below WA average and lowest in OCH region; 2 in 10 adults, similar to state and best in region (Change Plan includes the following Outcome: Oral health education, screening and/or preventive procedures are integrated into care)
 - High rates of beneficiaries with OUD (Change Plan includes the Outcome: Best practices for opioid prescribing are promoted and used)

- Nearly 30% of Medicaid beneficiaries has a MH diagnosis; 15% SUD; 9% co-occurring MH+SUD (Change Plan includes the following Tactic: Standardize identification of and track sub-populations needing more efficient management and effective care based on conditions and/or risk levels such as a) substance use disorder, b) opioid use disorder, c) co-occurring MH-SUD, d) depression and e) BH and chronic disease)
- Only 55% of children aged 3-6 get well child visits; 6% below WA average (Change Plan includes the following Outcome: Coordinated, targeted outreach and engagement to increase well-child visits and immunizations rates is conducted)
- Rate of providers prescribing opioids (2015 data) nearly double Kitsap; lower rate of patients per provider (Change Plan includes the Outcome: Best practices for opioid prescribing are promoted and used)
- *Jefferson NCC:*
 - Dental services utilization for all ages 15% lower than WA average and lowest in OCH region overall (Change Plan includes the following Tactic: Expand dental care through capital campaign projects)
 - Highest ratio of residents per provider in OCH region, 56% higher than WA average (Change Plan includes the following Tactics: (1) Share workforce with another organization; (2) Partner with an institute to establish a residency training program; (3) Partner with community college programs to recruit allied health professionals as they graduate; (4) Partner with community college programs to recruit allied health professionals as they graduate; (5) Incorporate telehealth into your practice)
 - Percent of MAT with Buprenorphine lowest in OCH region (Change Plan includes the following Tactics: (1) Increase the number of providers waived to provide MAT; (2) Offer patients MAT)
 - Rate of Chlamydia screening 7% below WA average and lowest in OCH region (Change Plan includes the following Tactic: Screen sexually active females aged 16-24 for chlamydia)
 -
- *Kitsap NCC:*
 - High rate of ED utilization; 44% higher than WA average (Change Plan includes the following Outcome: At ED visit, patients are linked to a patient-centered medical home (PCMH) and appropriate services to treat MH, SUD and/or co-occurring disorders)
 - 3 in 10 beneficiaries used dental services; below WA average. Adult rate 2.5 times lower than children (Change Plan includes the following Outcome: Access to care is increased; with the following Tactic: Expand dental care through capital campaign projects; Purchase operatories, supplies, and/or equipment to expand access to care)
 - Prenatal care in 1st trimester lower than WA average (Change Plan includes the following Outcome: Team members are trained in

- preconception health and have access to evidence-based guidelines and promising practices)
 - Medicaid Support Services participation rate 27%, just under half the WA average (Change Plan includes the following Tactic: Strengthen clinical-community linkages with schools and early intervention programs (child care, preschools, home visiting) to promote well-child visits and immunizations)
 - *Olympic Community of Health Region:*
 - Higher prevalence of BH conditions among beneficiaries with negative outcomes (arrest, unemployment, homelessness) (Change Plan includes the following Outcome: Standardize identification of and track sub-populations needing more efficient management and effective care based on conditions and/or risk levels with the following relevant subgroup Tactics: Behavioral health conditions with chronic disease; high utilizers of the criminal justice system; experiencing homelessness/food insecurity)
 - Higher prevalence of chronic disease among beneficiaries with BH, 70-80% (Change Plan includes the following Outcomes: (1) Culture shift across organization to prioritize chronic disease prevention and management is created; (2) Community-clinical linkages are enhanced to ensure patients are supported and active participants in their disease management; and (3) Care coordination protocols that include screening, appropriate referral, and closing the loop on referrals are developed to connect specific subpopulations to clinical or community services)
 - Almost no primary care providers address caries prevention or intervention as part of well/ill child visits (Change Plan includes the following Outcome: Oral health education, screening and/or preventive procedures are integrated into care)
5. Provide examples of community assets identified by the ACH and partnering providers that directly support the health equity goals of the region.

ACH Response:

At the OCH Regional NCC Convening in April 2018, OCH asked partners to complete a questionnaire about health equity, including examples of their current efforts and what they think would be helpful to address equity. OCH considers these responses to be examples of community assets that directly support the health equity goals of OCH.

Community assets to support health equity goals: Current partner activities

- *Providing support:* housing, resource referrals, collaborate to remove barriers, transportation, employment, and other financial supports
- *Providing tailored services to meet specific population needs:*

- targeted program/enhanced/specialized services
- services for specific populations: American Indian/Alaska Native (AI/AN), adolescents, men, homeless, people with SUD and/or MH disorders
- service delivery locations/modalities: schools, jail and co-location
- *Expanding access to services*: equal access to care/services, see patients regardless of ability to pay, materials in multiple languages/interpreters, residency program, place-based care, specific locations: schools, jail and co-location
- *Offering training to better serve specific populations*: tribal, trauma-informed care and adverse childhood experiences and LGBTQ+
- *Making health equity a strategic priority*:
 - Already an organization strategic priority or in strategic plan
 - Require equity-based assessment of projects funded
 - Focus grants/funding on rural underserved areas
- *Providing tailored outreach* for specific populations and/or for specific geographies
- *Using data*: collecting demographic and service screening data, disaggregating data to guide decision making, developing and sharing a disparities report
- *Participating in community advocacy*: serve on boards or coalitions, participate in cross-system collaboration

Community assets to support health equity goals: Planned partner activities

- *Top activities*: sharing best practices and resources, training, having tools to identify populations experiencing inequities, and developing a more diverse workforce
- *Other activities*: hiring more staff, developing a referral network for community supports outside of clinical care, establishing a community coalition specifically focused, generating and disseminating reports on equity in our community, including community voices (e.g., publicity to start/continue to the community conversation, funding to expand social services, opportunities to network w/ agencies that provide these services), providing Neuroscience, Epigenetics, Adverse Childhood Experiences, Resilience (NEAR) and Trauma-Informed Care training, funding, paying equitable and reasonable wages for workforce, providing access to training for workforce, performing workforce recruitment, and clinical outcomes data to incorporate into practice

Community assets to support health equity goals: Identified excluded or marginalized populations experiencing health inequities, organized by top population of focus within each category

- Socioeconomic Status: Low income
- Race/Ethnicity/Language: AI/AN, Hispanic and immigrants
- Sexual Orientation: LGBTQ+

- Housing: Homeless
- Gender Groups: Gender non-conforming
- Age Groups: Teens/youth/adolescents
- Other Groups: Mentally ill and SUD

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

ACH Response:

OCH has gathered input around health equity knowledge and skill gaps from partners. Using the OCH health equity questionnaire responses from the Regional NCC convening, OCH aggregated data around opportunities for improvement identified by partners:

- Top opportunities: (1) Housing, (2) Living wage jobs, (3) Availability of services, (4) Transportation, (5) Education, (6) Food security (7) Access to fresh, healthy food, (8) Childcare, (9) Access to opportunities for physical activity
- Other opportunities: MH treatment services available to adults and in school, chemical dependency treatment services, decrease social isolation, increase cohesion, phone/communication services language barriers addressed, health literacy/reading literacy, culturally responsive/specific services, community connections (relationships), awareness of aging services available, history of Adverse Childhood Experiences (ACEs), current history of ongoing multiple traumas, racial and gender equality/justice, affordable health care and accessible health care

OCH's next steps include ongoing administration of the health equity questionnaire to reach more partners and repeat administrations to track developments in organizational approaches and identified opportunities for improvements. OCH is beginning to map out strategies to address identified opportunities. The first such strategy was partnering with a local organization, Kitsap Strong, to provide a free NEAR training at the Regional NCC convening. Additionally, health equity is incorporated into the Change Plan as a training element and activity within population health management:

- Outcome: All staff understand the impact of trauma and health inequities on health.
- Tactics: (1) Offer training in health equity; (2) Offer training in LGBTQ-inclusive care; (3) Offer training in NEAR sciences, historical trauma, and trauma-informed care

OCH also incents providers in the Change Plan to disaggregate their data to identify and work to address inequities in access and outcomes across sub-populations.

Most of the initial top opportunities for improvement are closely connected to the second element of the OCH Transformation objectives, “effective linkages between primary care, social services and other community-based service providers.” Additionally, availability of services, is closely connected to the first element of the OCH Transformation objectives, “accessible, patient-centered healthcare system that effectively integrates physical, behavioral and dental health services.”

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

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

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

Yes	No
X	

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

ACH Response:

Not Applicable.

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

ACH Response:

OCH considers Domain 1 activity as foundational to the entire project portfolio and not specific to any one project. To that end, OCH integrated each Domain 1 focus area into the planning process to align Domain 1 strategies across all projects in the Change Plan Outcomes and Tactics (Attachment C: Physical Health/Behavioral Health Change Plan)

Olympic Digital Health Information Technology Commons – A Population Health Management System Strategy

In support of all project areas, OCH is piloting an IT platform to reduce barriers to care communication between providers on shared patients and clients. The pilot was described in the Project Plan as IT Care Coordination and is now called Olympic Digital Health Information Technology (HIT) Commons, or Commons. As mentioned earlier, there is a high interest across partners and NCCs for a shared PHM strategy (76% of respondents to the assessment survey indicated a strong interest)

The Commons pilot phase ended on time, under budget, and with encouraging results. The use case for the Commons pilot included one primary care provider and one SUD treatment provider sharing information on shared patients requiring treatment for OUD. Because of the pilot's success, the Board is deliberating over a proposal for Phase 2 – to expand the Commons to additional users.

If successful at full-scale Commons will be a central nervous line for partnering providers to share information in real-time about shared patients or clients across the entire 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.

Greater Columbia Accountable Community of Health and Puget Sound Fire in the Healthier Here ACH are collaborating with OCH on the development and potential cost-sharing of a statewide Commons.

Strategies for each Domain 1 focus area to support OCH’s project portfolio

The tables below (3a-d) below highlights two elements: (1) a current state assessment submitted by partners (please refer to section 1A); and (2) integration of each Domain 1 focus area into the Outcomes and Tactics of the Change Plan. Outcomes and Tactics comprise evidence-based programs, strategies and promising practices for Implementation Partners as part of their scope of work for the MTP.

Progress made by OCH January 1 thru June 30, 2018

Table 3a. Domain 1 Area: Value-Based Payment (VBP)
Current State Assessment (January -February 2018)
OCH repeated the questions from the Medicaid Value-Based Purchasing (MVP) Action Team in the webform: <ul style="list-style-type: none">- Do you currently have VBP contracts of any kind?- If you are receiving VBP from a health insurance company, please describe your overall experience with VBP.- If you are receiving VBP from any payer, what has enabled your participation in VBP?- What are the greatest barriers for engaging in VBP?- Realistically, how do you expect your participation in VBP to change over the next 12 months?

Change Plan (January-June 2018)

The Change Plan includes the following Outcomes and Tactics:

QI methods are used to improve care and care delivery*

- Form and maintain a diverse QI team of clinical and administrative staff with protected time to examine and improve upon clinical outcomes, quality of care, and patient satisfaction

Transformation is sustained beyond the MTP*

- Implement VBP arrangements with MCOs*
- Offer organization financial or in-kind match of Delivery System Reform Incentive Payment (DSRIP) funding
- Report on value-based metrics that will be in MCO contracts*
- Support all-payer collaboration to foster system-wide transformation

Table 3b. Domain 1 Area: Workforce

Current State Assessment (January -February 2018)

OCH assessed the respondent's interest in the following workforce opportunities:

- Telehealth; Cross-training, retraining, certification, uptraining; New workforce; Recruitment; Retention; Placement for new grads/nurses/residents

Change Plan (January-June 2018)

The Change Plan includes the following Outcomes and Tactics:

Culture shift across organization to prioritize chronic disease prevention and management is created*

- All levels of staff participate in Chronic Care Model training
- Support chronic care improvement at all levels of the organization, beginning with the senior leader
- Encourage transparent and systematic handling of errors and quality problems to improve chronic care

Team members are trained in preconception health and have access to evidence-based guidelines and promising practices

- Adopt guidelines, tools and EBP to improve provider knowledge and practice around preconception care and preconception risk
- Ensure clinicians are trained in assessment around common preconception risk categories

All staff understand the impact of trauma and health inequities on health

- Offer training in (1) health equity, (2) LGBTQ-inclusive care, (3) NEAR sciences, historical trauma, and trauma-informed care

Patients receive the care they need from a trained workforce

- Share workforce with another organization
- Partner with an institute to establish a residency training program
- Partner with community college programs to recruit allied health professionals as they graduate

- Hire Community Health Worker or similar workforce
- Incorporate telehealth into your practice

Table 3c. Domain 1 Area: Population Health Management Systems

Current State Assessment (January -February 2018)

OCH asked the following questions about PHM Systems:

- OCH is implementing a pilot multi-disciplinary system to facilitate care coordination between primary care, substance use treatment providers, housing, and criminal justice. Would you be interested in participating in its development?
- Does your organization have DSAs, MOUs, business associates agreements, or other similar agreements with partners in your NCC or other NCCs to support continuity of care and information sharing for shared patients or clients?
- How many DSAs, MOUs, business associates agreements, or other similar agreements with partners in your NCC or other NCCs do you have?
- Can we contact you about these DSAs, MOUs, business associates agreements, or other similar agreements with partners in your NCC or other NCCs?
- Would you like to have DSAs, MOUs, business associates agreements, or other similar agreements with partners in your NCC or other NCCs in place?
- What is your current EHR/EBHR?
- Would you like to change or upgrade this system?
- If you currently have a PHM system (e.g., i2i, Healthy Planet), please name.
- If you do not currently have a PHM system, which one(s) are you exploring?

Change Plan (January-June 2018)

The Change Plan includes the following Outcomes and Tactics:

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)

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 BH records or in the same shared record
- Establish and document a protocol for convening cross-sector care meetings

Providers are notified of patient/client ED visits*

- Establish notification system between hospital and patient's medical/BH home

- within NCC when a patient/client visits the ED
- Implement workflows to review Emergency Department Information Exchange (EDIE) feeds
- Implement Pre-Manage

Best practices for opioid prescribing are promoted and used*

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

Health information technology is used efficiently to facilitate effective care*

- Identify relevant sub-populations by creating disease-specific registry/module/report in EHR/or appropriate electronic tracking tool
- Close the loop for referrals
- Systematically integrate information from referrals into care plan

Health information is exchanged securely, appropriately, efficiently, and in a timely manner*

- Explore a shared PHM system within NCC
- Explore real-time exchange of health information with partners under the Commons or other platforms such as Pre-Manage or Consent to Share

Community-clinical linkages are enhanced to ensure patients are supported and active participants in their disease management*

- 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

* *Outcomes and Tactics that are required for all Implementation Partners.*

Table 3 Acronyms: CDSM – Chronic Disease Self-Management, EBHR – Electronic Behavioral Health Records, ED – Emergency Department, EDIE – Emergency Department Information Exchange, EHR – Electronic Health Records, DPP – Diabetes Prevention Program, DSA – Data Sharing Agreement, DSRIP – Delivery System Reform Incentive Payment, LGBTQ – Lesbian Gay Bisexual Transgender Queer, MCO – Managed Care Organization, MTP – Medicaid Transformation Project, MVP – Medicaid Value-Based Purchasing, NCC – Natural Community of Care, NEAR – Neuroscience Epigenetics Adverse Childhood Experiences Resilience, PDMP – Prescription Drug Monitoring Program, QI – Quality Improvement, PHM – Population Health Management, VBP – Value-Based Payment, WHAM – Whole Health Action Management; for a full list of acronyms in use in this document, refer to Attachment D: Glossary of Acronyms

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

ACH Response:

During the current state assessment, OCH learned that one NCC is interested in exploring alignment of EHR and population health management systems across partnering organizations. OCH is facilitating conversations across partners and vendors to assess the viability of this approach.

Since the Project Plan, OCH converted the proposed Domain 1 strategies into actionable

Change Plan Outcomes and Tactics (Attachment C: Physical Health/Behavioral Health Change Plan). Additionally, the OCH Board and Funds Flow Workgroup has advised staff to prioritize health systems capacity building and infrastructure when targeting DSRIP investment.

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

ACH Response:

Table 4 below represents the shared needs across all nine ACHs, included OCH, for additional support or resources from state agencies and entities to be successful in building health system capacity through the MTP.

Table 4. Shared ACH Needs		
Health System Capacity Building	Technical Assistance	Administrative
Strong partnerships with Washington Association of Public Hospital Districts	HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Approving general BH integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program, and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings
Strong partnerships with Washington Hospital Association	Support from HCA for guidance on the ACHs' role in moving towards whole person care and value-based payment.	Streamline the Washington State credentialing process for medical and BH professionals, including telemedicine, to lessen the costs of hiring.
Stronger collaboration between HCA and MCOs	ACH’s would benefit from additional training to fully understand our role in supporting VBP contracts between HCA, MCOs, and provider organizations.	Streamline informational requests from our partners. will enhance continued assessment and planning.
ACH and HCA continued collaboration to find interoperability solutions	ACH also seeks greater clarity on the state’s ongoing role in the PTSH, the P-TCPi Practice Transformation Network, and its vision for continuity after January 2019.	Regular communication and access to results from state-level health system capacity surveys such as the VBP survey, the Washington State Health Workforce Sentinel Network, and the Medicaid EHR Incentive Program

HCA and ACH collectively identify opportunities for collaboration with stakeholders and partners related to an educational/TA series regarding HIT/HIE	Clear timelines and transparency about the extent of continued support planned—and needed—for practice transformation resources and initiatives	Engagement of ACH staff and key partners in design and dissemination of these and other surveys will also limit redundancy and increase response rates to data collection processes.
In collaboration with stakeholders, identify solutions for provider shortages, increasing access and expanding the scope of practice for current providers and allowing for reimbursement on additional codes	Support from the state on VBP, specifically understanding how we can advance VBP to support project implementation and sustainability of health system transformation. This support can be facilitated through the MVP Action Team or other TA from the state.	ACHs wants to ensure that information held in these data repositories (<i>All-Payers Claims Database and Clinical Data Repository</i>) is accurate, accessible, timely, and useful to our transformation work and to our partners.
Systems for PHM support for: <ul style="list-style-type: none"> •Data governance •Interoperability •HIE •Disease registries •Telehealth •PreManage/EDIE •Centralized registries 	Training and TA for key workforce positions within required projects (e.g., Community Health Workers (CHWs), peer support specialists, care coordinators BH specialists)	MCO VBP and quality improvement requirements as well as VBP models to support CHWs, peers, and other positions not reimbursed by Medicaid
Stronger recruitment and tuition support at the state level for primary care, BH, nursing, and licensed social workers	Training and TA for common training needs: MAT, PDMP, 6BB, Transitional Care models, Trauma Informed Practices, Cultural Sensitivity	Establishing a career path for rural nursing and workforce needs, from high school, through 4-year programs
Support for Dental Health Aide Therapists and other dental professions that expand scope of practice will improve dental access	Increased capacity for practice transformation support directly to participating providers- i.e. practice transformation coaches, clinical subject matter expertise, change management expertise, workforce training and collaborative tools needed to work across ACH regions	Improved coordination with the Department of Health to ensure coordinated Opioid prevention efforts.

	Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) so they truly understand the types of VBP arrangements and rural multi-payer models and how it will impact them, and what steps they should take to be prepared.	Help bring more alignment to measures and incentives across payers. Reducing variability in how providers are rewarded for performance would allow providers to focus on the actual work of providing better care
	Resources tailored to BH providers who are having to build capacity around quality improvement and measurement as they look ahead and adapt to a landscape where they are rewarded for quality, not quantity.	Advocate for increased Medicaid rates in Washington State. Providing adequate financial incentives is key to supporting the sustainability of MTP.
	Best practices and strategies specific to billing/coding for healthcare providers that aligns payments with the intent behind bi-directional integration i.e. DOH's Practice Transformation Hub is coordinating with the UW AIMS Center to provide guidance around collaborative care codes.	Taking leadership role around regulations that are a barrier to MTP goals, specifically BH information exchange (42 CFR, 2). These laws prevent some of the ideals of healthcare reform and HIE from happening.

Table 4 Acronyms: 42 CFR 2 – Table 4 Acronyms: 42 Code of Federal Regulations Part 2, 6BB – Six Building Blocks, ACH – Accountable Communities of Health, AIMS – Advancing Integrated Mental Health Solutions, CHW – Community Health Worker, DOH – Department of Health, EDIE – Emergency Department Information Exchange, EHR – Electronic Health Records, HCA – Health Care Authority, HIE – Health Information Exchange, HIT – Health Information Technology, MAT – Medicaid Assisted Treatment, MCO – Managed Care Organization, MTP – Medicaid Transformation Project, MVP – Medicaid Value-based Purchasing, PDMP – Prescription Drug Monitoring Program, PHM – Population Health Management, TA – Technical Assistance, VBP – Value-Based Payment; for a full list of acronyms in use in this document, refer to Attachment D: Glossary of Acronyms

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

For this milestone, the ACH should either:

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

Or,

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

1. Medicaid Transformation Approaches and Strategies

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

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

- a. A description of the ACH’s evidence-based approaches or promising practices and strategies for meeting Medicaid Transformation Toolkit objectives, goals, and requirements.

[1a. is addressed together with 1b. below.](#)

- b. A list of transformation activities ACH partnering providers will implement in support of project objectives. Transformation activities may include entire evidence-based approaches or promising practices, sub-components of evidence-based approaches or promising practices, or other activities and/or approaches derived from the goals and requirements of a project area.

[1b. is addressed together with 1a. below.](#)

- c. If the ACH did not select at least one Project Toolkit approach/strategy for a project area, and instead chose to propose an alternative approach, the ACH is required to submit a formal request for review by the state using the Project Plan Modification form. The state and independent assessor will determine whether the ACH has sufficiently satisfied the equivalency requirement.

[Not applicable.](#)

OCH response to 1a. and 1b.:

[OCH’s approach to transformation and strategies for implementation is unique in two ways:](#)

1. [OCH integrated the six project areas into one comprehensive portfolio. The portfolio will be operationalized using a provider-centric Change Plan \(Attachment C: Physical Health Behavioral Health Change Plan\) that outlines](#)

the scope of work and desired outcomes for each activity for the terms of the MTP. A few key points of the Change Plan are presented below:

- a. The Change Plan contains desired *Outcomes*, defined as project objectives, and *Tactics*, defined as implementation strategies, activities, and practices, for the six project areas.
 - b. OCH integrated *Outcomes* and *Tactics* into four *Domains* that providers can easily understand: (1) Care Coordination; (2) Care Integration; (3) Care Transformation; and (4) and Care Infrastructure.
 - c. OCH incorporated Domain 1 activities, as defined in the Toolkit, into the Change Plan within each of the four domains as they are foundational for ensuring each of the six projects are successful and sustainable.
 - d. There are four versions of the Change Plan: (1) Hospital; (2) Primary Care; (3) Behavioral Health; and (4) Community-Based Organization. Attachment C: Physical Health Behavioral Health Change Plan, is designed for clinical providers and covers the first three Change Plan versions. OCH will be developing a separate Community-Based Organization and Social Services (CBOSS) Change Plan in August 2018 after reviewing the Physical Health Behavioral Health Change Plan submissions. This is to ensure that the transformation activities between our clinical and community providers align as closely as possible.
2. OCH translated each EBP for each of the six projects into manageable and clear elements and/or workflows. These are stated as either *Outcomes* or *Tactics* in the Change Plan. This approach offers OCH Implementation Partners a realistic understanding of the effort it will take to operationalize the EBPs, down to the sub-component and workflow. It provides Implementation Partners with a step-by-step approach to the implementation and tracking of each component.

Please refer to Table 5, “Terminology and Definitions of the OCH MTP Approach”, which defines key terminology within the OCH MTP approach and how each relates to the outlined items in the SAR application:

Domain of Care	Focus Area	Outcome	Tactic
1. Coordination 2. Integration 3. Transformation 4. Infrastructure	Specific areas of concentrated effort within each Domain of Care	Desired sustainable results at end of the MTP	Strategies, workflows, and transformation activities for implementation to achieve Outcomes
		<i>Includes components and sub-components of EBPs and promising practices and strategies from the toolkit</i>	

To present a comprehensive description of OCH’s unique approach in a way that is fully responsive to the SAR requirements, two items are included to respond to parts 1a and 1b of this question:

1. To respond to 1a, please refer to Table 6, “Evidence-based Approaches, Promising Practices and Strategies” that crosswalks OCH project areas with specific evidence-based approaches, promising practices and strategies in the Change Plan.
2. To respond to 1b, please refer to Attachment C: Physical Health/Behavioral Health Change Plan, specifically to columns E-V, where OCH identifies the associated project areas and EBP for each Outcome and Tactic.

Table 6. Evidence-based Approaches, Promising Practices and Strategies	
Project Area	Evidence-based Approaches, Promising Practices and Strategies
2A – Bi-directional integration of physical and BH	○ Collaborative Care Model
	○ Bree Collaborative Behavioral Health Integration
	○ <i>“Integrating primary care into Behavioral Health Settings: What works for individuals with serious mental illness”</i> Milbank Report Approaches: Collaborative Care on a Continuum (Coordinated, Co-located, and Integrated)
2D – Diversion interventions	○ ED is for Emergencies: a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or BH conditions
	○ Tailored Intensive Case Management (modified LEAD): a community-based diversion approach with the goals of improving public safety and public order, and reducing the criminal behavior of people who participate in the program
	○ Community Paramedicine: an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations.
3A – Addressing the opioid use public health crisis	○ WA State Agency Medical Directors’ Group Interagency Guideline on Prescribing Opioids for Pain
	○ CDC Guideline for Prescribing Opioids for Chronic Pain
	○ Substance Use during Pregnancy: Guidelines for Screening and Management
	○ 2017 and 2018 (*new*: the 2018 plan is just released and an update from the MTP toolkit) Washington State Interagency Opioid Working Plans

	<ul style="list-style-type: none"> ○ 6BBs: Team-Based Approach to Improving Opioid Management in Primary Care: a structured clinic redesign which facilitates engagement of primary care teams in providing safer, more effective care to patients with chronic pain. The 6BBs include: <ul style="list-style-type: none"> ○ Leadership and Consensus ○ Revising policies and standard work ○ Tracking patients on chronic opioid therapy ○ Planning for visits and providing patient-centered care ○ Developing resources to care for complex patients (e.g., addiction) ○ Measuring success <p><i>(this was approved by the independent assessor during the write-back phase of the Project Plan)</i></p>
3B – Reproductive and maternal/child health	○ CDC Preconception Recommendations
	○ FQHC collaborates with MCOs to perform targeted outreach to increase well-child checks <i>(this was approved by the independent assessor during the write-back phase of the project plan)</i>
3C – Access to oral health services	○ Mobile dental van
	○ Oral health in primary care
	○ Increased oral health access points
3D – Chronic disease prevention and control	○ Chronic Care Model
	○ Community Linkages to Self-Management Support: CDC-recognized National Diabetes Prevention Program, Stanford CDSM; WHAM, Asthma Self-Management Education

Table 6 Acronyms: 6BB – Six Building Blocks, CDC – Centers for Disease Control, CDSM – Chronic Disease Self-Management, ED – emergency department, FQHC – federally qualified health center, LEAD – Law Enforcement Assisted Diversion, MCO – Managed Care Organization, MTP – Medicaid Transformation Project; for a full list of acronyms in use in this document, refer to Attachment D: Glossary of Acronyms

2. Target Populations

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

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

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

The target populations the OCH portfolio of transformational strategies is intended to impact are outlined in Table 7 below. The table includes the project area, associated strategies/approaches, target populations, and criteria used to identify the populations during the Project Plan process in Fall 2017. These target populations will be further refined as partners complete their Change Plans and will evolve as the work moves from planning to implementation to scaling over the course of the MTP. The OCH reporting platform is designed in a way to track these changes over time.

Project Area	Associated Transformation Strategies/Approaches	Target Populations	Criteria
2A Bi-Directional Integration	Collaborative Care Model Bree Collaborative Behavioral Health Integration Milbank Report Approaches: Collaborative Care on a Continuum (Coordinated, Co-located, and Integrated)	All Medicaid beneficiaries in primary care: -with MH and/or SUD diagnosis; -with chronic disease and at least 1 BH comorbidity; -in MH and/or substance use treatment setting receiving MH and/or SUD specialty care; -in need of referral to specialty BH care or treatment; -BH diagnosis and 1) unnecessary use of ED for BH reasons; or 2) at discharge from jail; or 3) at imminent risk of or experiencing homelessness	Clinical diagnosis -MH disorder -SUD -Chronic disease

2D Diversions Intervention	ED is for Emergencies Tailored Intensive Case Management (modified LEAD)	Medicaid beneficiaries being discharged from the ED or released from jail: -Patients without a PCMH; -Diagnosis of asthma, diabetes, hypertension, BH disorder (emphasis on OUD diagnosis), dental pain; high recidivism (e.g. ED visits ≥ 5/year; arrests ≥ 3/year)	Lack access to care Diagnosis High recidivism
	Community Paramedicine	Medicaid residents of Port Angeles and Forks: -Patients referred from partnering providers with chronic medical conditions, such as chronic heart failure, chronic obstructive pulmonary disease, diabetes; and/or with complex BH conditions	Geography Diagnosis
3A Opioid Response	Agency Medical Directors Group's Interagency Guideline on Prescribing Opioids for Pain CDC Guideline for Prescribing Opioids for Chronic Pain Substance Use during Pregnancy: Guidelines for Screening and Management 2017 Washington State Interagency Opioid Working Plan 6BBs: Team-Based Approach to Improving Opioid Management in Primary Care	-Medicaid beneficiaries with an OUD or at risk for developing an OUD -Beneficiaries without a cancer diagnosis with an opioid prescription in the last year -Beneficiaries without a cancer diagnosis who are chronic opioid users -Beneficiaries without a cancer diagnosis who are on high dose prescriptions -Beneficiaries who have presented to the ED with an overdose -Beneficiaries under the age of 18 at risk for developing OUD	-Diagnosis -Prescription type -Prescription type/dose -Access to Care -Age
3B Reproductive, Maternal, and Child Health	CDC Preconception Recommendations	Women and men of reproductive age and their partners; classified as high-risk by provider intake/assessment; -All sexually active men and women; -all pregnant women; -all women following delivery;	Gender Sexually active Pregnant/postpartum

	FQHC collaborates with Medicaid MCOs to perform targeted outreach to increase well-child checks	Children ages 0 to 6 years and; Children attributed to a provider organization who have not come in for a well-child visit	Age Access to care
3C Oral Health Access	Mobile van	Adults and children on Medicaid without or with limited dental access; children in school	Geography Age Access to Care
	Oral health in primary care	Adults and children on Medicaid during primary care visit; emphasis on pregnant women, children, and adults on Medicaid	Age Pregnant Access to care
	Increased oral health access points	Adults and children on Medicaid in Jefferson County	Age Access to care Geography Pregnant
3D Chronic Disease Prevention and Control	Chronic Care Model	Adult Medicaid beneficiaries; Persons with mild MH issues; persons with severe mental illness and/or SUD; persons with congestive heart failure; AI/AN	Age Diagnosis Race
	Community Linkages to Self-Management Support: DPP, CDSM; WHAM; Asthma Self-Management Education	Adult and child Medicaid beneficiaries; -Persons with severe mental illnesses and/or SUD, -AI/AN; -Children; -Older adults; -smokers	Age Diagnosis Race Behavior

Table 7 Acronyms: 6BB – Six Building Blocks, AI/AN – American Indian/Alaskan Native, CDC – Centers for Disease Control, CDSM – Chronic Disease Self-Management, DPP – diabetes prevention program, ED – emergency department, FQHC – federally qualified health center, LEAD – Law Enforcement Assisted Diversion, MCO – Managed Care Organization, OUD – Opioid Use Disorder, PCMH – patient-centered medical home, SUD – Substance Use Disorder, WHAM – Whole Health Action Management; for a full list of acronyms in use in this document, refer to Attachment D: Glossary of Acronyms

3. Expansion or Scaling of Transformation Strategies and Approaches

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

Currently, OCH plans to contract with Implementation Partners through 2021, with an option to extend contracts to 2023 due to the time lag in payments through the Financial Executor Portal. Across the entire portfolio of projects, Implementation Partners will be asked to update the status of each Outcome throughout the duration of

their Change Plan; therefore, Implementation Partners will be updating the status of each Outcome, semi-annually throughout the course of the MTP.

The following status updates are being considered:

- Not started
- Planning
- Testing
- Limited implementation
- Fully implemented
- Scaling to other populations, sites, or providers

Due to the interactive, web-based architecture of the Change Plan, OCH will be able to track the status of Tactics and Outcomes on three nested levels:

- 1) Implementation Partner level
- 2) Natural Community of Care level
- 3) Regional level

For example, Implementation Partners will report to OCH every 6 months on the following questions:

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 describe any new partnerships - informal or formal (e.g., formal would include signed agreement, MOU, etc.) - your organization has formed in the previous six months.
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 VBP contracts? How do you anticipate your participation in VBP will change in the next 6 months?

This and other information will continuously inform how OCH targets shared learning support opportunities. It will also provide detailed information on how Implementing Partners may expand transformation strategies and approaches, target populations, and/or activities in later DSRIP years.

Additionally, the Change Plan tracks and incentivizes progress towards value-based care contracts with MCOs and other payers, including commercial payers. OCH has received feedback from partners that scaling and sustainability of the strategies and approaches in the MTP are directly tied to obtaining and thriving under multi-payer value-based contracts.

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

ACH Response:

The OCH Board of Directors established a four-element Transformation Vision which defines key overarching objectives for partnering providers to accomplish. Table 8 is a cross-walk of these objectives to the high-level focus area Outcomes of the Implementation Partner Change Plan that the OCH expects Implementing Partners will achieve, the MTP pay-for-performance measures, and additional OCH-developed measures aligned to each element to monitor and evaluate success.

Table 8. OCH Board of Directors Transformation Vision

OCH Change Plan Focus Area Outcomes	Objective 1 1. Accessible, patient-centered healthcare system that effectively integrates physical, behavioral and dental health services	Object 2 2. Effective linkages between primary care, social services and other community-based service providers	Objective 3 3. Common data metrics and shared information exchange	Objective 4 4. Provider adoption of value-based care contracts
PHM	X	X	X	X
Shared Care Management	X	X	X	
ED Diversion	X	X	X	
Jail Diversion	X	X	X	
Primary Care Integrating BH	X	X	X	X
Primary Care Integrating Oral Health	X	X	X	X
BH Integrating Primary Care	X	X	X	X
BH Integrating Oral Health	X		X	
Opioid Prevention of Misuse and Abuse	X	X	X	X
Opioid Overdose Prevention	X	X	X	X
OUD Treatment	X	X	X	X
Chronic Disease Prevention and Control	X	X	X	X

Reproductive and Maternal and Child Health	X	X	X	X
Capacity Infrastructure	X	X	X	
Sustainability			X	X
Administrative			X	X
MTP P4P Measures	Reduce ED Utilization	Reduction in % Homeless	Increase follow-up after ED visit for alcohol/other drug dependence	
	Increase Child and Adolescents' Access to Primary Care Practitioners	Reduction in % Arrested	Increase follow-up after ED visit for mental illness	
	Increase MH Treatment Penetration			
	Increase SUD Treatment Penetration			
	Increase Opioid Treatment Penetration			
	Increase Utilization of Dental Services			
WA State Common Measure Set	Increase Adult Access to Preventive/Ambulatory Care			
OCH Measures	85% of contracted providers report level 4 or 5 care integration collaboration	100% of contracted providers have signed agreements with CBOs for SDoH services	100% of contracted providers submit monitoring data for OCH measures in ORCA platform	90% of OCH providers adopt VBP care contracts <i>VBP Roadmap goal= 90% by 2021</i>
	Reduce disparities among sub-populations for MTP P4P measures	100% of individuals with positive screen for SDoH are referred to and receive services from CBOs	Increase EHR compatibility	
			Increase electronic information exchange (Olympic Digital HIT Commons)	

Table 8 Acronyms: CBO – community-based organization, ED – emergency department, EHR – electronic health record, HIT – health information technology, OCH – Olympic Community of Health, ORCA – Olympic Reporting and Community Activities, the online reporting and communication platform for Implementation Partners, MH – Mental health, MTP – Medicaid Transformation Project, P4P – pay-for-performance, PHM – Population Health Management, SDoH – social determinants of health, SUD – substance use disorder, VBP – value-based payment; for a full list of acronyms in use in this document, refer to Attachment D: Glossary of Acronyms

D. Milestone 4: Identification of Partnering Providers

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

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

[Refer to D.1 in the Semi-Annual Report Workbook.](#)

Section 2: Standard Reporting Requirements

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

ACH-Level Reporting Requirements

A. ACH Organizational Updates

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

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

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

ACH Response:

Not Applicable.

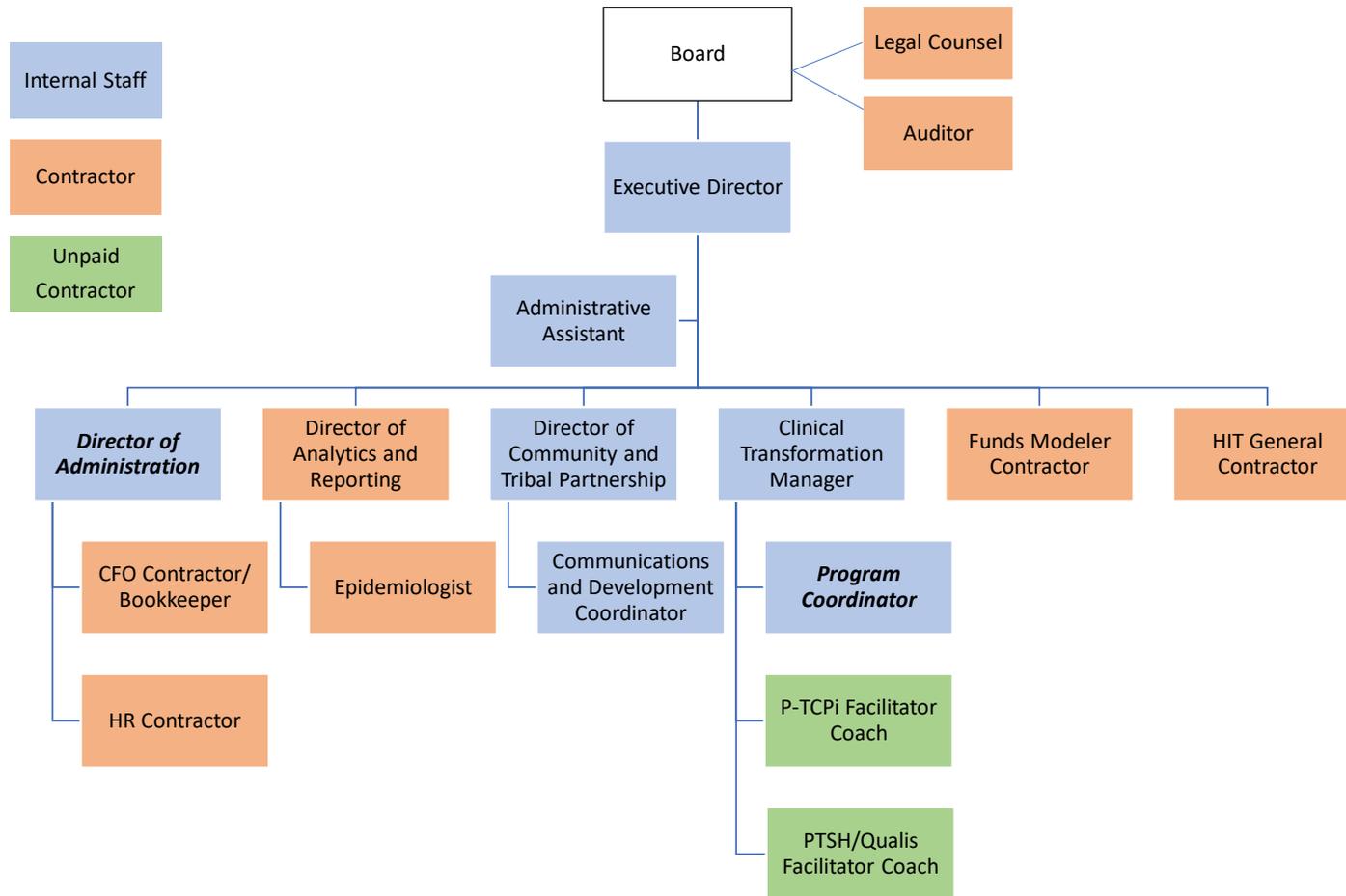
3. **Key Staff Position Changes:** Provide a current organizational chart for the ACH. Use **bold italicized font** to highlight changes, if any, to key staff positions during the reporting period. Place an “X” in the appropriate box below.

	Yes	No
Changes to Key Staff Positions during Reporting Period	X	

Insert or Include as an Attachment: Organizational Chart

Organizational Chart

Note: Key staff positions created and filled during Reporting Period are bolded.



B. Tribal Engagement and Collaboration

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

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Participate in monthly Tribal/IHCP/HCA call	1/03	AI/AN Health Directors, tribal leaders, staff, HCA, DOH, DBHR, etc.	AI/AN Health Directors, tribal leaders, staff, HCA, DOH, DBHR, etc.	To keep tribes and those who work with tribes and IHCPs informed about work related to AI/ANs in WA	Varies each month
PTSH/Qualis PGST Integration QI Team PCMH-A	1/5/18	PGST Integration QI Team. PTSH/Qualis Practice Coach	PGST Integration Team and PTSH Practice Coach	Facilitated PCMH-A	Re-assessment as integrated team/Part 1
Weekly ACH/Tribal opioid project collaboration call	1/06/18 - 6/23/18 (weekly)	ACHs and Tribes/IHCPs working on the MTP opioid project	ACHs and Tribes/IHCPs working on the MTP opioid project	To collaborate and share resources across ACHs and Tribes/IHCPs for the opioid response project	Varies each week
OCH Board of Directors meeting	1/09	OCH Board of Directors and general public	OCH Board of Directors and general public	OCH Board business; each of the 7 Tribes has a seat on the OCH Board.	Varies – see Board minutes
P-TCPI Assessment	1/11	Lower Elwha Staff. WA DOH Practice Coach	Lower Elwha Staff. WA DOH Practice Coach	Facilitate Assessment	6-month action plan; Re-assessment.
Tribal Consultation on 1115 Waiver	1/22	Tribal leaders, Tribal health directors, HCA, AIHC, staff at ACHs who partner with Tribes/IHCPs	Tribal leaders, Tribal health directors, HCA, AIHC, staff at ACHs who partner with Tribes/IHCPs	Consultation on 1115 Waiver and impact on Tribes/IHCPs. OCH Director of Community and Tribal Partnership attends to stay informed and to	N/A

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
				inform tribal partners	
PTSH/Qualis PGST BH Integration Team Meeting	1/23	PGST BH Integration Team and PTSH/Qualis PTSH Coach	Directors of Health and Wellness, PCP, PGST Integration Team from Primary Care, BH & SUD and PTSH Practice Coach	Team goal of integration and transparency with NextGen for care continuity, all staff de-escalation training scheduled	Plan for integration of BH provider in primary care and IT issues addressed
P-TCPi Action Plan Meeting	1/25	Lower Elwha Staff. WA Dept of Health Practice Coach	Lower Elwha Staff. WA Dept of Health Practice Coach	6-month action plan	Re-assessment
Participate in monthly Tribal/IHCP/HCA call	2/07	AI/AN Health Directors, tribal leaders, staff, HCA, DOH, DBHR, etc.	AI/AN Health Directors, tribal leaders, staff, HCA, DOH, DBHR, etc.	To keep tribes and those who work with tribes and IHCPs informed about work related to AI/ANs in WA	Varies each month
Attend quarterly AIHC meeting	2/08	Tribal leaders, Tribal health directors, HCA, AIHC, staff at ACHs who partner with Tribes/IHCPs	Tribal leaders, Tribal health directors, HCA, AIHC, staff at ACHs who partner with Tribes/IHCPs	AIHC business; OCH Director of Community and Tribal Partnership attends to stay informed and to inform tribal partners	N/A
Meeting at Lower Elwha Klallam Tribe	2/09	Lower Elwha interim health director, Jessie Dean, Lena Nachand, Vicki Lowe, Lisa Rey Thomas	Lower Elwha interim health director, Jessie Dean, Lena Nachand, Vicki Lowe, Lisa Rey Thomas	Meet LEKT interim health director and strategize how to strengthen ACH outreach and partnership with tribes across the state	AIHC, HCA Tribal Affairs Administrator and Tribal Liaison and OCH Director of Community and Tribal Partnership will plan and implement a series of meetings and presentations to ACHs regarding

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
					best practices for outreach and partnership with Tribes
OCH Board of Directors meeting	2/12	OCH Board of Directors and public	OCH Board of Directors and public	OCH Board business; each of the 7 Tribes has a seat on the OCH Board.	Varies – see Board minutes
OCH Funds Flow Workgroup	2/15	OCH funds flow workgroup members including tribes; public	OCH funds flow workgroup members including tribes; public	Model funds flow for MTP funds through 2023	Varies – see funds flow meeting notes
OCH Funds Flow Workgroup	2/20	OCH funds flow workgroup members including tribes; public	OCH funds flow workgroup members including tribes; public	Model funds flow for MTP funds through 2023	Varies – see funds flow meeting notes
PTSH/Qualis PGST Integration QI Team PCMH-A, Part 1	2/20/18	PGST Integration QI Team. PTSH/Qualis Practice Coach	Directors of Health and Wellness, PCP, PGST Integration Team from Primary Care, BH & SUD and PTSH Practice Coach	Facilitation of PCMH-A	Reassessment with PCMH-A with newly formed BH Integration Team of Primary Care, BH and SUD members
Meeting with Healthier WA Tribal Liaison and OCH Director of Community and Tribal Partnership	3/09	Lena Nachand and Lisa Rey Thomas	Lena Nachand and Lisa Rey Thomas	Update on MTP and IHCP work; strategize how to strengthen tribal partnership; describe OCH MTP process to ensure that Lena can support tribal/IHCP partners effectively	Continue to collaborate to strengthen tribal partnership
PTSH/Qualis Port Gamble S'Klallam Tribe PCMH-A, Part 2	3/9/18	Directors of Health and Wellness, PCP, PGST Integration Team from	Directors of Health and Wellness, PCP, PGST Integration Team from	Facilitation of PCMH-A Part 2	Reassessment with PCMH-A with newly formed BH Integration Team of Primary

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
		Primary Care, BH & SUD and PTSH Practice Coach	Primary Care, BH & SUD and PTSH Practice Coach		Care, BH and SUD members
OCH Board of Directors meeting	3/12	OCH Board of Directors and public	OCH Board of Directors and public	OCH Board business; each of the 7 Tribes has a seat on the OCH Board.	Varies – see Board minutes
P-TCPi meeting at Lower Elwha	3/15	Lower Elwha staff and WA Dept of Health Practice Coach	Lower Elwha staff and WA Dept of Health Practice Coach	Plan pediatric community engagement activity	Future meetings
Call with Ann Donovan from Suquamish Tribe	3/21	Ann Donovan and Lisa Rey Thomas	Ann Donovan and Lisa Rey Thomas	Provide information and answer questions that Suquamish Tribe has regarding the MTP and potential participation	Ann will take information back to leadership at Suquamish
Tribal/IHCP Roundtable	3/21	Tribal leaders, Tribal health directors, HCA, DBHR, AIHC, staff at ACHs who partner with Tribes/IHCPs	Tribal leaders, Tribal health directors, HCA, DBHR, AIHC, staff at ACHs who partner with Tribes/IHCPs	Information regarding impact on Tribes/IHCPs when DBHR moves from DSHS to HCA. OCH Director of Community and Tribal Partnership participates to stay informed and share info with Tribal partners	Consultation scheduled for 4/30/18
PTSH/Qualis Lower Elwha Tribe QI Team Training	3/22	LEKT QI Team and PTSH/Qualis Coach	LEKT Interim health director, QI Team and PTSH Coach	Introduce basic QI concepts to team and PDSA/ Analytics, Interoperability, and Measurement statement	Learn value of QI team and PDSA process

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
P-TCPi Lower Elwha PDSA training	3/22	Lower Elwha Staff and WA Dept of Health Practice Coach	Lower Elwha Staff and WA Dept of Health Practice Coach	Introduce basics of PDSA cycles	Learn value of PDSA cycles and ways to apply toward clinic flow
OCH Change Plan pilot with Lower Elwha Klallam Tribe team	3/22	Interim health director at LEKT and LEKT staff; OCH staff	Interim health director at LEKT and LEKT staff; OCH staff, PTSH Coach	OCH is piloting the draft MTP Change Plan with a number of agencies across the region. LEKT agreed to participate in the pilot to help ensure that the change plan would be acceptable for Tribal/IHCP partners	After completing all pilots, revise change plan to incorporate partner suggestions and schedule second round of change plan pilots
Candice Wilson and Lisa Rey Thomas meet via phone	3/23	Candice Wilson and Lisa Rey Thomas	Candice Wilson and Lisa Rey Thomas	Candice is the Tribal Liaison with North Sound ACH and Lisa is the Director of Community and Tribal Partnership with OCH. Candice and Lisa want to collaborate across ACHs to strengthen Tribal/IHCP partnership	Continue to collaborate, share resources, and strengthen Tribal/IHCP partnership across the state
PTSH/Qualis PGST BH Integration Team Meeting	3/26	PGST Health and Wellness Directors, PCP, clinicians, staff and PTSH/Qualis Coach	PGST Health and Wellness Directors, PCP, clinicians, staff and PTSH Coach	Debrief PCMH-A, Action Planning and QI Projects for BH integration	QI project and workflow to address integrated BH in primary care clinic
Makah Tribe and OCH conference call	3/29	Makah interim health director and OCH staff	Makah interim health director and staff; OCH staff	Provide information and answer questions that the Makah Tribe	Makah interim health director will discuss with Makah leadership

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
				has regarding the MTP and potential participation	
OCH Funds Flow Workgroup	4/3	OCH funds flow workgroup members including tribes; public	OCH funds flow workgroup members including tribes; public	Model funds flow for MTP funds through 2023	Varies – see funds flow meeting notes
Participate in monthly Tribal/IHCP/HCA call	4/05	AI/AN Health Directors, tribal leaders, staff, HCA, DOH, DBHR, etc.	AI/AN Health Directors, tribal leaders, staff, HCA, DOH, DBHR, etc.	To keep tribes and those who work with tribes and IHCPs informed about work related to AI/ANs in WA	Varies each month
IHCP planning funds call	4/06	Tribal leaders, Tribal health directors, HCA, DBHR, AIHC, staff at ACHs who partner with Tribes/IHCPs	Tribal leaders, Tribal health directors, HCA, DBHR, AIHC, staff at ACHs who partner with Tribes/IHCPs	AIHC and HCA provide information and plan for the IHCP specific funds. OCH Director of Community and Tribal Partnership participates to stay informed and share info with Tribal partners	Continue to participate, stay informed, and share information with Tribal/IHCP partners
OCH Board of Directors meeting	4/09	OCH Board of Directors and public	OCH Board of Directors and public	OCH Board business; each of the 7 Tribes has a seat on the OCH Board.	Varies – see Board minutes
PTSH/Qualis PGST BH Integration Team Meeting	4/10	PGST Health and Wellness Directors, PCP, clinicians, staff and PTSH/Qualis Coach	PGST Health and Wellness Directors, PCP, clinicians, staff and PTSH Coach	Presented summary of 6-month PCMH-A scores and Action Plan to integration team	Team strategized QI Projects to close care gaps between primary care, BH and SUD providers

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Meeting with Karol Dixon (Health Services Director) with the Port Gamble S'Klallam Tribe	4/12	Karol Dixon and Lisa Rey Thomas	Karol Dixon and Lisa Rey Thomas	Provide information and answer questions that Port Gamble S'Klallam Tribe has regarding the MTP and potential participation	Karol Dixon will keep PGST leadership informed; will continue to collaborate
OCH Funds Flow Workgroup	4/13	OCH Funds Flow Workgroup members including tribes; public	OCH Funds Flow Workgroup members including tribes; public	Model funds flow for MTP funds through 2023	Varies – see funds flow meeting notes
IHCP planning funds call	4/18	Tribal leaders, Tribal health directors, HCA, DBHR, AIHC, staff at ACHs who partner with Tribes/IHCPs	Tribal leaders, Tribal health directors, HCA, DBHR, AIHC, staff at ACHs who partner with Tribes/IHCPs	AIHC and HCA provide information and plan for the IHCP specific funds. OCH Director of Community and Tribal Partnership participates to stay informed and share info with Tribal partners	Continue to participate, stay informed, and share information with Tribal/IHCP partners
OCH and HCA/AIHC meeting to discuss OCH Change Plan process and IHCP specific funds	4/19	AIHC, HCA, OCH staff	Vicki Lowe, Jessie Dean, Lena Nachand, JooRi Jun, Lisa Rey Thomas	Share OCH MTP Change Plan Process and IHCP specific funds process and how best to support participation and reduce burden for Tribal/IHCP partners	Continue to collaborate and support participation; schedule meetings with Tribal/IHCP partners, HCA, AIHC, and OCH in August
ACH/Tribe opioid project collaboration call with Governor's Office and state leadership	4/20	ACH/Tribes working on MTP opioid project; Governor's Office; HCA/DSHS/	ACH/Tribes working on MTP opioid project; Governor's Office; HCA/DSHS/	Share all of the work being done by ACHs and Tribes on the opioid project; learn what is	Continue to collaborate; work with Governor's Office to plan and implement

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
		DOH leaders	DOH leaders	going on through the state	statewide convening for opioid project
OCH Regional NCC Convening	4/24	Providers and partners across the three counties including Tribes/IHCPs	Providers and partners across the three counties including Tribes/IHCPs	Present draft shared change plans and have partners sign	Continue working on collaboration among providers and partners in the region for the MTP including Tribes/IHCPs
Tribal/IHCP Consultation	4/30	Tribal leaders, Tribal health directors, HCA, DBHR, AIHC, staff at ACHs who partner with Tribes/IHCPs	Tribal leaders, Tribal health directors, HCA, DBHR, AIHC, staff at ACHs who partner with Tribes/IHCPs	Information regarding impact on Tribes/IHCPs when DBHR moves from DSHS to HCA. OCH Director of Community and Tribal Partnership participates to stay informed and share info with Tribal partners	Ongoing work
Health and Human Services Region 10 Tribal Consultation	5/2	Tribal leaders, Urban Indian Health agencies, federal and state government officials, AI/AN	Tribal leaders, Urban Indian Health agencies, federal and state government officials, AI/AN	Identify and address concerns and issues put forward by AI/AN leaders	Annual consultation between federal and state agencies and Tribes/Urban Indian organizations
OCH Funds Flow Workgroup	5/3	OCH Funds Flow Workgroup members including tribes; public	OCH Funds Flow Workgroup members including tribes; public	Model funds flow for MTP funds through 2023	Varies – see funds flow meeting notes
PTSH/Qualis PGST BH Integration Team Meeting	5/8	PGST Health and Wellness Directors, PCP, clinicians, staff and PTSH/Coach	PGST Health and Wellness Directors, PCP, clinicians, staff and PTSH Coach	42 CFR 2, HIPPA and integration activities discussed	Referred to PGST Legal to address shared electronic health record between primary care, BH and SUD

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Attend quarterly AIHC meeting	5/10	Tribal leaders, Tribal health directors, HCA, AIHC, staff at ACHs who partner with Tribes/IHCPs	Tribal leaders, Tribal health directors, HCA, AIHC, staff at ACHs who partner with Tribes/IHCPs	AIHC business; OCH Director of Community and Tribal Partnership attends to stay informed and to inform tribal partners	N/A
P-TCPi meeting at Lower Elwha	5/10	Lower Elwha Staff and WA Dept of Health Practice Coach	Lower Elwha Staff and WA Dept of Health Practice Coach	Plan pediatric community engagement activity	Future meeting
Meet with new Health Director at Makah Tribe	5/14	Engage new Health Director at Makah	OCH ED, Makah Health Director, OCH Director of Community and Tribal Partnership	OCH ED, Makah Health Director, OCH Director of Community and Tribal Partnership	Agreement to participate in OCH Board meetings and will schedule additional meetings going forward
OCH Board of Directors meeting	5/14	OCH Board of Directors and public	OCH Board of Directors and public	OCH Board business; each of the 7 Tribes has a seat on the OCH Board.	Varies – see Board minutes
Tribal Consultation on the Opioid Crisis in Indian Country – in Minnesota	5/21-22	Tribal leaders, Urban Indian organizations, AI/AN, SAMHSA, NIHB, NIH	Tribal leaders, Urban Indian organizations, AI/AN, SAMHSA, NIHB, NIH	Tribal leaders, Urban Indian Organizations, AI/ANs inform federal and state agencies about the opioid crisis and solutions underway	Summary is forthcoming
ACH Tribal Liaisons meeting	5/24	Tribal liaisons at ACHs and ACH leaders; HCA Tribal Affairs Administrator and Liaison	Tribal liaisons at ACHs and ACH leaders; HCA Tribal Affairs Administrator and Liaison	Bring together ACH Tribal liaisons to collaborate and learn from each other how to best serve AI/AN communities across the state regarding MTP	Ongoing
OCH Funds Flow Workgroup	5/29	OCH Funds Flow Workgroup members	OCH Funds Flow Workgroup members	Model funds flow for MTP	Varies – see funds flow meeting notes

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
		including tribes; public	including tribes; public	funds through 2023	
PTSH/Qualis Lower Elwha Tribe Integration Team PCMH-A Six Month Re-assessment, Part One	5/30	LEKT primary care, BH, SUD, Dental QI Team and PTSH Practice Coach	LEKT primary care, BH, SUD, Dental QI Team and PTSH Practice Coach	Facilitated PCMH-A for six-month reassessment to assess strengths and gaps of integrated care	Identified care coordination gaps between primary care, BH and SUD providers
PTSH/Qualis Lower Elwha Tribe Integration Team PCMH-A Six Month Re-assessment, Part Two	6/6	LEKT primary care, BH, SUD, Dental QI Team and PTSH Practice Coach	LEKT primary care, BH, SUD, Dental QI Team and PTSH Practice Coach	Facilitated PCMH-A for six-month reassessment to assess strengths and gaps of integrated care	Identified QI process to track treatment to target for shared clients
Participate in monthly Tribal/IHCP/HCA call	6/6	AI/AN Health Directors, tribal leaders, staff, HCA, DOH, DBHR, etc.	AI/AN Health Directors, tribal leaders, staff, HCA, DOH, DBHR, etc.	To keep tribes and those who work with tribes and IHCPs informed about work related to AI/ANs in WA	Varies each month
OCH Board of Directors meeting	6/11	OCH Board of Directors and public	OCH Board of Directors and public	OCH Board business; each of the 7 Tribes has a seat on the OCH Board.	Varies – see Board minutes
Tribal Prevention Gathering	6/19	AI/ANs in Washington State	AI/ANs in Washington State	Share prevention work being implemented in Indian Country	Annual gathering

Tribal Engagement Table Acronyms: 42 CFR 2 – 42 Code of Federal Regulations Part Two, ACH – Accountable Community of Health, AI/AN – American Indian/Alaska Native, AIHC – American Indian Health Commission of Washington State, BH – Behavioral Health, DBHR – Division of Behavioral Health and Recovery, DOH – Department of Health, DSHS – Department of Social and Human Services, ED – Executive Director, HCA – Health Care Authority, IHCP – Indian Health Care Provider, LEKT – Lower Elwha Klallam Tribe, MTP – Medicaid Transformation Project, NIH – National Institutes of Health, NIHB – National Indian Health Board, OCH – Olympic Community of Health, PC – Primary Care, PCP – Primary Care Provider, PDSA- Plan Do Study Act, PCMH-A – Patient Centered Medical Home Assessment, PGST – Port Gamble S’Klallam Tribe, P-TCPI – Pediatric Transforming Clinical Practice Initiative, PTSH – Practice Transformation Support Hub, QI – Quality Improvement, SAMHSA – Substance Abuse and Mental Health Services Agency, SUD – Substance Use Disorder; for a full list of acronyms in use in this document, refer to Attachment D: Glossary of Acronyms

Project Reporting Requirements

C. Project Status Update

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

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

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

Project Status Update			
Key Activity (#)	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Hosted NCC Convenings for partnering providers in Clallam County (3)	All	Y	Reconvene in August to discuss Change Plans and next steps
Hosted NCC Convenings for partnering providers in Jefferson County (3)	All	Y	Reconvene in August to discuss Change Plans and next steps
Hosted NCC Convenings for partnering providers in Kitsap County (3)	All	Y	Reconvene in August to discuss Change Plans and next steps
Conducted Current State Assessments with partners in all	All	Y	Conduct additional assessment as needed from

Project Status Update			
Key Activity (#)	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
three NCCs and debriefed results at convenings (55)			implementation partners once they sign a contract with OCH
Hosted Regional Convening for partners across all three NCCs and collected signatures for Shared Change Plans (1)	All	Y	None
Contracted with CSI, a healthcare IT vendor, to provide an online platform for community resource space, data collection, project management, and contract management	All	Y	Build out platform for Change Plan by late August and reporting platform ORCA by December
Developed and piloted PHBH Change Plan V1.0 with partners across all sectors and counties (6)	All	Y	Develop PHBH Change Plan V2.0
Develop and pilot CBOSS Change Plan V1.0 with partners across all counties	All	Y	Develop CBOSS Change Plan V2.0
Developed and piloted PHBH Change Plan V2.0 with partners across all sectors and counties (9)	All	Y	Develop PHBH Change Plan V3.0
Convened Funds Flow Workgroup meetings (7)	All	Y	Continue to host Workgroup meetings to finalize funds allocation algorithm
Hosted NEAR Training for partners across the region (1)	All	Y	Schedule additional trainings
Organized demonstration of population health management platform (i2i) for partners across the region (1)	All	Y	Convene interested partners for demonstration of alternative platforms

Project Status Update			
Key Activity (#)	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Developed contract for implementation partners (1)	All	Y	Release late July and start collecting signed contracts by August 20
Developed and finalized Change Plan V3.0, started programming in ORCA	All	Y	Release to partners mid-July, online training and site visits with partners to support their Change Plan development
Held OCH Team (staff, contractors and key collaborators) Transformation Planning Meetings (9)	All	Y	Ongoing weekly OCH Team Transformation Planning meetings
Developed and released Medicaid Transformation Policy for release of DSRIP funds (1)	All	Y	None
Enrolled OCH and Domain 1 partners in Financial Executor Portal (78)	All	Y	Schedule payments for September
Developed and released online communities via CSI platform for all three NCCs (3)	All	Y	Promote use among partners
Conducted Health Equity survey among partners in NCCs (83)	All	Y	Evaluate and develop regional plan
Reconvened the 3 County Coordinated Opioid Response Project (3CCORP) Steering Committee and Workgroups	3A	Y	3COORP Steering Committee and Workgroups will continue meeting to oversee 3A
Participated in monthly regional Hub & Spoke meetings (6) to expand access to the best practice treatment for OUD and increase	3A	Y	Continue to participate and support efforts to expand and strengthen integrated network

Project Status Update			
Key Activity (#)	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
coordination between primary care providers and SUD providers			
Met with the 6BB team to develop strategy for implementing 6BB in the OCH region (4)	3A	Y	Sign contract with 6BB Team and begin with first 2-3 clinics
Hosted weekly ACH/Tribal opioid project collaboration calls	3A	Y	Continue to host calls on a regular basis to share resources across ACHs and Tribes
Met with U.S. Senators Cantwell and Murray to discuss regional opioid needs and successful responses to date (2)	3A	Y	Keep Senators informed of regional needs and work for opioid response
Participated in monthly regional SUD provider and SBHO meetings	3A	Y	Continue to participate to keep SUD partners informed and connected to primary care
Participated in MAT training for primary care and drug court/criminal justice to increase coordination between primary care, criminal justice, and SUD providers for treatment of OUD	3A	Y	Continue trainings and networking to increase care coordination for community members with OUD
Completed the OCH HIT Commons Pilot Project on time and on budget among a subset of Implementation Partners in the Clallam NCC.	All	Y	Prepare proposal for the OCH Board for second phase of project to scale to social service sectors and other NCCs
Began negotiations with Qualis for 2019 transition of PTSH/Qualis Coach	2A, 2D, 3A, 3D	Y	Finalize negotiations

Project Status Update			
Key Activity (#)	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Begin negotiations with ARCORA Foundation to create an oral health local improvement network	3C	Y	Finalize MOU

Project Status Table Acronyms: 3CCORP – Three County Coordinated Opioid Response Project, 6BB – Six Building Blocks, ACH – Accountable Community of Health, CBOSS Change Plan – Community-Based Organization and Social Services Change Plan, CSI – vendor providing data and communications management services, DSRIP – Delivery System Reform Incentive Payments, NCC – Natural Community of Care, NEAR - Neuroscience, Epigenetics, Adverse Childhood Experiences, Resilience, OCH – Olympic Community of Care, ORCA – Online Reporting and Community Activities, OUD – Opioid Use Disorder, PHBH Change Plan – Physical Health Behavioral Health Change Plan, PTSH – Practice Transformation Support Hub, SBHO – Salish Behavioral Health Organization, SUD – Substance Use Disorder; for a full list of acronyms in use in this document, refer to Attachment D: Glossary of Acronyms

Portfolio-Level Reporting Requirements

D. Partnering Provider Engagement

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

ACH Response:

The ACH executive directors are in constant communication with one another and meet in person monthly to align strategies to engage and implement projects across shared partnering provider systems. Specific examples of how ACHs are coordinated to engage partnering providers include:

- The OCH executive director is in regular contact with the executive directors of Pierce ACH and Healthier Here regarding Catholic Health Initiatives health system and with Cascade Pacific Action Alliance regarding Peninsula Community Health Services and Olympic Area Agency on Aging. These partnering providers span our ACH boundaries.
- The ACHs are coordinating efforts with Collective Medical Technologies, a HIT vendor located in every hospital emergency room in the State.
- North Sound ACH, Cascade Pacific Action Alliance and Healthier Here have adopted or are considering adoption of the same partnering provider reporting platform, CSI.

Partnering providers span across each ACH regions.

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

ACH Response:

OCH expects the following from Implementation Partners in 2018 in support of transformation activities:

1. Complete the OCH current state assessment webform
 2. Sign the NCC Shared Change Plan
 3. Sign the 2018-2021 OCH Standard Agreement
 4. Complete a draft Change Plan
 5. Create an account and upload Change Plan onto ORCA, the OCH communications and reporting platform
 6. Co-develop Implementation Plan and performance measures
 7. Begin work on at least one transformation activity in the Change Plan
 8. Sign 2019 contract amendment to Implementation Partner-Specific Agreement
3. Describe the ACH's efforts during the reporting period to engage partnering providers that are critical to success in transformation activities. What barriers to their participation have been identified, and what steps has the ACH taken to address those barriers? Include the steps has the ACH taken to reach partnering providers with limited engagement capacity.

ACH Response:

NCC Convenings

During the reporting period, OCH held ten NCC convenings. Nine convenings were held within the respective NCC regions to address barriers to travel. OCH held one Regional NCC Convening with break-out sessions for each respective NCC in a central location. All partnering providers were invited to attend each convening. Wherever possible, audio and webinar capabilities were available to reduce barriers to participation.

Shared Change Plans

During these convenings OCH helped each NCC complete a Shared Change Plan, an overarching document outlining the NCC partners' commitment to collaborating on key strategies. The Shared Change Plans provide a filter for each Change Plan. For example, in an NCC that does not select community paramedicine, OCH will not accept any Change Plan outcomes specific to community paramedicine from providers within that NCC. In April, partnering providers signed the Shared Change Plan, committing to the following:

*We agree to cooperate with other agencies and Tribes/Indian Health Care Providers in our Natural Community of Care to implement the activities of the Shared Change Plan. We will share lessons learned and best practices with partners. We will participate with a sincere spirit of collaboration, an open mind, willingness to listen, mutual respect, and a commitment to **doing the right work.***

Nearly all partnering providers attended at least one NCC Convening. To address barriers to participation, staff circulated materials for input online and/or travelled to or called partners to obtain feedback between meetings. OCH staff continues with this personalized approach as requested by partners. Although time consuming, one-on-one meetings with partnering providers is a vital strategy to obtain honest input and build critical relationships that may not be feasible in a large group.

Change Plan Pilots

From March through June 2018, OCH staff developed and finalized PHBH Change Plans for: (1) primary care providers; (2) BH providers (including MH and SUD treatment); and (3) hospitals. The CBOSS Change Plan went through one pilot and will be refined and released in September 2018.

In April and May, OCH piloted two versions of each PHBH Change Plans within a group of partnering providers (see list below), OCH-incorporated input, remodeled results, and shared findings with the OCH Board of Directors, Funds Flow Workgroup and at the NCC Regional Partner Convening in April. Multiple partnering providers assisted in the piloting and ultimate design of the PHBH Change Plans:

- federally qualified healthcare centers (2)
- tribal health clinic (1)
- hospital (1)
- substance use treatment disorder providers (2)
- community MH clinic (1)
- primary care clinic (2)

The following partnering providers assisted in piloting the first version of the CBOSS Change Plan:

- community action agency (1)
- area agency on aging (1)

During the pilot phase, OCH staff travelled to pilot sites to administer the Draft Change Plan. OCH is committed to offering this service going forward, particularly for the geographically isolated and smaller partnering providers.

3 County Coordinated Opioid Response Project (3CCORP)

3CCORP was launched as the OCH State Innovation Model “early win” project in September of 2016 before opioid response (project 3A) was a required project in the MTP. 3CCORP convened a Steering Committee with multi-sector, three-county representation including:

- primary care providers
- BH (MH and SUD) providers
- hospitals
- emergency departments
- Tribes/IHCP
- elected officials
- law enforcement
- criminal justice
- public health
- lived experience
- schools
- FQHC

- fire/emergency medical services
- pharmacies

In early 2017, 3CCORP established three workgroups: Prevention, Treatment, and Overdose Prevention. These workgroups are aligned with the first three goals of the state response plan. Workgroup membership is also multi-sector and across the three counties. The 3CCORP steering committee and workgroups met bi-monthly and monthly, respectively, throughout 2017 to identify priorities and strategies to inform the OCH project plan portfolio.

From January through May 2018, 3CCORP members participated in the NCC convenings and regional convenings and participated in the development of the Shared Change Plan and Draft Change Plan. The 3CCORP steering committee and workgroups resumed meeting in May of 2018 to guide the drafting of the opioid specific sections of the Change Plan and will guide the drafting of the opioid specific sections of the Implementation Plan.

Ongoing Practice Facilitation and Coaching

OCH embeds practice facilitator coaches from PTHS/Qualis Health and P-TPCi into the OCH team to engage partners in support of transformation activities. Both coaches are included in team meetings and are encouraged to communicate directly through a shared email regarding regional updates, QI measures and collaboration throughout the three NCCs. Both coaches work closely with the OCH Clinical Transformation Manager and are beginning to align their clinic/agency work with ORCA and the newly hired OCH Program Coordinator. Because coaches are working directly with QI teams across the region, they provide linkages and introductions to providers to share best practices. They also convened partners to begin discussions about co-location of staff, new billing codes, logistics of sharing space and other considerations as they plan to deliver whole person care to Medicaid consumers.

During the reporting period of January 1, 2018 through June 30, 2018, the two practice facilitator coaches assigned to the OCH region continued working with their partnering clinics/agencies to facilitate PCMH-A, MeHAF and PAT assessments, identify care gaps and develop action plans with QI teams. Participating clinics/agencies are:

Practice Transformation Support Hub/Qualis	Pediatric-Transformation Primary Care Initiative
1. North Olympic Healthcare Network	1. Bainbridge Pediatrics
2. Jefferson Healthcare and Primary Care Clinics	2. Lower Elwha Health Clinic
3. Port Gamble S'Klallam Tribe Health Clinic	3. West Sound Treatment Services
4. Port Gamble S'Klallam Tribe Wellness Services	4. Peninsula Community Health Services (all clinics)
5. West End Outreach Services	5. Silverdale Pediatrics 6. Kitsap Mental Health Services 7. One Heart Wild Education Sanctuary

6. Peninsula Community Health Services (all clinics)–	8. West End Outreach Services
7. Peninsula Community Health Services-Kitsap County	9. Reflections Counseling Services Group
8. Discovery Behavioral Health	10. Jefferson Public Health School Based Clinics (Chimacum and Port Townsend)
9. Agape Unlimited SUD Services	11. Kitsap Children's Clinic
10. Reflections Counseling Services Group	
11. Kitsap Mental Health Services	
12. West Sound Treatment Services	
13. Kitsap Medical Clinics	
14. Lower Elwha Tribe Health and Wellness	
15. NW Washington Family Medical Residency	

Summaries from these assessments and resulting QI projects are shared with OCH and will be integrated into the Change Plans.

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

ACH Response:

Not Applicable.

E. Community Engagement

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

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

Community Engagement Activities for the Reporting Period						
Activity Description	Date	Objective	Target Audience	Associated Project Areas	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
P-TCPi Assessment with Bainbridge Pediatrics	1/2	Facilitate Assessment	Clinic Staff. WA DOH Practice Coach	2A	Provide coaching for pediatric clinical improvement	Y*
Meeting at West Sound Treatment and Recovery Services STCS	1/2	Respond to queries from local SUD provider	West Sound Treatment Center leadership and OCH staff	2A, 3A	Initiate partnership with West Sound Treatment Center	N
PTSH/Qualis Coach Meeting w/ Kitsap Medical and KMHS	1/3	Begin to plan for integration between primary care & BH	PTSH Coach, Kitsap Medical/ KMHS Provider and Admin	2A	Identify steps to deliver MH services in Bremerton clinic as pilot site	N
Monthly SBHO Advisory Board Meeting	1/5	Engage with regional providers, clinic leaders, consumers	Regional providers, consumers, community members	2A, 3A	Stay informed regarding SBHO; increased engagement	N

Monthly SBHO Providers Meeting	1/9	Engage with regional SUD providers	Regional SUD providers	2A, 3A	Increased engagement with regional SUD providers	N
PTSH Qualis Agape Unlimited SUD MeHAF Assessment	1/10	Facilitated MeHAF assessment with OCH, QI Team and PTSH Qualis Coach	Agape leadership , OCH Staff, PTSH Qualis	2A, 3A	Provide coaching for developing and implementing integration strategies	N
Meeting with Peninsula College leadership	1/11	Initiate partnership with Peninsula College	Peninsula College leadership	Domain One, 3A	Address regional workforce needs, partner regarding treatment of Chemical Dependency Professionals for best practices in treatment of OUD	N
Clallam County NCC Convening #1	1/11	First of a series of 3 Clallam NCC Convenings to develop SCP	Clallam NCC providers (primary care and BH), CBOs, and community partners	All projects	NCC knowledge of NCC health data, NCC priorities, MTP process, Shared Change Plan	N
Jefferson County NCC Convening #1	1/17	First of a series of 3 Jefferson NCC Convenings to develop SCP	Jefferson NCC providers (primary care and BH), CBOs, and community partners	All projects	NCC knowledge of NCC health data, NCC priorities, MTP process, SCP	N
PTSH/Qualis Reflections Counseling Group SUD	1/17	Facilitated workflow mapping to address	QI team and PTSH/Qualis Coach	2A	Identified current state care gaps and new protocol to increase	

		care gaps in treatment			continuity of care	
Kitsap NCC Convening #1	1/18	First of a series of 3 Kitsap NCC Convenings to develop SCP	Kitsap NCC providers (primary care and BH), CBOs, and community partners	All projects	NCC knowledge of NCC health data, NCC priorities, MTP process, SCP	N
P-TCPI Assessment and 6-month action plan meeting with Chimacum High School Based Health Clinic	1/22	Facilitate assessment and develop 6-month action plan	Clinic staff. WA Dept of Health Practice Coach	2A	Provide coaching for pediatric clinical improvement and develop strategies to move Initiative goals forward	Y*
PTSH/Qualis Coach met Jefferson Healthcare and Discovery Behavioral Health Champion Provider	1/23	Leadership meeting to address strengths and gaps in current integration	Dr. Ehrlich, Discovery Behavioral Health CEO Medical Director and primary care Psych Provider and PTSH Qualis Coach	2A	Identified next steps for coaching and aligning with OCH NCC Change Plan	N
P-TCPI assessment with West Sound Treatment Center	1/29	Facilitate Assessment	Clinic staff. WA Dept of Health Practice Coach	2A	Provide coaching for pediatric clinical improvement	Y*
Jefferson County MH/SUD Advisory Committee meeting	1/30	Engage with local leaders who oversee MH/SUD 1/10 th funding in Jefferson County	Jefferson Public Health, clinic leaders, providers, consumers,	All	Strengthen regional partnerships	N

			community partners			
PTSH/Qualis Coach met with KMHS Admin	1/30	Identify coaching goals that align with OCH NCC Change Plan	KMHS Admin and PTSH/Qualis Coach		Identified VBP strengths and care gaps and steps to introduce treatment to target and registries to teams	N
Kitsap Children's Clinic	1/31	Engage with the largest pediatric practice in Kitsap	Clinic director	2A, 3B, 3C, 3D	Kitsap Children's Clinic Director agreed to attend the Kitsap NCC Convening	N
PTSH/Qualis Jefferson Healthcare and DBH Integration Team Meeting	2/1	Leadership Meeting with JHC and DBH to write integration plan	JHC and DBH Integration QI Team and PTSH/Qualis Coach	2A	Identified steps to shift team to collaborative care model and need for licensed MH referrals for Medicare patients	N
Jefferson NCC Convening #2	2/1	Second of a series of 3 Jefferson NCC Convenings to develop SCP	Jefferson NCC providers (primary care and BH), CBOs, and community partners	All projects	NCC knowledge of NCC health data, NCC priorities, MTP process, review SCP	N
Clallam County Drug Court	2/1	Attend drug court graduation by invitation	Drug court staff and participants	2C, 3A	Initiated engagement with Clallam County drug court	N
Monthly SBHO Advisory Board Meeting	2/2	Engage with regional providers, clinic leaders, consumers	Regional providers, consumers, community members	2A, 3A	Stay informed regarding SBHO; increased engagement	N

P-TCPi Assessment with Peninsula Community Health Services	2/2	Facilitate Assessment	Clinic Staff. WA Dept of Health Practice Coach	2A, 3A	Provide coaching for pediatric clinical improvement	Y*
Kitsap NCC Convening #2	2/5	Second of a series of 3 Kitsap NCC Convenings to develop SCP	Kitsap NCC providers (primary care and BH), CBOs, and community partners	All projects	NCC knowledge of NCC health data, NCC priorities, MTP process, review SCP	N
Clallam Convening #2	2/9	Second of a series of 3 Clallam NCC Convenings to develop SCP	Clallam NCC providers (primary care and BH), CBOs, and community partners	2A, 2C, 3A, 3B, 3C, 3D	NCC knowledge of NCC health data, NCC priorities, MTP process, review SCP	N
Monthly SBHO Providers meeting	2/13	Engage with regional SUD providers	Regional SUD providers	2A, 3A	Increased engagement with regional SUD providers	N
P-TCPi Assessment with Silverdale Pediatrics	2/13	Facilitate Assessment	Clinic Staff. WA Dept of Health Practice Coach	2A, 3A	Provide coaching for pediatric clinical improvement	Y*
Bi-monthly SBHO Executive Board Meeting	2/16	Engage with SBHO, regional providers and clinic leaders, elected officials, consumers	SBHO, providers and clinic leaders, elected officials, consumers	2A, 3A	Increased engagement	N
P-TCPi Action Plan meeting with Reflections	2/19	Develop 6-month action plan	Clinic staff. WA Dept of Health	2A	Develop strategies to move Initiative goals forward	N

Counseling Services			Practice Coach			
Clallam NCC Convening #3	2/20	Third of a series of 3 Clallam NCC Convenings to develop SCP	Clallam NCC providers (primary care and BH), CBOs, and community partners	All projects	Finalize draft Shared Change Plan	N
P-TCPI Assessment and 6-month action plan meeting with Port Townsend School Based Health Clinic	2/20	Facilitate assessment and develop 6-month action plan	Clinic staff. WA Dept of Health Practice Coach	2A	Provide coaching for pediatric clinical improvement and develop strategies to move Initiative goals forward	Y*
Kitsap NCC Convening #3	2/21	Third of a series of 3 Kitsap NCC Convenings to develop SCP	Kitsap NCC providers (primary care and BH), CBOs, and community partners	All projects	Finalize draft Shared Change Plan	N
Jefferson NCC Convening #3	2/23	Third of a series of 3 Jefferson NCC Convenings to develop SCP	Jefferson NCC providers (primary care and BH), CBOs, and community partners	All projects	Finalize draft Shared Change Plan	N
Roundtable with Senator Cantwell	2/23	Meet with Senator Cantwell to discuss regional activities and needs regarding the opioid crisis	Senator Cantwell, providers, consumers	3A	Inform Senator Cantwell of regional successes and needs to address opioid crisis	N

P-TCPi Action Plan meeting with West Sound Treatment Center	2/26	Develop 6-month action plan	Clinic staff. WA Dept of Health Practice Coach	2A	Develop strategies to move Initiative goals forward	N
Kitsap Strong meeting	2/27	Initiate engagement with local partners and coalitions serving youth	Local providers and partners who serve youth	All projects	Initiate engagement with local partners who serve youth	N
PTSH/Qualis Attended VBP Academy in SeaTac with KMHS	2/28	VBP Academy Event to teach process of QI for payment restructure	KMHS VBP Team and PTSH Qualis Coach	2A	Identify QI Project for VBP and steps to implement	N
Monthly Regional Hub and Spoke Meeting	2/28	Strengthen partnership with regional providers who provide services to community members with OUD	Regional providers who provide services to community members with OUD	2A, 3A	Strengthen care coordination in the region, share resources	N
P-TCPi MOA meeting with Kitsap Children's Clinic and Kitsap Mental Health Services	3/6	Sign MOA to work on asthma population health project	Clinic staff. WA State Dept of Health Practice Coach	2A	Improve integration of care within pediatric community	Y*
PTSH/Qualis KMHS VBP Academy Team Meeting	3/6	Debrief VBP Academy and build QI Project for staff implementation	KMHS VBP Leadership team and PTSH/Qualis Coach	2A	Plan to provide overview of VBP for Admin/Managers meeting	N

PTSH/Qualis WestEnd Outreach MeHAF Assessment	3/7	MeHAF assessment to identify current state of integration	WEOS QI Team, PTSH/Qualis Coach and P-TCi Coach	2A	Completed MeHAF assessment and identified QI Projects	N
Jefferson Community Foundation	3/8	Align communication efforts	Foundation staff	All projects	Agreement to share communications across readership	N
NW WA Family Medicine Residency Program Meeting WFMR	3/9	Initiate engagement with new family medicine residency program	NWWFMR staff, PTSH Qualis Coach	All projects	Engage with NWWFMR	N
PTSH/Qualis Health Peninsula Community Health Services Six-month reassessment PCMHA	3/9	Reassessment with Peninsula Community Health Services QI Team	QI Team and PTSH/Qualis Coach	2A	Complete Reassessment and Identify QI Project for care coordination	N
P-TCPi Action Plan Meeting with Bainbridge Pediatrics	3/13	Develop 6-month action plan	Clinic Staff. WA Dept of Health Practice Coach	2A	Develop strategies to move Initiative goals forward	N
PTSH/Qualis VBP Academy Presentation to KMHS Staff	3/14	Presented principles of VBP to KMHS Managers	KMHS Managers and PTSH/Qualis Coach	2A	Presented QI overview for VBP payment reform and tracking treatment to target and chronic disease	N
WSHA	3/19	Initiate engagement with WSHA staff focused on opioid response	WSHA staff	2A, 3A	Initiated engagement	N

P-TCPi meeting with Reflections Counseling Services	3/26	Determine baseline metric goals	Clinic staff. WA Dept of Health Practice Coach	2A	Determined baseline metric goals as part of 6-month action plan	N
Monthly Regional Hub and Spoke Meeting	3/28	Strengthen partnership with regional providers who provide services to community members with OUD	Regional providers who provide services to community members with OUD	2A, 3A	Strengthen care coordination in the region, share resources	N
P-TCPi meeting with West Sound Treatment Center	3/28	Create Provider Resource tool	Clinic staff. WA Dept of Health Practice Coach	2A	Begin developing Provider resource tool as part of Action Plan	N
PTSH/Qualis Health West Sound Treatment Leadership Team Meeting	3/29	Review MeHAF current state and alignment with OCH NCC Change Plan	WSTC Leadership Team, PTSH/Qualis Coach	2A, 3A	Identify strengths and gaps of current state to prepare for VBP and OCH NCC Change Plan	N
Regional Re-Entry Task Force meeting	3/30	Initiate engagement with local providers and coalitions addressing re-entry from incarceration back into the community	Providers, coalitions, consumers, community partners addressing re-entry needs	2A, 2C, 3A	Engagement with regional partners serving community members transitioning from incarceration	N
PTSH/Qualis Coach and Kitsap Medical Leadership Meeting	3/30	Review Collaborative Care Codes and implementation	Kitsap Medical QI team and PTSH/Qualis Coach	2A	Identified protocol for implementing Collaborative Care Codes in	N

					primary care Clinic	
PTSH/Qualis Coach and KMHS/Peninsula Community Health Services PCMH-A	4/4	PCMH-A with KMHS and Peninsula Community Health Services integrated team	KMHS, Peninsula Community Health Services QI Team and PTSH/Qualis Coach	2A	Identified strengths and gaps of care coordination and continuity of care between BH and primary care on campus	N
PTSH/Qualis Environmental Scanning for Medicare MH Providers Jefferson County	4/6	Completed scanning for resource document of MH providers who accept Medicare	PTSH/Qualis Coach	2A	Provided resource to JHC Integrated Team	N
PTSH/Qualis MeHAF Reassessment with Discovery Behavioral Health	4/10	MeHAF six-month reassessment with DBH QI Team	DBH QI Team and PTSH/Qualis Coach	2A	Identified current state and continuity of care gaps in integrated system of care	N
Monthly SBHO providers meeting	4/10	Engage with regional SUD providers	Regional SUD providers	2A, 3A	Increased engagement with regional SUD providers	N
Meeting with new nurse care manager at Olympic Medical Physicians	4/10	Engage with regional providers treating community members with OUD	Nurse Case Manager	2A, 3A	Engage and network with regional providers	N
Monthly Clallam County MH/CD Advisory Committee	4/10	Engage with local leaders who oversee MH/SUD 1/10 th funding in Jefferson County	Clallam Public Health, clinic leaders, providers, consumers,	All projects	Strengthen regional partnerships	N

			community partners			
P-TCPi Assessment with Kitsap Mental Health Services	4/10	Facilitate Assessment	Clinic Staff. WA Dept of Health Practice Coach	2A	Provide coaching for pediatric clinical improvement	Y*
PTSH/Qualis NW WA Family Medical Residency	4/11	Review PCMH-A QI Project Goals	Clinic QI Team and PTSH/Qualis Coach	2A	Identified Collaborative Care Codes as focus for QI team project	N
Jefferson County Community Health Improvement Plan meeting	4/11	New community-based coalition focused on implementing MH/CD plans in county Community Health Improvement Plan	Providers, consumers, and community members focused on MH/CD services	2A, 3A	Collaborate with local efforts	N
Forks Community Hospital	4/11	Engage Forks Community Hospital	Hospital CEO and OCH ED	2A, 2D, 3A, 3D	Initiated engagement for OCH Board Meetings	N
P-TCPi Assessment with One Heart Wild	4/12	Facilitate Assessment And develop 6-month action plan	Clinic Staff, WA State Dept of Health Practice Coach	2A	Provide coaching for pediatric clinical improvement and develop plan to move Initiative goals forward	Y*
PTSH/Qualis WestSound Treatment Leadership Team	4/12	Team Meeting to review current Action Plan	QI Team and PTSH/Qualis Coach		Identified alignment with OCH NCC Change Plan	N
P-TCPi MOA meeting with Silverdale Pediatrics and Kitsap Mental	4/17	Sign MOA to work on asthma population	Clinic staff. WA Dept of Health	2A	Improve integration of care within pediatric community	Y*

Health Services		health project	Practice Coach			
Monthly Olympic Peninsula Health Communities Coalition Meeting	4/18	Engagement with local coalition to improve regional health outcomes	Members from regional CBOs	All	Collaborate with existing efforts	N
Bi-Annual Olympic College (OC) Human Services Advisory Committee meeting	4/19	Engage with regional community college	Olympic College Human Services staff and faculty, regional SUD providers	Domain One, 3A	Collaborate with regional community colleges	N
P-TCPI meeting with Reflections Counseling Services	4/19	Develop Provider community resource guide	Clinic staff. WA Dept of Health Practice Coach	2A	Created rough draft of community resource guide as part of Action Plan	N
Bi-Monthly SBHO Executive Board Meeting	4/20	Engage with SBHO, regional providers and clinic leaders, elected officials, consumers	SBHO, providers and clinic leaders, elected officials, consumers	2A, 3A	Increased engagement	N
NEAR Training	4/24	Host NEAR training for community partners	Regional providers, consumers, community partners	All	Provide training as requested by community partners	N
Regional NCC Convening	4/24	Convene regional NCC partners to review sign Shared Change Plan	Regional NCC partners	All projects	Reviewed and signed Shared Change Plan	N
PTSH/Qualis WestEnd Outreach	4/25	Action Plan and PDSA based on	WEOS Team, PTSH/Qu		Identified registry and treatment to	N

Services WEOS		scoring from MeHAF	alis Coach and P-TCPi Coach		target for high utilizers of ED	
P-TCPi Assessment with WestEnd Outreach Services	4/25	Facilitate Assessment	Clinic Staff. WA Dept of Health Practice Coach	2A	Provide coaching for pediatric clinical improvement	Y*
Monthly Hub and Spoke meeting	4/25	Strengthen partnership with regional providers who provide services to community members with OUD	Regional providers who provide services to community members with OUD	2A, 3A	Strengthen care coordination in the region, share resources	N
Monthly SBHO Advisory Board Meeting	5/4	Engage with regional providers, clinic leaders, consumers	Regional providers, consumers, community members	2A, 3A	Stay informed regarding SBHO; increased engagement	N
PTSH/Qualis Reflections SUD six-month MeHAF Assessment	5/4	Assessment with QI team to identify strengths and care gaps	QI Team and PTSH/Qualis Coach	2A	Completed assessment and identified integration challenges for VBP	N
Olympic Medical Center Opioid Overdose Pilot meeting	5/7	Become informed about a pilot opioid overdose notification program	Regional providers, law enforcement, fire/emergency medical services, public health	2A, 3A	OCH region will be the pilot site for the opioid overdose notification project being implemented by WHSA, Washington State Medical Association, and DOH	N
PTSH/Qualis Kitsap	5/7	Kitsap Medical Meeting to	Clinic QI Team and	2A	Identified workflow protocol for	N

Medical Meeting		review Action Plan and OCH NCC integration goals	PTSH/Qualis Coach		delivering Collaborative Care Model in one clinic as pilot	
P-TCPI meeting with Reflections Counseling Services	5/7	Develop Provider community resource guide	Clinic staff. WA Dept of Health Practice Coach	2A	Continued to develop community resource guide as part of Action Plan	N
Monthly SBHO Providers meeting	5/8	Engage with regional SUD providers	Regional SUD providers	2A, 3A	Increased engagement with regional SUD providers	N
Clallam County Chemical Dependency/Mental Health Retreat	5/8	Facilitate Clallam County Chemical Dependency/Mental Health Advisory Committee retreat	Chemical Dependency/Mental Health Advisory Committee members	All projects	Facilitated retreat at invitation of committee	N
P-TCPI meeting with One Heart Wild	5/10	Develop patient and volunteer satisfaction surveys	Clinic staff and WA Dept of Health Practice Coach	2A	Provide coaching to move Initiative goals forward	N
P-TCPI check-in with Jefferson Public Health school-based health clinics	5/11	Check-in meeting to discuss Action Plan	Clinic staff. WA Dept of Health Practice Coach	2A	Provide coaching for pediatric clinical improvement	N
PTSH/Qualis KMHS Leadership Team Meeting	5/16	Review goals of VBP tracking in BH	Admin, Clinical Director and PTSH/Qualis Coach	2A	Identified training needs for staff to understand treatment to target and registries	N
Monthly Olympic Peninsula Health Communities	5/16	Engagement with local coalition to improve regional	Members from regional CBOs	All	Collaborate with existing efforts	N

Coalition Meeting		health outcomes				
P-TCPi MOA meeting with Silverdale Pediatrics and One Heart Wild	5/17	Sign MOA to improve referral relationship between Primary Care and Behavioral Health	Clinic Staff. WA State Dept of Health Practice Coach	2A	Improve integration of care within pediatric community	Y*
i2i Demonstration to Clallam and Jefferson NCC Partners	5/17	Introduce partners to i2i as a population health management resource	OCH staff and hospital, SUD, MH, and FQHC leadership	All projects; Domain One: population health management strategies	Follow-up with Epic Community Connect and check back with i2i	N
PTSH/Qualis Coordination Meeting with Kitsap Medical and KMHS	5/18	Address steps to begin Collaborative Care Pilot	Kitsap Medical QI Team and Provider and KMHS Admin and Clinician and PTSH Qualis Coach	2A	Reviewed protocol for billing and workflow issues for integrated KMHS clinician at primary care clinic	N
Monthly Regional Hub and Spoke Meeting	5/23	Strengthen partnership with regional providers who provide services to community members with OUD	Regional providers who provide services to community members with OUD	2A, 3A	Strengthen care coordination in the region, share resources	N
Meeting with WA Senator Cantwell's aide	5/24	Inform Senator Cantwell regarding OCH	Public health officers from each of the	2A, 3A	Strengthen networking with elected officials	N

		regional opioid response work	three counties			
P-TCPI meeting with West Sound Treatment Center	5/24	Create Provider Resource tool	Clinic staff. WA Dept of Health Practice Coach	2A	Continue developing Provider resource tool as part of Action Plan	N
3CCORP	5/24	Convene 3CCORP Steering Committee	3 county, multi-sector committee to oversee 3CCORP work and work groups	2A, 3A	Review progress of regional opioid response and guide next steps	N
P-TCPI MOA meeting with Peninsula Community Health Services and Kitsap Mental Health Services	5/28	Sign MOA to work on asthma population health project	Clinic staff. WA Dept of Health Practice Coach	2A	Improve integration of care within pediatric community	Y*
Opioid Round Table with Senator Murray	5/31	Inform Senator Murray regarding OCH regional opioid response work	Kitsap County providers and community members	2A, 3A	Strengthen networking with elected officials	N
P-TCPI MOA meeting with Kitsap Children's and One Heart Wild	5/31	Sign MOA to improve referral relationship between Primary Care and Behavioral Health	Clinic Staff. WA State Dept of Health Practice Coach	2A	Improve integration of care within pediatric community	Y*
P-TCPI meeting with KMHS	6/5	Discuss asthma population health project	Clinic staff. WA Dept of Health	2A	Finalize in-home assessment curriculum	N

			Practice Coach			
P-TCPi Follow-up Assessment with Reflections Counseling Services	6/6	Facilitate Assessment	Clinic Staff. WA Dept of Health Practice Coach	2A	Provide coaching for pediatric clinical improvement	Y*
MAT training	6/6	Provide MAT training to SUD providers, MAT prescribers, and Drug Court judge and staff	SUD providers, MAT prescribers, public health, Drug Court judge and staff	2A, 3A	Shared understanding of MAT, increased coordination of care for community members with OUD	N
PTSH/Qualis KMHS VBP Academy Meeting	6/7	VBP Academy Team Meeting to review tracking and collaborative care project	VBP Academy Lead, KMHS Team and PTSH/Qualis Coach	2A	Identified new protocol to introduce to track treatment to target with PHQ9 and other screening tools	N
Monthly SBHO Providers meeting	6/12	Engage with regional SUD providers	Regional SUD providers	2A, 3A	Increased engagement with regional SUD providers	N
P-TCPi Action Plan meeting	6/12	Develop 6-month action plan	Clinic Staff. WA Dept of Health Practice Coach	2A	Develop strategies to move Initiative goals forward	N
P-TCPi Assessment with Kitsap Children's Clinic	6/12	Facilitate Assessment and develop 6-month action plan	Clinic staff. WA State Dept of Health Practice Coach	2A	Provide coaching for pediatric clinical improvement and develop plan to move Initiative goals forward	Y*

P-TCPi Action Plan with West End Family Counseling	6/13	Develop 6-month action plan	Clinic Staff. WA Dept of Health Practice Coach	2A	Develop strategies to move Initiative goals forward	N
Criminal Justice Opioid Workgroup meeting	6/14	Statewide Criminal Justice Opioid Workgroup	Address opioid response for community members involved with the criminal justice system	2A, 2C, 3A	Increased engagement with criminal justice system	N
P-TCPi MOA meeting with One Heart Wild and Silverdale Pediatrics	6/14	Check-in discussion to discuss new referral process	Clinic Staff. WA Dept of Health Practice Coach	2A	Improve integration of care within pediatric community	N
Bi-Monthly SBHO Executive Board Meeting	6/15	Engage with SBHO, regional providers and clinic leaders, elected officials, consumers	SBHO, providers and clinic leaders, elected officials, consumers	2A, 3A	Increased engagement	N
3CCORP Treatment Work Group	6/18	Convene 3CCORP Treatment Workgroup	3 county, multi-sector work group focusing on increasing access to best practice treatment for OUD	2A, 3A	Develop and implement opioid response for treatment of OUD	N
PTSH/Qualis NW WA Family Medicine	6/18	Met to review Collaborative Care Model and	Clinic QI Team and PTSH/Qualis Coach	2A	Identified action steps to develop protocol for collaborative	N

Residency Team Meeting		new positions in three clinics with KMHS			care model and billing process	
Meeting with West Sound Treatment Services	6/19	MeHAF Facilitated Assessment with PTSH Qualis Coach	WSTS leadership , OCH and PTSH/ Qualis Coach	2A, 3A	Provide coaching for developing and implementing integration strategies	N
Monthly Olympic Peninsula Health Communities Coalition Meeting	6/20	Engagement with local coalition to improve regional health outcomes	Members from regional CBOs	All	Collaborate with existing efforts	N
PTSH/Qualis KMHS Older Adults Care Team PCMH-A	6/20	Continued PCMH-A facilitation with KMHS Care Team	QI Team and PTSH/Qualis Coach	2A	Identified strengths and gaps to care coordination with primary care on campus	N
3CCORP Prevention Work Group	6/21	Convene 3CCORP Prevention Workgroup	3 county, multi-sector work group focusing on prevention of opioid misuse and abuse	2A, 3A	Develop and implement opioid response for prevention of opioid misuse and abuse primarily through improving prescribing practices	N
Monthly Regional Hub and Spoke Meeting	6/27	Strengthen partnership with regional providers who provide services to community members with OUD	Regional providers who provide services to community members with OUD	2A, 3A	Strengthen care coordination in the region, share resources	N
PTSH/Qualis KMHS VBP Academy	6/27	VBP Academy Team	KMHS VBP Team and	2A	Identified need to review assessment	N

		Meeting to address workflow protocol for new assessment process	PTSH/Qualis Coach		documents and tracking in electronic health record for VBP	
WSHA Rural Hospital Retreat	6/25-6/27	Present OCH work on opioid response and housing to hospital commissioners	Hospital commissioners/elected officials	2D, 3A	Resources on Initiatives 2 & 3; social financing, and opioid response	N
SBHO meeting with SUD providers and MCOs	6/29	SBHO convened contracted SUD providers and MCOs	Better shared understanding of FIMC and how to prepare	2A, 3A	First of a series of meetings to support SUD providers' readiness for FIMC	N

* P-TCPI incentive funds

Community Engagement Table Acronyms: 3CCORP – Three County Coordinated Opioid Response Project, AB – Advisory Board, BH – Behavioral Health, CBO – Community Based Organizations, CP – Change Plan, DOH – Department of Health, ED – Executive Director, FQHC – Federally Qualified Health Center, izi – Refers to a population health management data and insight company, FIMC – Fully Integrated Managed Care, KMHS – Kitsap Mental Health Services, MAT – Medication Assisted Treatment, MCO – Managed Care Organization, MH – Mental Health, MOA- Memorandum of Agreement, MTP – Medicaid Transformation Project, NCC- Natural Community of Care, NEAR – Neuroscience, Epigenetics, Adverse Childhood Experiences, Resiliency, NWWFMR – Northwest Washington Family Medicine Residency, OCH – Olympic Community of Health, OUD – Opioid Use Disorder, P-TCPI – Pediatric – Transforming Clinic Practice Initiative, SBHO – Salish Behavioral Health Organization, SCP – Shared Change Plan, SUD – Substance Use Disorder, WA – Washington, WSHA – Washington State Hospital Association, WSTS – West Sound Treatment Services; for a full list of acronyms in use in this document, refer to Attachment D: Glossary of Acronyms

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

ACH Response:

Twenty-one unduplicated partnering provider clinics in the Olympic region completed the PCMH-A which specifically addresses the issue of health literacy related to comprehension for English speakers and consumers where English is their second language. Consensus among QI teams reflected limited assessment of consumers regarding comprehension, and that this could create a care gap due to lack of reporting by consumers. Below is the question and teaching point related to health literacy. Many

groups reported that consumers typically share their comprehension difficulties with a person in the clinic other than the health provider. Health navigators, care coordinators and medical assistants are often the trusted team members that Medicaid consumers seek out to assist with comprehension issues.

	1	2	3	4	5	6	7	8	9	10	11	12
23. Patient comprehension of verbal and written materials	...is not assessed.			...is assessed and accomplished by ensuring that materials are at a level and language that patients understand.			...is assessed and accomplished by hiring multi-lingual staff, and ensuring that both materials and communications are at a level and language that patients understand.			...is supported at an organizational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop) ensuring that patients know what to do to manage conditions at home.		
<p>QUESTION: To what degree does the practice ensure that patients understand verbal and written communication and materials?</p> <p>TEACHING POINTS: Health literacy is an important factor in healthcare and all facets should be assessed.</p> <p>LEVEL C EXAMPLE(S): We ensure that all materials are in our patients' preferred languages and are not above an eighth-grade reading level.</p> <p>LEVEL B EXAMPLE(S): We hire and train multi-lingual staff whenever possible.</p> <p>LEVEL A EXAMPLE(S): Translation needs for the day are assessed during huddles and provided as needed; we use teach back techniques to ensure patient understanding; we engage patients to assist with creating materials that are at a level and in a form that is easy for patients to understand.</p>												
	1	2	3	4	5	6	7	8	9	10	11	12

OCH is currently accepting nominations for the Community and Tribal Advisory Committee. The Committee will proactively engage community-based organizations, Tribes and the beneficiaries of services to ensure that their voice guides and informs the decision making of OCH. The Committee will provide recommendations to the OCH Board of Directors, including but not limited to: project implementation, transparent communication strategies, regional whole person health priorities, social justice, and health equity for our community members including those with limited English proficiency.

Updates to the OCH Regional Health Needs Inventory will include descriptions of populations with limited proficiency in English across the region derived from data shared by partnering providers and from sources such as the Healthier Washington Data Dashboard and the American Community Survey. These data will be shared with the Community and Tribal Advisory Committee to develop and carry out targeted outreach activities.

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

ACH Response:

According to responses in the OCH Health Equity Questionnaire, underrepresented community groups in the OCH region include: young adults, Tribal Elders, sexual orientation, non-English speakers, Hispanic/Latino/as, AI/AN, Black/African Americans, Guatemalan and Asian immigrants, disabled persons, persons with behavioral health conditions, those living in poverty, incarcerated or previously incarcerated persons, transgender individuals, persons with minimal education, geographically isolated individuals, homeless, returning military, veterans, and foster children.

Challenges to engaging and partnering with underrepresented community members are listed in the table below alongside strategies OCH and partnering providers have undertaken to address them.

Table 8. Engaging and Partnering with Underrepresented Community Members: Challenges and Strategies to Address Challenges		
	Challenge	Strategies to Address Challenge
A.	AI/AN persons have the worst health outcomes of all populations.	Each of the seven Tribes in the region has a seat on the OCH Board of Directors; OCH has a Director of Community and Tribal partnership to ensure that AI/AN-specific needs are included and addressed in the work of the OCH.
B.	Geographic – rural and remote communities make it challenging to have underrepresented community members participate and contribute to the MTP work of OCH.	Convene meetings in various locations in all areas of the region; attend existing coalition meetings and events; establish networks that extend across the region to leverage existing platforms; facilitate virtual meeting participation.
C.	Historical and current mistrust of healthcare systems and organizations result in underrepresented community members’ apprehension and unwillingness to engage and participate.	Provide timely, accurate, transparent information to partners and community regarding OCH activities; attend existing coalition and community meetings to be present and visible in the community; establish networks that extend across the region to leverage existing platforms.
D.	OCH messaging is not easily accessible to all partners; varying widely across the region and age groups	Add a full time Communications and Development Coordinator to the OCH team to develop and implement communication strategies to reach underrepresented community members using strategies that are best suited to different age groups.

E.	Providers need training in culturally appropriate and trauma informed care.	Identify training needs via the OCH health equity questionnaire and develop and implement trainings in the OCH region. PHBH Change Plan includes training elements for health equity, LGBTQ-inclusive care, NEAR/historical trauma/trauma-informed care.
F.	It can be challenging to reach and engage some underrepresented groups such as homeless, incarcerated/recently incarcerated, community members with behavioral health conditions, non-English speakers	Work with non-clinical partners such as law enforcement, fire/emergency medical services, criminal justice, community-based organizations, community coalitions to network and outreach (for example law enforcement, behavioral health and public health are active in the 3COORP)

Table 8 Acronyms: 3CCORP – Three County Coordinated Opioid Response Project, AI/AN – American Indian/Alaskan Native, LGBTQ – Lesbian Gay Bisexual Transgender Queer, MTP – Medicaid Transformation Project, NEAR - Neuroscience, Epigenetics, Adverse Childhood Experiences, Resilience, OCH – Olympic Community of Health, PHBH Change Plan – Physical Health Behavioral Health Change Plan; for a full list of acronyms in use in this document, refer to Attachment D: Glossary of Acronyms

Partners that complete an assessment through the PTSH/Qualis Coach-Connector are coached in SDoH as a tool to assist Medicaid beneficiaries in obtaining transportation, food security, housing support and other basic needs that can positively impact health. The Coach-Connector has shared several SDoH tools that can be introduced in a Plan Do Study Act (PDSA) format through a QI process including Health Leads and PRAPARE. PRAPARE is compatible EPIC electronic health record, which is currently in use in two of the four hospitals in the region and may expand to a third. It is also in use in the large medical group in Port Angeles, a tribal health clinic in Sequim, and all outpatient clinics in Jefferson County.

PTSH/Qualis Coach-Connector provides coaching to Jefferson Healthcare Primary Care Clinics and Kitsap Medical Clinics on community referrals for social and MH services for Medicaid patients.

F. Health Equity Activities

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

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

ACH Response:

Project plans submitted in November were informed by regional health disparities data to identify and address health inequities in the OCH project portfolio.

The Change Plan, which is the primary MTP implementation tool, requires providers/partners to implement a population-based platform to systematically risk stratify and follow subpopulations for more efficient and effective care. The Change Plan also requires providers/partners to assess for SDoH and to integrate addressing SDoH and referring to community providers for services into standard practice. Specifically, “SDoH are assessed and integrated into standard practice” is an outcome required of all Implementation Partners.

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

ACH Response:

OCH implemented a regional health equity questionnaire in April. The preliminary results to date inform the current SAR (see Section A) and the final results will be analyzed in August to inform the Implementation Plan and guide OCH leadership in decision making.

The health equity questionnaire has eleven questions, including:

- “Please rank the following in order of what would be most helpful to your organization to support addressing health equity in your work.”
- “Please share some examples of what your organization is doing to address health equity.”
- “What would your organization want to do to improve health equity in our region and what do you need to do it?”

Respondents identified the following as excluded/marginalized groups in the OCH region:

- Young adults
- Elders
- LGBTQ+ individuals
- Non-English speakers
- Hispanic/Latino/a
- AI/AN
- Black/African Americans
- Guatemalan and Asian immigrants
- Disabled individuals
- Persons with behavioral health conditions
- Persons living in poverty
- Incarcerated or previously incarcerated individuals
- Persons with minimal education
- Geographically-isolated individuals
- Homeless individuals
- Returning military, veterans

- Foster children

Throughout the MTP, OCH and partnering providers will disaggregate data to identify and track subpopulations including marginalized and previously excluded groups to assess and address disparities across subpopulations.

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

ACH Response:

OCH has taken the following steps to provide the Board of Directors, staff, and partnering providers with tools to address health equity:

- OCH presents health disparities/health equity data at NCC convenings, Board meetings and other OCH provider/partner convenings.
- At the Regional NCC convening, providers/partners participated in an activity to explore and share health equity issues within their organizations.
- OCH hosted a NEAR training at the Regional NCC convening and will host additional NEAR trainings over the course of the MTP.
- The OCH Board received training in AI/AN health and health systems in 2017 and will receive a government-to-government training in 2018.
- The PCMH-A tool, which is administered by the PTSH Connector-Coach to partnering providers, specifically addresses health literacy.
- OCH's PTSH/Qualis Connector-Coach attended the Southcentral Foundation NUKA System of Care three-day training. NUKA is an Alaska Native word that means strong, giant structures and living things.
- OCH's Director of Community and Tribal Partnership attended the Joint National Institute of Health, Indian Health Service, Substance Abuse and Mental Health Services Administration Tribal Consultation/Listening Session on the Opioid Crisis in Indian Country in Minnesota.

OCH will monitor the use of health equity tools by partnering providers via the following steps:

- The PTSH/Qualis Connector-Coach will re-administer the PCMH-A to partnering providers to track progress health literacy awareness and tools
- Every six months, Implementation Partners will report progress in their Change Plan towards this outcome: *SDoH are assessed and integrated into standard practice* via the following tactics:
 - Train staff about the impacts of SDoH on health and using SDoH screening tool
 - Integrate SDoH screening tool in intake process and routine care
 - Patients/clients are screened for specific SDoH needs
 - a. Housing status/needs
 - b. Employment status/needs
 - c. Transportation status/needs
 - d. Food status/needs
 - e. Other

- Semi-annually, Implementation Partners will respond to six questions in an open narrative. One of these questions is: *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?*
- OCH is providing financial support to add two health equity measures into the Olympic region’s Behavioral Risk Factor Surveillance System, the nation's premier system of health-related telephone surveys that collect adult self-reported data regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. These are: food security and ACEs.
- OCH plans to implement a health equity questionnaire at every NCC convening throughout the MTP to identify improvements and gaps in achieving health equity.
- OCH is researching additional health equity tools and strategies to track provider/partner use of the tools.

G. Budget and Funds Flow

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

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

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

Yes	No
X	

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

There were no findings from OCH’s independent audit.

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

Not applicable.

2. Design Funds

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

Please refer to tab G.2 Design Funds in the attached OCH SAR Workbook.

3. DY 1 Earned Incentives

Please refer to tab G.3 DY1 Incentives in the attached OCH SAR Workbook.

4. Integration Incentives

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

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

Not applicable

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

Not applicable.

5. Total Medicaid Transformation Incentives

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

Attachment A: Practice Transformation Support Hub Aggregated Report

Olympic Region Practice Transformation Support Hub/Qualis Health Coach Connector Activities

Clinics/Agencies	Action Steps & Quality Improvement
Agape Unlimited SUD Services/Kitsap	<ul style="list-style-type: none"> Track MAT clients with SDoH reporting metrics for SBHO Shared Qualis Health Integrated Billing Tool for preparing for MCO contracting
Discovery Behavioral Health Services (DBH)/Jefferson	<ul style="list-style-type: none"> DBH QI Team will address the following care coordination gaps: <ul style="list-style-type: none"> Treatment plan for PC and BH exists but are separate and uncoordinated with occasional sharing of information Team states that rules and regs of 42 CFR 2 and HIPPA dictate what can/cannot be shared and this impacts level of accessibility and efficiency of BH practitioners Client Care Teams are currently not in place Data systems are currently shared among providers on an ad hoc basis Funding driven by SBHO Valent is new EHR that will be implemented in 8-9 months and should improve data systems, reports and coordination Medication lists are kept in separate EHR Team has no way to know if their clients have been seen in the ED There are gaps in cross training with staff due partially to turn-over of staff. This creates QI issues around documentation.
Jefferson Healthcare Primary Care Clinics/Jefferson	<ul style="list-style-type: none"> Integrated QI Team currently planning for implementation of Collaborative Care Model Currently working with three medical social workers who primarily see Medicare patients. Team believes Collaborative Care Model will be more sustainable and serve more patients Coach-Connector provided environmental scanning document to identify private therapists in surrounding Jefferson County who accept Medicare and preferred referral process for patients
Kitsap Medical Clinics/Kitsap	<ul style="list-style-type: none"> Update pain contract and workflow map random Urine Drug Screen protocol

Clinics/Agencies	Action Steps & Quality Improvement
	<ul style="list-style-type: none"> • Coach-Connector conducted Environmental Scanning for Medicare covered mental health providers and social workers in Kitsap County • Pilot project with KMHS to utilize Collaborative Care Codes with LPN on site functioning as care coordinator and KMHS therapist providing 8 hours month of BH service.
Kitsap Mental Health Services (KMHS)Admin/Kitsap	<ul style="list-style-type: none"> • Reviewing SUD consent management workgroup goals and considering being pilot site for state-developed SUD consent management tool • Admin staff participating in VBP Academy and pilot project with tracking treatment to target for BH diagnoses and chronic disease • Build templates for Valent for population health for all four Behavioral Health Agencies • Utilize PreManage • Pilot Registries bases on Navos model to track treatment to target with PHQ9
Kitsap Mental Health Older Adults Team/Kitsap	<ul style="list-style-type: none"> • Workflow map ROI process and limitations of 42CFR2. Admin addressing this issue. • Workflow map care continuity between established KMHS clients and co-located PCP from Harrison Health Partners and Peninsula Community Health Services • Utilize champion clinician to pilot care consultation between KMHS and PCPs
Lower Elwha Tribe Health Services/Clallam	<ul style="list-style-type: none"> • Formation of QI Team and teaching principles of quality improvement that includes Dental, BH, SUD and PCP services • Securing funding for new electronic health record, likely NextGen • PDSA with population health Icare screens for chronic disease and prevention tracking • Address health literacy issues related to comprehension and language services • Pilot Excel registry to track treatment to target of high ED utilizers and high risk clients
North Olympic Healthcare Network/Clallam BEST PRACTICE	<ul style="list-style-type: none"> • PhD Psychologist managing MAT and BH Services with three BH providers as of 8/2018. • Planning for crisis response in North Olympic Healthcare Network clinic to provide warm hand-offs for providers • Coach researching billing by chemical dependency provider in FQHC
NW Washington Family Medicine Residency/Kitsap	<ul style="list-style-type: none"> • Medical Assistants weekly Healthcare Maintenance follow up for preventative care with empaneled patients • Administer PHQ-2 and GAD-2 for all patient visits • Collaboration with KMHS to fund three employees of KMHS to integrate in all Kitsap clinics to provide BH services and referrals to KMHS for intake and mental health services

Clinics/Agencies	Action Steps & Quality Improvement
Peninsula Community Health Services-KMHS Campus/Kitsap	<ul style="list-style-type: none"> • Co-located ARNP is a member of the QI team and completed the PCMH-A with team • Care gaps exist due to inability to see any shared client records • Work around developed for care continuity
Peninsula Community Health Services-Community Clinics BEST PRACTICE/Kitsap	<ul style="list-style-type: none"> • Champion provider who conducts huddles daily with her medical assistant will be offered as a best practice for other provider teams to pilot • Lowest Score of 9 from PCMH-A #17. Organized Evidence Based Care: Visits are organized around acute problems but with attention to ongoing illness and prevention needs if time permits. The practice also uses subpopulation reports to proactively call groups of patients in for planned care visits.
Port Gamble S’Klallam Tribe Wellness Clinic (BH &SUD) and Health Clinic/Kitsap	<ul style="list-style-type: none"> • Behavioral Integration Team formed to lead efforts to care coordination • Preparing to share NextGen between all staff for full transparency between BH, SUD and PCP services • Workflow mapping for new integrated mental health position in primary care • Outreach strategies for substance use pre-contemplative clients • Tribe sending group to Southcentral Foundation Nuka System of Training in Anchorage, Alaska June 27-29 to develop competencies to: <ul style="list-style-type: none"> ○ Identify recruitment, onboarding, retention strategies for integrated BH and psychiatry professionals within the primary care setting ○ Examine Southcentral Foundations’ journey of integration, including challenges and success measures ○ Take a deep dive into the recommended steps and best practices for fully integrating BH and psychiatry ○ Compare various models and levels of integrating BH
Reflections Counseling Services Group/Clallam	<ul style="list-style-type: none"> • Shared Qualis Health Integrated Billing Tool for preparing for MCO contracting • Workflow map care gap with no show/cancelled clients and implement protocol for more immediate follow up to maintain engagement of client • Building referral relationships with MAT program at North Olympic Healthcare Network • Develop new family orientation event • Consider LPN or RN one day per week on-site • Purchase of new EHR Reliatrax to improve care coordination

Clinics/Agencies	Action Steps & Quality Improvement
West End Outreach Services/Clallam	<ul style="list-style-type: none"> • First PDSA addressed care gap with primary care providers referrals of patients to WEOS for services and workflow mapped process to improve client engagement in services • Second PDSA to improve whole person care through Excel Registry Tool. 1) Create an Excel spreadsheet to track 30 registered WEOS high utilizers to track use of ED, jail, PCP, WEOS intake history (scheduled, attended, no show status), SUD Dx, and Treatment & Housing Status with look-back history of at least three months. Include Chronic Disease column for PCP to complete 2) QI Team will work together to check spreadsheet throughout the week to keep tracking up to date. They will utilize the data they collect during huddles to consider how to engage and support clients and close care gaps with PCP. Team believes a more pro-active approach with PCPs during visits might decrease frequency of emergencies. The tracking sheet can inform this process. Director and QI and team will decide on the 30 clients to track, build the Excel Spreadsheet and populate it for previous three months. 3) Director and Integrated Mental Health Provider in Forks Primary Care Clinics will ask PCP to complete columns on Chronic Disease diagnoses and update as needed.
West Sound Treatment Services/Kitsap	<ul style="list-style-type: none"> • Shared Qualis Health Integrated Billing Tool for preparing for MCO contracting • Workflow map urine analysis protocol and convene all staff meeting to address client care gaps to design new measures for more effective urine analysis services • Consider role in ED to provide on-call SUD Evaluations and bridge into SUD services

Acronyms in use in this attachment: 42 CFR 2 – 42 Code of Federal Regulations Part 2, ARNP – advanced registered nurse practitioner, BH – behavioral health, DBH – Discovery Behavioral Health, ED – emergency department, EHR – electronic health records, FQHC – federally qualified health center, GAD – generalized anxiety disorder, HIPPA – Health Insurance Portability and Privacy Act, KMHS – Kitsap Mental Health Services, LPN – Licensed Practical Nurse, MAT – medication assisted treatment, MCO – Managed Care Organization, PC – primary care, PCMH-A – patient-centered medical home assessment, PCP – primary care provider, PDSA – Plan Do Study Act, PHQ – patient health questionnaire, QI – quality improvement, RN – Registered Nurse, ROI – release of information, SBHO – Salish Behavioral Health Organization, SDoH – social determinants of health, SUD – Substance Use Disorder, VBP – value-based payment, WEOS – West End Outreach Services

Attachment B: Pediatric – Transforming Clinical Practices Initiative Aggregated Report

Olympic Region P-TCPI Facilitator Coach Activities

Clinics/Agencies Kitsap	Action Steps & Quality Improvement
Bainbridge Pediatrics	<ul style="list-style-type: none"> • Improving Reporting on clinical measures and Provider productivity • Implementing PCMH quality goals; initiating ‘Meaningful Use’ module in EHR and training staff • Implementing “Family Experience Survey” in collaboration with Seattle Children’s; develop specific QI goals from results
Kitsap Children’s	<ul style="list-style-type: none"> • Immunization rates • Patient education on proper use of ED • Empanelment
Kitsap Mental Health Services	<ul style="list-style-type: none"> • Integration with primary care; see regional project summary below
Peninsula Community Health Services	<ul style="list-style-type: none"> • Have graduated from P-TCPI, but will be included in MOA and best practice examples for other partner clinics; involved in several MOAs with regional clinics to improve primary care and BH integration
One Heart Wild Education Sanctuary	<ul style="list-style-type: none"> • Developing tools with outside Consultant to measure specific clinical outcomes • Developing Patient and Volunteer satisfaction surveys • Practice Facilitator conducted PDSA training for all staff and interns • Have signed 2 MOAs with local PC clinics and referral relationship has been established
Silverdale Pediatrics	<ul style="list-style-type: none"> • Establishing new part-time Provider 1x day a week • Developing new standard operating procedure of dictation in room with Pt; improving patient education • Developing color code for charts with MA team to help with daily patient flow (Clinic uses paper charts)

West Sound Treatment Center	<ul style="list-style-type: none"> • Developing a policy for establishing a Point of Contact/Support Person for every patient • Have written a job description for a Care Coordinator • Developing a community resource reference tool for Provider team • Establishing a MOA with Peninsula Community Health Services
Clinics/Agencies Clallam	Action Steps & Quality Improvement
Lower Elwha	<ul style="list-style-type: none"> • Lead MA conducted up-training on Child Profile and Immunizations for MA Team and Nurses • Developing a recall process to clarify who is an active patient • Building trust among the community through increased community engagement: Holding quarterly small events in partnership with local community partners including immunization day, to include Government Performance and Results Act data collection activities • Practice Facilitator conducted PDSA training for staff
Reflections Counseling Services Group	<ul style="list-style-type: none"> • Practice Facilitator conducted PDSA training for all staff • Formalizing process to assist all clients with establishing a medical home • Recently implemented Relia Trax. Developing reports to track the following: <ul style="list-style-type: none"> ○ Emergency Room visits ○ Jail ○ Residential placement ○ No Show rates ○ MAT referrals • Through improved reporting, will improve the following over the next 6 months (beginning July 1): <ul style="list-style-type: none"> ○ Reduce No Show rates by 10% ○ Improve diversion from ED and Jail by 10% ○ Ensure SBHO requirement of no more than 14 days between initial intake and follow-up visit • Developing a community resource reference tool for Provider team • Developing a standard operating procedure regarding client re-engagement • Writing a formal employee handbook
West End Family Counseling	<ul style="list-style-type: none"> • Tracking CFT (Child Family Team meeting) rates as required by SBHO. Goal of 75% success rate for all pediatric clients • Tracking results of diagnoses tools used with pediatric population. Reduce identified symptoms by 10% over the next 6 months

	<ul style="list-style-type: none"> Improving referral relationships with primary care, Cedar Grove, Forks Abuse, and Concerned Citizen. Developing standard referral process and forms for each organization Developing a community resource reference tool for Provider team
Enrolled Clinics: Jefferson	Action Steps & Quality Improvement
Jefferson Public Health School Based Health Clinics (Port Townsend and Chimacum)	<ul style="list-style-type: none"> Improved relationship and understanding with Billing department; developing new Billing reports Improved relationship with school nurse and Administration staff to improve immunization rates and overall referrals Credentialing Office Manager (also an MA) to do blood draws in clinic to improve efficiency

Regional Projects

Asthma population health:

Kitsap Mental Health Services (KMHS) has identified a list of patients who have chronic asthma/over utilizing the ED for asthma. Cross referencing list with Peninsula Community Health Services, Silverdale Pediatrics, and Kitsap Children’s. Developing a curriculum for in-home assessments and patient/family education, potentially to include peer education. If successful, will extend out to other counties.

Acronyms in use in this attachment: BH – behavioral health, ED – emergency department, EHR – electronic health records, MA – medical assistant, MAT – medication assisted treatment, MOA – Memorandum of Agreement, PC – primary care, PCMH – patient-centered medical home, PDSA – Plan Do Study Act, P-TCPi – Pediatric Transforming Clinical Practices Initiative, QI – quality improvement

Attachment D: Glossary of Acronyms

3CCORP – Three County Coordinated Opioid Response Project
42 CFR 2 – 42 Code of Federal Regulations Part Two
6BB – Six Building Blocks
AB – Advisory Board
ACEs – Adverse Childhood Experiences
ACH – Accountable Community of Health
AI/AN – American Indian/Alaska Native
AIHC – American Indian Health Commission of Washington State
AIMS – Advancing Integrated Mental Health Solutions
BH – Behavioral Health
CBO – Community-Based Organizations
CBOSS Change Plans – Community-Based Organization and Social Services Change Plan
CDC – Centers for Disease Control
CDSM – Chronic Disease Self-Management
CHIP – Community Health Improvement Plan
CHW – Community Health Worker
CSI - refers to a health care consulting firm that offers data reporting and knowledge management systems for facilitating health care improvement initiatives
DBHR – Division of Behavioral Health and Recovery
DOH – Department of Health
DPP – Diabetes Prevention Program
DSA – Data Sharing Agreement
DSHS – Department of Social and Human Services
DSRIP – Delivery System Reform Incentive Payment
EBP – Evidence-based Practice
ED – Emergency Department
EDIE – Emergency Department Information Exchange
EHR – Electronic Health Record
EBHR – Electronic Behavioral Health Record
FIMC – Fully Integrated Managed Care
FQHC – Federally Qualified Health Center
HCA – Health Care Authority
HIPPA – Health Insurance Portability and Privacy Act
HIE – Health Information Exchange
HIT Health Information Technology
HIT Commons – an IT platform to reduce barriers to care communication between providers on shared patients and clients
i2i – Refers to a population health management data and insight company
IHCP – Indian Health Care Provider

IT – Information Technology
KMHS – Kitsap Mental Health Services
LEAD – Law Enforcement Assisted Diversion
LEKT – Lower Elwha Klallam Tribe
LGBTQ+ - Lesbian, Gay, Bisexual, Transgender, Queer, plus
MAT – Medication Assisted Treatment
MCO – Managed Care Organization
MeHAF – Maine Health Access Foundation
MH – Mental Health
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MTP – Medicaid Transformation Project
MVP – Medicaid Value-Based Purchasing
NCC – Natural Community of Care
NEAR – Neuroscience, Epigenetics, Adverse Childhood Experiences, Resilience
NIH – National Institutes of Health
NIHB – National Indian Health Board
NUKA - an Alaska Native word that means strong, giant structures and living things
NWWFMR – Northwest Washington Family Medicine Residency
OCH – Olympic Community of Health
OC – Olympic College
ORCA – Olympic Reporting and Community Activities
OUD – Opioid Use Disorder
P4P – Pay for Performance
PCMH – Patient Centered Medical Home
PCMH-A – Patient Centered Medical Home Assessment
PCP – Primary Care Provider
PDMP – Prescription Drug Monitoring Program
PDSA- Plan Do Study Act
PGST – Port Gamble S’Klallam Tribe
PHBH Change Plan – Physical Health Behavioral Health Change Plan
PHM – Population Health Management
P-TCPi – Pediatric – Transforming Clinical Practices Initiative
PTSH – Practice Transformation Support Hub
QI – Quality Improvement
SAMHSA – Substance Abuse and Mental Health Services Agency
SAR – Semi-Annual Report
SBHO – Salish Behavioral Health Organization
SDoH – Social Determinants of Health
SUD – Substance Use Disorder
TA – Technical Assistance
VBP – Value-Based Payment
WA - Washington

WHAM – Whole Health Action Management
WSHA – Washington State Hospital Association
WSTS – West Sound Treatment Services

				2A Bi- Integration of Physical and Behavioral Health			2D Diversion Interventions			3A Addressing the Opioid Use Public Health Crisis				3B Reproductive and Maternal/Child Health		3C Access to Oral Health Services			3D Chronic Disease Prevention and Control		Other			
Domain	Focus Area	Outcome (Project Objectives, Evidence-Based Approaches)	Tactics (Transformation Activities)	Collaborative Care Model	Bree Collaborative BH Integration	Milbank Report Approaches	ED is for Emergencies	Tailored Intensive Case Mgmt	Community Parmedicine	CDC/AMDG Interagency Guidelines	Six Building Blocks	Substance Use during Pregnancy	2017 WA Interagency Opioid Working Plan	CDC Preconception Recs	FQHC collaborates with MCOs	Mobile Dental Van	OH in Primary Care	Increased OH access points	Chronic Care Model	Community Linkages to self-Mgmt Support				
			3. Create informal referral relationships with providers who offer these services	x						x			x											
	4. Chronic Disease Prevention and Control	A. Culture shift across organization to prioritize chronic disease prevention and management is created																	x					
			1. All levels of staff participate in Chronic Care Model training																	x				
			2. Support chronic care improvement at all levels of the organization, beginning with the senior leader																	x				
			3. Encourage transparent and systematic handling of errors and quality problems to improve chronic care																	x				
			B. Health information technology is used efficiently to facilitate effective care																	x				
				1. Identify relevant sub-populations by creating disease-specific registry/module/report in HER/or appropriate electronic tracking tool																	x			
				a) Asthma																	x			
				b) Diabetes																	x			
				c) Hypertension																	x			
				d) Cardiovascular																	x			
				e) Other																	x			
				2. Close the loop for referrals																x				
				3. Systematically integrate information from referrals into care plan																x				
			4. Provide timely reminders to patients and staff of case management activities (follow-up calls and appointments, bi-directional coordination with community providers)																x					
			5. Monitor performance of practice team and care system within agency's quality improvement (QI) processes; course correct as needed																x					
		C. Community-clinical linkages are enhanced to ensure patients are supported and active participants in their disease management																	x	x				

				2A Bi- Integration of Physical and Behavioral Health			2D Diversion Interventions			3A Addressing the Opioid Use Public Health Crisis				3B Reproductive and Maternal/Child Health		3C Access to Oral Health Services			3D Chronic Disease Prevention and Control		Other	
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			3. Use interconception period to provide additional intensive intervention to women who have had a previous pregnancy that ended in an adverse outcome (fetal loss, infant death, birth defects, low birthweight, preterm birth, perinatal depression/mood disorder)											x								
			4. Assist all individual patients (male and female) and couples in developing reproductive life plan											x								
			5. Provide consumer-friendly tools to help women self-assess risks, make plans, and take actions that will improve health											x								
			6. Offer as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy											x								
			7. Screen sexually active females aged 16-24 for chlamydia											x								
			8. Partner with public health and community partners to develop social marketing campaigns to promote healthy pre-conception care											x								
		B. Team members are trained in preconception health and have access to evidence-based guidelines and promising practices												x								
			1. Adopt guidelines, tools, evidence-based practices to improve provider knowledge and practice around preconception care and preconception risk											x								
			2. Ensure clinicians are trained in assessment around common preconception risk categories (reproductive history, environmental hazards/toxins, teratogens, nutrition/weight, genetic counseling/family history, substance use, chronic disease, infectious disease/vaccine history, family planning and social/mental health needs)											x								
		C. Coordinated, targeted outreach and engagement to increase well-child visits and immunizations rates is conducted													x							
			1. Develop protocols to guide outreach efforts for children overdue for well-child visits and immunizations												x							
			2. Coordinate outreach with MCOs through direct mail, email, phone campaigns, texts											x	x							

				2A Bi- Integration of Physical and Behavioral Health			2D Diversion Interventions			3A Addressing the Opioid Use Public Health Crisis				3B Reproductive and Maternal/Child Health		3C Access to Oral Health Services			3D Chronic Disease Prevention and Control		Other
Domain	Focus Area	Outcome (Project Objectives, Evidence-Based Approaches)	Tactics (Transformation Activities)	Collaborative Care Model	Bree Collaborative BH Integration	Milbank Report Approaches	ED is for Emergencies	Tailored Intensive Case Mgmt	Community Parmedicine	CDC/AMDG Interagency Guidelines	Six Building Blocks	Substance Use during Pregnancy	2017 WA Interagency Opioid Working Plan	CDC Preconception Recs	FQHC collaborates with MCOs	Mobile Dental Van	OH in Primary Care	Increased OH access points	Chronic Care Model	Community Linkages to self-Mgmt Support	
			3. Explore real-time exchange of health information with partners under the Olympic Digital HIT Commons or other platforms such as PreManage or Consent to Share	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	
			4. Integrate dental records into the medical EHR													x	x				
		C. All staff understand the impact of trauma and health inequities on health																			Health equity
			1. Offer training in health equity																		Health equity
			2. Offer training in LGBTQ-inclusive care																		Health equity
			3. Offer training in NEAR sciences, historical trauma, and trauma-informed care																		Health equity
		D. Patients receive the care they need from a trained workforce																			Work force
			1. Share workforce with another organization																		
			2. Partner with an institute to establish a residency training program																		
			a) MD																		
			b) DO																		
			c) ND																		
			d) ARNP																		
			e) Other																		
			3. Partner with community college programs to recruit allied health professionals as they graduate																		
			4. Hire Community Health Worker or similar workforce				x	x	x												
			a) Community Health Worker																		
			b) Peer Advocate																		
			c) Navigators																		
			d) Other																		
			5. Incorporate telehealth into your practice	x	x																
		E. Quality improvement methods are used to improve care and care delivery																			Value-based payment
			1. Form and maintain a diverse quality improvement (QI) team of clinical and administrative staff with protected time to examine and improve upon clinical outcomes, quality of care, and patient satisfaction	x	x						x								x		
2. Sustainability		A. Transformation is sustained beyond the Medicaid Transformation Project																			Value-based payment

