



**Medicaid Transformation  
Accountable Communities of Health (ACH)**

**Implementation Plan Template:  
Work Plan Instructions & Portfolio Narrative**

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## ACH CONTACT INFORMATION

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## SUBMISSION INSTRUCTIONS

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

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

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

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

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

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

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

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

**Questions.** Questions regarding the Implementation Plan Template and the application process should be directed to [WADSRIP@mslc.com](mailto:WADSRIP@mslc.com).

## PROJECT WORK PLAN REQUIREMENTS

### Instructions

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

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

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

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

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

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

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

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

- Beyond the milestones, ACH work plans must address additional, self-identified milestones and associated work steps to convey the work happening in their regions.
- Work plans that respond only to the milestones associated with the Toolkit below will not be sufficient.
- *Work Steps:* For each milestone, identify key tasks necessary to achieve the milestone.
  - *Health Systems and Community Capacity Building.* Work steps should include the collaborative work between HCA, the ACHs and statewide providers (e.g., UW, AWPHD) on health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment).
  - *Health Equity.* Equity considerations should be an underlying component of all transformation activities. Work steps should include activities related to health equity (e.g. conducting provider training to address health equity knowledge/skills gaps, distributing health equity resources).
- *Key Deliverables/Outcomes:* For each work step, identify concrete, specific deliverables and expected outcomes.
  - *Health Systems and Community Capacity Building.* Key deliverables/outcomes should reflect the collaborative work between HCA, the ACHs and statewide providers (e.g., UW, AWPHD) on health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment).
  - *Health Equity.* Equity considerations should be an underlying component of all transformation activities. Key deliverables/outcomes should reflect or be informed by health equity considerations (e.g., committee charter that acknowledges health equity goals).
- *ACH Organization:* For each work step, identify ACH staff role (e.g., Executive Director, Project Manager, Board Chair) who will be primarily accountable for driving progress and completion. ACH staff may also include contractors and volunteers. Contractors and volunteers should be identified at the organization level. If the ACH organization is not primarily accountable for the work step, “None” is an appropriate response.
- *Partnering Provider Organization:* For each work step, identify partnering provider organization(s) (e.g., Quality Care Community Health Center) that will be primarily accountable for driving progress and completion. If there are multiple partnering provider organizations, but a lead partnering provider organization is coordinating efforts, identify all organizations and designate the lead partnering provider organization as “Lead.” If a partnering provider organization is not primarily accountable for the work step, “None” is an appropriate response.
- *Timeline:* For each work step, identify the timeframe for undertaking the work. Identify completion of the work step at a calendar quarter level. (The timeline for the

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

## MINIMUM REQUIRED TOOLKIT MILESTONES

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

#### Stage 1: Planning Milestones

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

#### Stage 2: Project Implementation Milestones

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

#### Stage 3: Scale & Sustain Milestones

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

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

## Project 2B: Community-Based Care Coordination

### Stage 1: Planning Milestones

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

### Stage 2: Project Implementation Milestones

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

### Stage 3: Scale & Sustain Milestones

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

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

## Project 2C: Transitional Care

### Stage 1: Planning Milestones

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

### Stage 2: Project Implementation Milestones

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

### Stage 3: Scale & Sustain Milestones

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

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

## Project 2D: Diversion Interventions

### Stage 1: Planning Milestones

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

### Stage 2: Project Implementation Milestones

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

### Stage 3: Scale & Sustain Milestones

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

## Project 3A: Addressing The Opioid Use Public Health Crisis

### Stage 1: Planning Milestones

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

### Stage 2: Project Implementation Milestones

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

### Stage 3: Scale & Sustain Milestones

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

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

## Project 3B: Reproductive and Maternal/Child Health

### Stage 1: Planning Milestones

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

### Stage 2: Project Implementation Milestones

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

### Stage 3: Scale & Sustain Milestones

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

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

## Project 3C: Access to Oral Health Services

### Stage 1: Planning Milestones

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

### Stage 2: Project Implementation Milestones

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

### Stage 3: Scale & Sustain Milestones

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

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

## Project 3D: Chronic Disease Prevention and Control

### Stage 1: Planning Milestones

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

### Stage 2: Project Implementation Milestones

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

### Stage 3: Scale & Sustain Milestones

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

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

## REQUIRED PORTFOLIO NARRATIVE

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

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

ACHs should read each prompt carefully before responding.

ACH Name:	<b>Pierce County Accountable Community of Health</b>	Project(s): 2A, 2B, 3A, 3D
Entity-Type:	Nonprofit 501(c)3	
<p><b>ROLES &amp; RESPONSIBILITIES.</b></p> <p>Pierce County ACH is a regional community-based health collaborative and services organization built on a foundation of strong public-private partnerships. We strive to <i>catalyze</i> transformation by developing and deploying strategies to support providers and community-based organizations in achieving better whole-person care outcomes, and to <i>sustain</i> transformation by providing a regional architecture for long-term collective investment and impact. Our overall strategy is predicated on a simple core principle: to ensure that whole-person health, shared equitably, is a foundational value and common outcome for our entire community.</p> <p>Our strategy is built on the Quadruple Aim Framework, which expands the Institute for Healthcare Improvement's Triple Aim to explicitly add improved support for providers and caregivers to the primary goals of better quality of care, improved health &amp; well-being outcomes, and lower costs. Our work is designed to contribute to the health and well-being of all Pierce County communities through easy access to quality, whole-person care that improves physical, mental and social well-being, to decrease disparities in those outcomes, and to support providers, prevent burnout, and build and maintain a sustainable workforce that reflects and represents the rich diversity of our community. To accomplish this, we know we need to better integrate and improve existing systems of care, support prevention to help individuals and families thrive at every stage of life and create systems that improve the odds for health and health resiliency. We strive toward these goals for all Pierce County residents, but especially for communities with a history of inequitable health outcomes.</p> <p>As a key backbone entity for regional health transformation, Pierce County ACH holds the following core roles and responsibilities:</p>		

**Convene.** We act as a backbone organization and neutral convener for a regional, cross-sector collective impact coalition focused on supporting population health strategies, workforce transformation, and value-based payment. We operate and support a governance structure of diverse workgroups dedicated to advancing our mission and keeping it connected to the communities with whom we seek to partner.

**Catalyze.** In partnership with clinical and community partners, we work to drive implementation and spread across five key transformation domains:

- *Bi-Directional Integration.* Clinical integration of physical and behavioral health.
- *Financial Integration.* Adoption & spread of value-based contracting.
- *Community-based Care Coordination.* Linking clinical and community care & supports through the creation of a Community HUB for full spectrum care coordination and the operation of associated programs, including the Pathways and Health Engagement Team programs.
- *Addressing the Opioid Use Crisis.* Leveraging our whole-person care and community-clinical linkages work to address the opioid crisis through more effective treatment supports and relapse prevention.
- *Chronic Disease Management & Prevention.* Leveraging our whole-person care and community-clinical linkages work to improve management of complex chronic conditions and address prevention more effectively.

**Support.** In addition to implementing new programs, Pierce County ACH operates a *regional support infrastructure* designed to assist clinical and community-based partners in adopting and spreading change. An array of shared assets will be available through this infrastructure, including access to a regional data infrastructure, quality improvement methodologies and toolkits, and targeted coaching and technical assistance in support of key implementation and transformation activities.

**Sustain & Spread.** Finally, Pierce County ACH holds accountability for leading the region in building a *long-term sustainability strategy* that ensures the work can continue throughout and beyond the Demonstration Project period. As part of this work, we are working to drive the adoption of alternative payment strategies that can sustain our programs over the long term and leading a process to create flexible community funding options that operate in close alignment with our overall transformation strategy.

#### **KEY STEPS TO IMPLEMENT PROJECTS.**

Our role in most project implementation plans is to engage and support our community partners, catalyze and support the work, and connect the work to longer-term sustainability planning. Our plan is built on the following key action steps:

**Engage Providers.** Providers are the interface between our systems and the populations whose outcomes we hope to improve, and we know any transformation effort is a non-

starter without their engagement. We will work hard to partner *with* providers in developing a more comprehensive approach to health and creating improved experiences within and between all kinds of health settings.

**Engage the Communities.** We understand how important it is to design systems and programs with our communities rather than for them. We will leverage our *community voices council* and *community health worker* workforce to ensure our work remains connected to the needs, and reflects the wisdom of, the priority populations where we are hoping to create more equitable outcomes.

**Support Providers & Others in Driving Systems Change.** We know change won't happen just because we designed it that way - it takes continued effort. We will work to provide ongoing resources and supports for providers and other partners as they implement changes and progress along the continuum of integrated care.

**Support Financial Integration.** We see financial integration not as a distinct transformation issue, but a necessary component of effective and sustainable change within our transformation strategy. We will partner with the County government, providers, managed care organizations (MCOs) and administrative services organization (ASO) as they transition behavioral health and substance use providers into financial integration of managed care, moving from behavioral health organizations (BHOs) to MCOs and ASOs.

**Elevate & Assimilate Social Determinants of Health.** Health-related social determinants are a critical component of whole person care, and we will work to ensure that all systems engage with priority populations in a way that focuses on and supports linking the social determinants of health and clinical care delivery.

**Activate & Scale Clinical-Community Integration.** The core of our transformation strategy is to create better whole-person care and support experiences by improving both *clinical integration* and *clinical-community linkages*. We will support this vision across our different projects by creating and scaling a Community HUB – a shared architecture for community-based care coordinating across sectors that works to integrate and support the work of caregivers from across the continuum, including health care providers, community health workers, peer support specialists, and care coordinators from across the spectrum of clinical and community-based settings. From the HUB, we will:

- Operate programs, such as the Pathways and Health Engagement Team programs, designed to provide care coordination, transitions, diversion, and social determinants of health support for targeted populations in primary care, behavioral health, substance use disorder/opioid treatment, or with chronic disease management and prevention needs;
- Create and support a shared *community health record* that allows partners from across the continuum to share critical information about client's medical and social needs;

- Support a “care traffic control” function that helps support the transition of high-risk populations into better care management and optimizes the efficiency of care management and support provided across multiple systems;
- Support value-based care delivery and a movement toward value-based payment structures across the community;
- Support partnerships transitioning high-risk populations into better care management; and
- Support providers working at the top of their licenses in partnership with new and more diverse community-based and peer workforces.

**Support the Transition to Value Based Care.** We see value-based care as critical to the success of transformation and the long-term sustainability of our work. We will facilitate conversations with MCOs and other regional partners to explore potential value-based structures, identify key metrics of interest to partners engaging in value-based contracts, support the adoption of value-based contracting arrangements between regional partners, provide support around the transition and change management associated with the adoption of value-based contracts.

**Ensure Equity Remains at the Center of our Work.** We won’t consider our transformation successful unless it reduces disparities and makes better whole-person health an equitably shared outcome for everyone in our region. We will work vigilantly to ensure that equity remains at the center of our work as a core value and shared goal for all, that it informs implementation of all programs and activities, and that we use data and measure success through an equity-informed lens.

**Connect to Sustainability.** We seek lasting change. For each project we launch and support, we will create a sustainability strategy that connects the program’s work to long-term transformation efforts and funding streams that can help sustain and spread it.

### Partnering Provider Project Roles

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

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

In total, examples must reflect:

- A mix of providers traditionally reimbursed and not traditionally reimbursed by Medicaid.<sup>2</sup>
- All projects in the ACH’s portfolio.

ACH Response
<p>Responses must cover the following:</p> <ul style="list-style-type: none"> <li>• What is the name of the partnering provider organization?</li> <li>• What type of entity is the partnering provider organization?</li> <li>• In which project/project(s) is the partnering provider organization involved?</li> <li>• What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?</li> <li>• What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?</li> </ul>

Provider Name:	<b>Tacoma-Pierce County Health Department (TPCHD)</b>	Project(s): 2A, 2B, 3A, 3D
Entity Type:	Public Health	
<p><b>ROLES &amp; RESPONSIBILITIES.</b></p> <p>Tacoma-Pierce County Health Department (TPCHD) is a key partner in our transformation efforts, with particularly salient roles in our equity strategy, chronic disease and prevention work, and our plans to address the regional opioid crisis. The key strategy for achieving progress is through their participation in the Community Hub. Specific components include:</p> <p><b>Support a Strategic Roadmap.</b> TPCHD will participate as a partner in the regional governance and strategy work, with an emphasis on helping integrate interventions into a strategic roadmap adopted by the region to ensure our interventions and transformation efforts are well-targeted, non-redundant, and poised for maximum community impact.</p> <p><b>Support the Community HUB.</b> TPCHD will support the Community HUB, integrating our Health Engagement Team and Pathways programs into other existing interventions and workflows and partnering as a Care Coordination Agency to ensure connectivity and communication through our <i>Care Coordination Systems</i> information platform.</p> <p><b>Support the Equity Lens.</b> TPCHD will provide equity training in the form of “Cultural Humility and Anti-Racism” workshops for an array of regional partners as well as partnering with the Institute for Healthcare Improvement (IHI) to embed equity in its community trainings.</p>		

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

**Support Better Prevention & Management for Chronic Conditions.** TPCHD will support improved prevention and management of chronic disease, including asthma, cardiovascular disease, COPD, diabetes, hypertension, and obesity, with a special focus on African-American and American Indian/Alaska Native (AI/AN) women who are pregnant, parenting or of child-bearing age.

**Support Behavioral Health Prevention & Management.** TPCHD will support an improved regional response to behavioral health, with a focus on male clients of TPCHD's Methadone Treatment Services who have co-occurring mental health and substance-use disorder diagnoses and are vulnerable to homelessness or who were previously incarcerated, as well as women of childbearing age (18-44 years), including pregnant and parenting women, with co-occurring mental health and substance-use disorders.

**Support the Opioid Misuse Prevention & Management Strategy.** TPCHD will support efforts to address the opioid crisis via the Pierce County Opioid Taskforce, with a focus on applying the Regional Strategy for Clinical-Community Linkages to address the opioid crisis. Focus populations for this work include patients with opioid-use disorder (OUD), women who are pregnant, parenting or of child-bearing age with OUD, and patients receiving Medication Assisted Treatment (MAT) in primary care settings. TPCHD will also support primary care providers who are interested in prescribing MAT but do not have capacity to provide behavioral health and/or psychosocial supports.

**Lead Unnecessary Hospitalizations Work.** TPCHD will also lead a regional effort to address potentially avoidable hospital readmissions, working in collaboration with Pierce County ACH, providers and community organizations.

#### **KEY STEPS TO IMPLEMENT PROJECTS.**

**Conduct Equity Trainings.** Provide expert equity training for organizational partners and new workforce members, including community health workers and peer specialists working through the Community HUB, including Cultural Humility and Anti-Racism Workshops.

**Improve Equity Practices.** Put policies in place for hiring multilingual staff, utilizing translation and interpretation services. Ensure all staff receive training in providing culturally and linguistically appropriate services.

**Facilitate Creation of an Opioid Misuse Prevention & Management Strategy.** Support implementing the opioid prevention & management project by:

- Facilitating two meetings of the Pierce County Opioid Task Force and six meetings for each of three Task Force committees, for a total of 20 meetings. In service to facilitating, meet with Task Force co-chairs and/or planning teams regularly to understand meeting objectives and project goals, incorporate best practice

approaches to quality improvement, team development and adult coaching, and provide agendas and minutes for all meetings.

- Finalizing the Task Force's opioid system process map; identify the main processes (from prevention to crisis intervention to treatment and recovery) and assess the most significant challenge points in the process for potential improvement.
- Designing a county-wide social marketing campaign to reduce stigma associated with opioid use disorder and medication assisted treatment. Research existing local, state and national resources that may support or align with this campaign and develop a plan and budget for the campaign.
- Researching existing local resources and need for a Pierce County opioid-specific resource directory. Identify existing best-practice models and send recommendations to the Task Force and Pierce County ACH.

**Launch a Multidisciplinary Health Engagement Team (HET).** Create a multi-disciplinary health engagement team (HET) to address co-occurring mental health and substance use disorder in the target clients identified above. Include a peer support specialist as part of the HET, using the Community HUB including Pathways community-based care coordination to coordinate and support a continuum of care that addresses the social determinants of health, including especially housing supports. Ensure providers are using appropriate prescribing guidelines.

**Adopt Empanelment Strategies.** TPCHD will adopt an empanelment strategy for patients in Methadone clinic with opioid disorder, including:

- Assigning patients to providers;
- Reviewing updated panel assignments on a regular basis;
- Using point of care reminders at time of visit based on clinical guidelines;
- Providing self-management support at every visit through goal-setting, action planning and follow-up;
- Using panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, and community, cultural, and family needs; and
- Testing and implementing a standard process for reviewing panel level data on patients in cohorts.

**Operate as a Care Coordination Agency (CCA) for the Community HUB within Pathways.**

TPCHD will be a CCA within the Pathways pilot, with a focus on opioid using populations.

They will support Pathways and the Community HUB by:

- Developing policies and workflows for referrals into the HUB for opioid populations;
- Addressing co-occurring mental health and substance use disorder diagnoses in focus populations and ensuring access to social determinants of health support;
- Integrating CHWs with "lived experience" into care for vulnerable populations;
- Implementing referrals into the HUB;

- Working within the HUB model to develop community-clinical linkages to increase access to Naloxone and methadone treatment programs;
- Partnering with providers to ensure MAT is not interrupted when patients are hospitalized;
- Utilizing the CCS platform to manage pathways and coordinate care regionally to provide continuity of care across the continuum for vulnerable patients;
- Following HIPAA standards and ensure risk management;
- Attending monthly CCA/HUB meetings
- Supporting maintenance of the community resource pool with the Community HUB;
- Increasing partnership as the populations expand beyond the initial Pathways pilot.

**Support Opioid Misuse Prevention & Management Project.** In addition to their work around the Community HUB including Health Engagement Team and Pathways, TPCHD will support regional efforts to address the opioid crisis by:

- Partnering with faith-based and community-based organizations throughout Pierce County to establish locations for provision of behavioral health counseling and therapeutic group sessions for patients receiving Office Based Opioid Treatment (OBOT) in primary care settings; and
- Implementing validated substance use screenings such as SBIRT, including evaluation for MAT;
- Increasing access to methadone treatment programs, including collaboration with Tacoma Needle Exchange and TPCHD/Treatment Services to provide broader access to naloxone; and
- Working to ensure providers are using appropriate prescribing guidelines.

**Support the Chronic Disease Prevention & Management Project.** TPCHD will support better chronic disease prevention and management in the region. To do this, they will:

- Partner with existing coalitions, community-based organizations, tribal health organizations, health care and others that serve the target population to identify;
- Develop and implement strategies for the focus population, such as peer support coordinating with Pathways to address the social determinants of health; and
- Provide self-management support at every visit through goal-setting, action planning, and follow-up.

**Develop Readmissions & Diversion Strategies.** TPCHD will continue developing strategies for key transformation challenges, including:

- Developing strategies for addressing potentially preventable hospital readmissions and integrating them into the regional transformation framework in collaboration with the Pierce County ACH; and
- Under the leadership of the TPCHD, and in partnership with the Pierce County ACH, provider partners, and community-based organizations, develop and deploy innovative care transitions and diversion strategies in partnership with EMS,

community paramedicine, specialty care, dental care, the criminal justice system, pharmacies, CHWs and more.

**Adhere to the Transformation Rules of Engagement.** Pierce County’s Transformation Rules of Engagement outline the expectations for all partners participating in Pierce County’s coordinated transformation effort. While accomplishing the tasks outlined above, partners will be expected to:

- *Put Equity at the Center.* Implement the Institute for Healthcare Improvements (IHI’s) Equity guidelines within both organizations and in clinical practices
- *Advance Data Sharing.* Work with other organizations through HIE/HIT solutions and participate in HIE platforms that support sharing across organizations
- *Move Toward Value:* Start the transition to value based payment arrangements and contracts with managed care organizations
- *Measure:* Collaborate to co-develop metrics and outcomes that drive improvement, with a special focus on the payor lens and an eye toward sustainability
- *Use Best Practices for Change.* Train staff and implement the use of IHI’s Science of Improvement quality improvement model. Develop processes for providers and staff to have dedicated times for improvement activities. Commit to using the Pierce County ACH WA Portal (and the associated transformation tools and learning community)
- *Enrich & Develop Partnerships.* Commit to partnership development toward “gold status” on the Partnership Accelerator Framework adopted by Pierce County ACH
- *Engage Regionally.* Actively engage and collaborate in the larger strategy via Pierce County ACH’s Community-Driven Shared Learning & Action opportunities, including the RHIP (regional health improvement) Council, Provider Integration Panel, Opioid Workgroup, Data and Learning Team, Learning Network, Learning Collaborative, Board of Trustees or Board Committee or other connection points)

Provider Name:	<b>HopeSparks Family Services</b>	Project(s): 2A, 2B, 3A, 3D
Entity-Type:	Small independent regional behavioral and physical health provider that serves the pediatric population	

**ROLES & RESPONSIBILITIES:**

HopeSparks, in collaboration with Pediatrics Northwest (Peds NW), is committed to evidence-based, trauma-informed, integrated care in the pediatric population. They are working to build the capacity for providing services in a value-based payment environment meeting the regional objective of the equity-based Quadruple Aim (better health, better care, lower cost, and better provider experience). Their partnership with Pediatrics NW is a critical piece of our strategy to provide integrated, whole-family pediatric care and support in the region, especially for high-risk families. Specific roles and responsibilities include:

**Care Coordination with a Pediatric Focus.** HopeSparks currently serves as a Care Coordination Agency (CCA) for the Community HUB within the Pathways pilot and is committed to increasing their partnership as the populations expand beyond the pilot. HopeSparks will target populations from birth across the lifespan, with a primary focus on integration for a pediatric population up to 21 years old, but also including:

- Infant mental health = 0-3 years old
- Early Childhood Mental Health = 3-6 years old
- Children / Adolescents = 7-17 years old
- Adults = 18+.

**Clinical Integration.** HopeSparks will work toward behavioral health integration, with a special focus on the following domains of special relevance to their focus population: trauma, behavioral health, anxiety, depression, eating disorders, and social/emotional well-being. They will root their integration efforts in the Institute for Healthcare Improvement's (IHI) Science of Improvement methodology and strive to move toward a level five or six on the Substance Use and Mental Health Services Administration (SAMHSA) Scale for bi-directional integration of physical and behavioral health. This work will help address the opioid crisis, embed care coordination (through the Community HUB, Pathways, and Health Engagement Teams) and assimilate chronic disease management and prevention within their organization.

**Expanding Partnerships.** Pediatrics NW and HopeSparks are also committed to increasing their partnership as the ACH focus populations expand beyond the initial pilots to include Health Engagement Teams (HET) linked with Pathways for clinical-community care coordination and linkages for a broader range of clients.

#### **KEY STEPS TO IMPLEMENT PROJECTS:**

**Partner with Pediatrics NW for Bi-Directional Integration.** HopeSparks will embed behavioral health consultants in three Pediatrics NW locations-- Tacoma Baker Center, Tacoma James Center, and Gig Harbor – to promote bidirectional integration. In addition, HopeSparks and Pediatrics NW will work together to:

- Collaborate to capacity for value-based services;
- Develop a shared communications strategy;
- Implement team-based care training;
- Develop & Implement policies and procedures for collaboration and colocation; and
- Partner to build and improve referral processes into Pediatric NW's EHR system to streamline shared workflows and identify ways to simplify processes.

The critical elements from this collaborative partnership will help build a new model of care delivery and enhance the ability to care for children and families with the greatest need in the region. This will allow support for the transformative goals that include health equity.

**New Hiring & Workforce Diversification.** HopeSparks will undertake a range of efforts aimed at expanding the workforce to better support its focus population within the new care model. Specific plans include:

- Hiring & supervising a Community Health Worker (CHW) workforce through the Community HUB;
- Developing Behavioral Health Consultant job descriptions; posting new positions and hiring to meet the population's needs; and
- Hiring a Psychiatric Advanced Registered Nurse Practitioner (ARNP).

**Use the Multidisciplinary Team (MDT) to Improve Care.** HopeSparks and Peds NW have developed a Multi-Disciplinary Team (MDT) for cross education, collaboration, shared learning, training, case staffing and referral coordination. The MDT is currently meeting monthly but will increase their frequency going forward; sample topics include:

- Infant mental health and early parent-child relationships;
- managing client/patient suicide;
- making an appropriate behavioral health referral; and
- developing shared clinical measures between practices and other care settings.

In addition to training and shared learning, the MDT will come together regularly to refine and evolve the work, including assessments of case staffing, shared treatment planning, complex case management approaches, and shared outcomes.

**Develop a Health Engagement Team.** HopeSparks will develop a peds-focused Health Engagement Team supporting clinical-community linkages through the Community HUB, using the Pathways program to coordinate and support a continuum of care that addresses the social determinants of health. As part of this work, they will assess the training needs the team and implement a training plan with emphasis on stigma and trauma reduction, trauma informed care, cultural and language diversity, health literacy and motivational interviewing.

**Enhance Empanelment Strategies.** Focus on empanelment in the high-risk pediatric population by:

- Assigning patients to providers;
- Reviewing update panel assignments on a regular basis;
- Using panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, and community, cultural, and family needs;
- Testing and implementing a standard process for reviewing panel level data on patients with opioid use disorder;
- Developing and implementing (or improving) processes that support continuity of care for all screening, treatment and follow-up needed by patients; and
- Promoting and expanding access by ensuring that established patients have 24/7 continuous access to their care team via phone, email, tele-health or in-person visits, and develop mechanism to follow patients through the continuum and ensure

achieving care outcomes through a well-developed transition process and communication loop.

**Support the Regional Opioid Strategy.** Pediatrics NW and HopeSparks will collaborate to support the regional opioid strategy. In addition to the other aspects of their partnership to improve care for at-risk women including substance users, they will:

- Secure medication management component into Peds NW through a partnership with a Child Psychiatrist in late fall 2018; and
- Register providers with Prescription Monitoring Program (PMP) and integrate PMP with electronic medical record (EMR).

**Partner with Pierce County ACH to Manage Change.** Pediatrics NW will partner with Pierce County ACH to fulfill several key change management functions, including:

- Developing workflows for integration and new care teams;
- Managing timelines for transformation within their specialty areas;
- Resource and space planning to support the new model of care;
- Training and go-live support for implementation across the sites;
- Strategy development around value-based performance and ways to successfully perform the work under a value-based payment system;
- Identifying and implementing technology changes/improvements that help support the new model of care; and
- Acting as a regional expert in transformation for the pediatric population in Pierce County, supporting learning and sharing of successes, barriers and improvements for others to learn and follow.

**Adhere to the Transformation Rules of Engagement.** Pierce County's Transformation Rules of Engagement outline the expectations for all partners participating in Pierce County's coordinated transformation effort. While accomplishing the tasks outlined above, partners will be expected to:

- *Put Equity at the Center.* Implement the Institute for Healthcare Improvements (IHI's) Equity guidelines within both organizations and in clinical practices
- *Advance Data Sharing.* Work with other organizations through HIE/HIT solutions and participate in HIE platforms that support sharing across organizations.
- *Move Toward Value:* Start the transition to value based payment arrangements and contracts with managed care organizations
- *Measure:* Collaborate to co-develop metrics and outcomes that drive improvement, with a special focus on the payor lens and an eye toward sustainability.
- *Use Best Practices for Change.* Train staff and implement the use of IHI's Science of Improvement quality improvement model. Commit to using the Pierce County ACH WA Portal (and the associated transformation tools and learning community).
- *Enrich & Develop Partnerships.* Commit to partnership development toward "gold status" on the Partnership Accelerator Framework adopted by Pierce County ACH.

- *Engage Regionally.* Actively engage and collaborate in the larger strategy via Pierce County ACH’s Community-Driven Shared Learning & Action opportunities, including the RHIP (regional health improvement) Council, Provider Integration Panel, Opioid Workgroup, Data and Learning Team, Learning Network, Learning Collaborative, Board of Trustees or Board Committee or other Pierce ACH related connection points.

Provider Name:	<b>Pediatrics Northwest (Peds NW)</b>	Project(s): 2A, 2B, 3A, 3D
Entity-Type:	Large independent regional, multi-specialty pediatric provider serving Medicaid. Headquartered in Pierce County also serving Southern King County	
<b>ROLES &amp; RESPONSIBILITIES:</b>		
<p>Pediatrics Northwest is committed to evidence-based, trauma-informed, integrated care in the pediatric population. Their partnership with HopeSparks is a critical piece of our strategy to provide integrated, whole-family pediatric care and support in the region, especially for high-risk families.</p> <p><b>Transform The System to Support Whole-Person (Whole Family) Pediatrics Care.</b> Pediatrics Northwest will partner with HopeSparks to ensure evidence-based, trauma-informed, integrated care in the pediatric population, with a focus on building capacity to provide services in a value-based payment environment that meet the regional objectives of the equity-based Quadruple Aim (better health, better care, lower cost and better provider experience). This collaboration, rooted in IHI’s Science of Improvement methodology, will move toward a level 5 or 6 on the SAMHSA Scale for bi-directional integration of physical and behavioral health, addressing the opioid crisis, and embedding care coordination (via the Community HUB’s Pathways and Health Engagement Teams) and assimilating chronic disease management and prevention within their organization’s clinical practices, including workflows and referral processes.</p> <p><b>Expand Partnerships.</b> Pediatrics NW is committed to increasing their partnership as the ACH focus populations expand beyond the initial pilots to include Health Engagement Teams (HET) linked with Pathways for clinical-community care coordination and linkages for a broader range of clients.</p>		
<b>KEY STEPS TO IMPLEMENT PROJECTS:</b>		
<p><b>Partner for Bi-Directional Integration.</b> Pediatrics NW will partner with HopeSparks to embed behavioral health consultants in three Pediatrics NW sites -- Tacoma Baker Center, Tacoma James Center, and Gig Harbor – for bidirectional integrated care. In addition, HopeSparks and Pediatrics NW will work together to:</p>		

- Partner to co-develop job descriptions for the behavioral health consultants and hire new staff based on the needs of the collaboration;
- Collaborate to capacity for value-based services;
- Develop a shared communications strategy;
- Implement team-based care training;
- Develop & Implement policies and procedures for collaboration and colocation; and
- Partner to build and improve referral processes into Pediatric NW's EHR system to streamline shared workflows and identify ways to simplify processes. Initial builds are completed and now the two agencies will work to streamline the workflow, simplify the process, and identify metrics that can be applied to the assess the improvement.

The critical elements from this collaborative partnership will help build a new model of care delivery and enhance the ability to care for children and families with the greatest need in the region. This will allow support for the transformative goals that include health equity.

**Use the Multidisciplinary Team (MDT) to improve care.** HopeSparks and Peds NW have developed a Multi-Disciplinary Team (MDT) for cross education, collaboration, shared learning, training, case staffing and referral coordination. The MDT is currently meeting monthly but will increase their frequency going forward; sample topics include:

- Infant mental health and early parent-child relationships;
- managing client/patient suicide;
- making an appropriate behavioral health referral; and
- developing shared clinical measures between practices and other care settings.

In addition to training and shared learning, the MDT will come together regularly to refine and evolve the work, including assessments of case staffing, shared treatment planning, complex case management approaches, and shared outcomes.

**Enhance Empanelment Strategies.** Pediatrics NW will focus on creating improved empanelment strategies in the target population by:

- Assigning patients to providers;
- Reviewing update panel assignments on a regular basis;
- Using panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, and community, cultural, and family needs;
- Testing and implementing a standard process for reviewing panel level data on patients with opioid use disorder;
- Developing and implementing (or improving) processes that support continuity of care for all screening, treatment and follow-up needed by patients;
- Developing processes for sharing the care plan within and across partnering organizations; and
- Promoting and expanding access by ensuring that established patients have 24/7 continuous access to their care team via phone, email, tele-health or in-person visits,

and develop mechanism to follow patients through the continuum and ensure achieving care outcomes through a well-developed transition process and communication loop.

**Support the Regional Opioid Strategy.** Pediatrics NW and HopeSparks will collaborate to support the regional opioid strategy. In addition to the other aspects of their partnership to improve care for at-risk women including substance users, they will:

- Secure medication management component into Peds NW through a partnership with a Child Psychiatrist in late fall 2018; and
- Register providers with Prescription Monitoring Program (PMP) and integrate PMP with electronic medical record (EMR).

**Develop a Health Engagement Team.** Pediatric NW will partner with HopeSparks to develop a pediatrics-focused *Health Engagement Team* supporting clinical-community linkages through the Community HUB, using the Pathways program to coordinate and support a continuum of care that addresses the social determinants of health. As part of this work, they will assess the training needs the team and implement a training plan with emphasis on stigma and trauma reduction, trauma informed care, cultural and language diversity, health literacy and motivational interviewing.

**Support the Improving Chronic Disease Management Strategy.** In addition to its work in the areas of bi-directional integration and clinical-community linkages outlined above, Pediatrics NW will work to improve chronic disease management, with a focus on improving asthma care for the pediatric population. In service to this, they will:

- Define team roles to support asthmatic patients;
- Implement evidence-based guidelines for asthma care;
- Identify high-risk populations and ensure they are receiving appropriate care and care management services; and
- Place an asthma educator on staff for asthma management and prevention strategies, including education.

**Partner with Pierce County ACH to Manage Change.** Pediatrics NW will partner with Pierce County ACH to fulfill several key change management functions, including:

- Developing workflows for integration and new care teams;
- Managing timelines for transformation within their specialty areas;
- Resource and space planning to support the new model of care;
- Training and go-live support for implementation across the sites;
- Strategy development around value-based performance and ways to successfully perform the work under a value-based payment system;
- Identifying and implementing technology changes/improvements that help support the new model of care; and

- Acting as a regional expert in transformation for the pediatric population in Pierce County, supporting learning and sharing of successes, barriers and improvements for others to learn and follow.

**Adhere to the Transformation Rules of Engagement.** Pierce County’s Transformation Rules of Engagement outline the expectations for all partners participating in Pierce County’s coordinated transformation effort. While accomplishing the tasks outlined above, partners will be expected to:

- *Put Equity at the Center.* Implement the Institute for Healthcare Improvements (IHI’s) Equity guidelines within both organizations and in clinical practices
  - *Advance Data Sharing.* Work with other organizations through HIE/HIT solutions and participate in HIE platforms that support sharing across organizations.
  - *Move Toward Value:* Start the transition to value based payment arrangements and contracts with managed care organizations
  - *Measure:* Collaborate to co-develop metrics and outcomes that drive improvement, with a special focus on the payor lens and an eye toward sustainability.
  - *Use Best Practices for Change.* Train staff and implement the use of IHI’s Science of Improvement quality improvement model. Commit to using the Pierce County ACH WA Portal (and the associated transformation tools and learning community).
  - *Enrich & Develop Partnerships.* Commit to partnership development toward “gold status” on the Partnership Accelerator Framework adopted by Pierce County ACH.
- Engage Regionally.* Actively engage and collaborate in the larger strategy via Pierce County ACH’s Community-Driven Shared Learning & Action opportunities, including the RHIP (regional health improvement) Council, Provider Integration Panel, Opioid Workgroup, Data and Learning Team, Learning Network, Learning Collaborative, Board of Trustees or Board Committee or other connection points).

Provider Name:	<b>CHI Franciscan Health</b>	Project(s): 2A, 2B, 3A, 3D
Entity-Type:	Health System	

**ROLES & RESPONSIBILITIES:**

CHI Franciscan Health’s role in our regional transformation plan centers on the following:

**Transform the Health System to Support Whole-Person Integrated Care.** CHI Franciscan Health will work to implement and spread a team-based care model that advances bi-directional integration of physical and behavioral health, introduces tools and workflows for improved chronic disease management, improves pain management resources for helping address the opioid crisis, and enhances patient-provider-family partnerships and shared decision making as a key component of care.

**Connect the Health System to the Community.** CHI Franciscan Health’s transformation work within its own systems will also connect to the regional infrastructure supported by Pierce

County ACH, including referral pathways to connect patients to social determinants of health resources through enhanced care coordination and the Community HUB, integration of community health worker and peer workforces, and partnering with other community organizations to support innovate work in care transitions and diversion.

**Advance Value-Based Contracting.** CHI Franciscan Health is currently in value-based contracts with three managed care organizations and is talks with a fourth; they will seek a fifth value-based contract if coverage changes move the region from four to five managed care organizations.

#### **KEY STEPS TO IMPLEMENT PROJECTS:**

**Integrate with Community HUB to support better clinical-community connections.** CHI Franciscan Health will partner with Pierce County ACH’s community HUB to implement the following changes in support of better clinical-community connections as part of the integrated whole person care model:

- Train and integrate into the Community HUB as a care coordination agency;
- Expand the Community Health Worker force from 5 to 8 full time CHWs to support residents of Pierce County, with a focus on reduce Emergency Department visits;
- Establish a Health Engagement Team (HET) with integrated team of Nurses, Social workers, dietitians, pharmacists and other professionals that supports the HET model;
- Integrate the Community Health Workforce and Peer Support Specialists into the workforce; and
- Embed care coordination via the Community HUB, utilizing Pathways and Health Engagement Teams to support continuity of care, transitions and diversions).

**Implement and Support a Team-Based Healing Care Model.** CHI Franciscan Health will implement a team-based care model designed from the ground up to provide integrated, whole person care. To accomplish this, they will:

- Establish and provide organizational support for *multidisciplinary care delivery teams* who will be jointly accountable for patient needs;
- Define roles and distribute tasks among care teams to reflect the skills, abilities and credentials of team members;
- Assess the training needs of the care teams;
- Implement a training plan for the care teams, with a special emphasis on stigma and trauma reduction, trauma informed care, cultural and language diversity motivational interviewing and prevention;
- Develop partnerships for Graduate Medical Education Programs to train new clinicians in the team-based healing care model.
- Integrate CHWs and peer support specialists into care team workflows;
- Activate Health Engagement Teams for focused work with specialized high-need target populations who match ACH priority criteria; and
- Establish a *Complex Care Clinic* for high risk patients with high social needs; and

**Implement Approaches for Improved Care Coordination & Disease Management.** CHI Franciscan Health will undertake the following tasks designed to improve care coordination and management of chronic conditions:

- Build chronic disease management programming and workflows within the health system, including asthma, cardiovascular disease, COPD, Diabetes, Hypertension and obesity, initially targeting populations being served by Health Connections, Primary care practices, high utilizers of the emergency department, and advance care team designated patients;
- Implement at least one of the following: the Stanford Chronic Disease self-management program, Million Hearts campaign, Diabetes Prevention Program, or Community Paramedicine;
- Partner with community-based organizations for innovative care transitions work, including EMS, Community Paramedicine, and the use of CHWs to support transitions;
- Participate in the regional HIE platform that supports sharing data across organizations through Community HUB in support of better regional and cross-partner care coordination;
- Implement referrals to the Community HUB for patients requiring help with resources that can be provided through the Pathways program or other partner services.

**Integrate Physical & Behavioral Health.** CHI Franciscan Health will undertake the following tasks designed to increase bi-directional integration:

- Expand the Collaborative Care Model for up to four primary care clinics in Pierce County integrating behavioral health and primary medical care
- Work to move clinics to a level five or six on the SAMHSA Scale for bi-directional integration of physical and behavioral health;
- Develop criteria and planning for partnering with additional clinical providers;
- Collaborate with *Community Health* by embedding an integration specialist in two primary care clinics;
- Develop a collaboration agency Integration Specialist in two primary care clinics; and
- Identify two or more validated screening tools to be adopted for behavioral health conditions and/or substance use disorders in the clinics.

**Support the Regional Opioid Strategy.** CHI Franciscan Health will help address the opioid crisis by following WSHA guidelines and local subject matter expertise to ensure continuity throughout organization. In addition to the contributions its team-based care and care coordination work can make to opioid care, the will also:

- Develop enhanced processes and workflows for pain patients in emergency room settings, primary care clinics, and pain clinics throughout system;
- Create a system-wide Opioid Reduction Task Force;
- Increase the number of providers with MAT prescribing authority;
- Develop community-clinical linkages to increase access to MAT providers; and

- Share knowledge and learnings throughout their own system and with other organizations in the Pierce County ACH partnership network.

**Enhance Empanelment Strategies.** CHI Franciscan Health will focus on creating improved empanelment strategies by:

- Assigning patients to providers;
- Reviewing updated panel assignments on a regular basis;
- Using panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, and community, cultural, and family needs; and
- Testing and implementing a standard process for reviewing panel level data on patients in cohorts.

**Improve Person/Family Engagement.** CHI Franciscan Health will work to strengthen patient/family engagement and improve patient-centeredness in its care model by:

- Developing and implementing processes for engaging patients and families in decision making for plan of care;
- Obtaining feedback from patients and families about their healthcare experience and use for quality improvement; and
- Creating and implementing a Patient Care Advisory Council for the Advance Care Team and Complex Care Clinics.

**Improve Access to Critical Services.** CHI Franciscan Health will work to improve access to care at several points along the continuum, including:

- Promoting and expanding access by ensuring that established patients have 24/7 continuous access to their care team via phone, email, telehealth or in-person visits;
- Providing scheduling options that are patient and family centered and accessible to all patients;
- Implementing telehealth program to enhance access;
- Developing a Complex Care Clinic;
- Increasing the number of providers with MAT prescribing authority;
- Developing community-clinical linkages to increase access to MAT providers, and
- Using *My Chart* for standardized patient screenings (i.e., the PHQ8)

**Adhere to the Transformation Rules of Engagement.** Pierce County's Transformation Rules of Engagement outline the expectations for all partners participating in Pierce County's coordinated transformation effort. While accomplishing the tasks outlined above, partners will be expected to:

- *Put Equity at the Center.* Implement the Institute for Healthcare Improvements (IHI's) Equity guidelines within both organizations and in clinical practices
- *Advance Data Sharing.* Work with other organizations through HIE/HIT solutions and participate in HIE platforms that support sharing across organizations.

- *Move Toward Value:* Start the transition to value based payment arrangements and contracts with managed care organizations
- *Measure:* Collaborate to co-develop metrics and outcomes that drive improvement, with a special focus on the payor lens and an eye toward sustainability.
- *Use Best Practices for Change.* Train staff and implement the use of IHI’s Science of Improvement quality improvement model. Develop processes for providers and staff to have dedicated times for improvement activities. Commit to using the Pierce County ACH WA Portal (and the associated transformation tools and learning community).
- *Enrich & Develop Partnerships.* Commit to partnership development toward “gold status” on the Partnership Accelerator Framework adopted by Pierce County ACH. *Engage Regionally.* Actively engage and collaborate in the larger strategy via Pierce County ACH’s Community-Driven Shared Learning & Action opportunities, including the RHIP (regional health improvement) Council, Provider Integration Panel, Opioid Workgroup, Data and Learning Team, Learning Network, Learning Collaborative, Board of Trustees or Board Committee or other connection points).

Provider Name:	<b>MultiCare Health System</b>	Project(s): 2A, 2B, 3A, 3D
Entity-Type:	Not-for-Profit health care organization based in Tacoma, Washington	

**Roles & Responsibilities:**  
 Founded in 1882, MultiCare provides health care services at dozens of locations, including eight hospitals, across the Puget Sound and Eastern Washington regions; MultiCare provides hospital, clinic, primary care, specialty, emergency and urgent care health care services.

MultiCare’s role in our regional transformation plan centers on the following:

**Transform the Health System to Support Bi-directional Integration.** MultiCare will implement integration and whole-person care models in several adult and pediatric clinics initially, then expand and scale over time. They will work to implement strategies that advance bi-directional integration, introduce tools and workflows for improved chronic disease management, improve pain management resources for helping address the opioid crisis, and enhance the use of data for patient-centered care and for population health management.

**Connect the Health System to the Community.** In addition to transformation work within its own system, MultiCare will connect to the regional infrastructure supported by Pierce County ACH to create a continuum of care for its patients. This work will include establishment of care teams and referral pathways to connect patients to social determinants of health resources through enhanced care coordination and the Community HUB, integration of community health worker and peer workforces, and partnering with other community organizations to support community-based care coordination.

**Advance Value-Based Contracting.** MultiCare is a leader in value-based payment; they are currently in value-based contracts with three managed care organizations and in talks with a fourth. They intend to seek a fifth value-based contract if coverage changes move the region from four to five managed care organizations. MultiCare will assist others in the region in moving toward value-based payment structures.

**Provider Supports.** MultiCare is committed to the Quadruple Aim and includes provider experience of care as an essential component of its transformation efforts.

**KEY STEPS TO IMPLEMENT PROJECTS:**

MultiCare's regional transformation plan centers on regulatorily permissible models with Sea Mar to achieve the following outcomes:

**Advance Bi-Directional Integration & Whole-Person Care.** MultiCare will work to increase integration and implement and expand whole-person care approaches. To do this, they will:

- Manage integration strategy starting with two clinics and then moving to scale and spread;
- Co-locate primary care and behavioral health services in two clinics, integrate a specialist into the primary care settings, and develop care teams;
- Place a behavioral health therapist in two primary care clinics, developing workflows that include assessments, initial treatment plan, and continuation of care with specialists if long-term care is required;
- Plan and implement a training program on integration and clinical/therapy skills for primary care and behavioral health care staff for continuous and team-based health relationships;
- Recruit and train workforce to support the needs of the population and transformation efforts, including various members for care teams;
- Collaborate to address recruitment needs and shortage of primary care providers;
- Expand training opportunities for primary care providers to help increase access;
- Implement the Collaborative Care Model for adult populations, including:
  - establishing behavioral health services as part of whole person care;
  - Assisting primary care providers in providing the essential care for patients with one or more chronic diseases with standard chronic disease management options; and
  - Building communication between specialist providers and primary care providers to increase access and provide efficient care across populations.
- Increase use and effectiveness of patient stated goals documentation in EHR at all primary care sites to increase patient engagement and partnership in their own care;
- Move equitably toward a level five (5) or six (6) on the SAMHSA Scale for bi-directional integration of physical and behavioral health.

**Implement Whole-person care for Pediatric populations.** MultiCare will also work to implement and expand whole-person care in pediatrics. They will:

- Implement bi-directional care for pediatric behavioral health patients who are high utilizers of community crisis and emergency department services;
- Partner to ensure pediatric patients can receive multidisciplinary services through a mental health children’s advocacy center comprised of community partners in law enforcement, emergency medical services (EMS), education, child welfare, community mental health, and Mary Bridge;
- Integrate behavioral health services via a collaborative care model following UW AIMS model, including screening for social determinants and mental health needs, tiered treatment to target behavioral health interventions based on need, and use of metrics to monitor outcomes for pediatric patients seen within subspecialty medical clinics (neurology, developmental behavioral pediatrics, GI services).
- Explore use of tele-care management services to link patients and care managers within a pediatric clinic. For pediatric patients seen within Mary Bridge pediatric primary care, the hand off will either be direct, or a telehealth visit from clinic site to foster linkage to necessary community resources.

**Implement Community Based Care Coordination.** MultiCare will expand its integrated whole-person care model outside of its own system and establish a continuum of care by connecting to the regional community care coordination infrastructure. To do this, they will:

- Establish a Health Engagement Team (HET) to serve high risk / high cost populations, including: IV drug users, homeless persons with chronic diseases or mental illness, and “super utilizers” of care.)
- Create and utilize a patient enrollment and engagement center for patients to improve communication and flow with complex patients;
- Utilize the Community HUB and Pathways to connect patients to community resources and supports;
- Engage two Community Health Workers for Community HUB (Health Engagement Teams / Pathways); scale and spread after initial pilot
- Utilize technology provided by the Community HUB for continuity of care for clinical and community-based care coordination; and
- Partner with community organizations for chronic disease management and prevention via connections through the HUB.

**Improve Pain Management & Support the Regional Opioid Strategy.** MultiCare will work to improve its processes around pain management and prescriptions, and will also participate in regional efforts to address the opioid crisis, including:

- Organizing a multi-disciplinary team to address standardization of care and quality improvement for pain management across sites of care and specialties, with committed leadership, clinician, operational, IS&T, and analytics support;
- Implementing a Nurse Care Manager and HUB and Spoke model for MAT intervention;

- Identification and implementation of a high reliability SUD and OUD assessment tool;
- Reviewing and revising standard drug monitoring processes;
- Developing and implementing or improving processes that support continuity of care for all screening, treatment, and follow up for patients with opioid use disorder;
- Further developing a year-long post-graduate program to train Family Physicians in addiction medicine;
- Assessing the bandwidth of current infrastructure in behavioral health and adjusting accordingly to support transformation and bi-directional integration; and
- Continuing its participation in statewide-efforts to improve care related to pain and opioids via the Bree Collaborative.

**Promote Information Integration.** In addition to its work in clinical and financial integration, MultiCare will work to increase information integration by:

- Increasing systems capacity through health information technology and health information exchange;
- Provide productive access to common electronic health record for collaboration in support of bi-directional physical and behavioral health integration, opioid interventions, chronic disease management and the care continuum;
- Identifying critical providers that need to be engaged common electronic health record (EHR); and
- Transitioning to an integrated (PH/BH) Electronic Health Record Platform to allow data analytics on quality outcomes associated with bi-directional/integrated care.

**Advance Payment Reform.** MultiCare is a leader in value-based contracting and will continue advancing payment reform in the region by:

- Continuing to work with Managed Care Organizations (MCOs) on unique payment models and value-based payment (VBP);
- Participating with Pierce County ACH Learning Network for trainings and support regarding process changes and requirements associated with VBP;
- Participating in the state-wide Value-based Payment academy; and
- Developing additional mechanisms to increase risk in value-based contracts.

**Improve the Population Health Management Infrastructure.** MultiCare is committed to helping the region use data to manage population health rather than simply informing transactional patient care and encounters. To do this, they will:

- Establish a population health management system to ensure patients are provided the most appropriate care site for primary and behavioral health needs;
- Increase the level of population health management being done across region to ensure whole-person care;
- Improve panel analytics and reporting functions in the system to help providers more effectively manage their panels;
- Implement/improve a process for reviewing panel level data on patients with chronic disease and/or who are at risk of chronic disease or opioid use disorder; and

- Develop strategies to achieve system level population health aims, then monitor and respond to data to steer execution of the strategy.

**Build Partnerships for Change.** MultiCare will actively partner with several other key entities in the region to advance specific transformation goals, including:

- Participation in the collaborative and committees' structure (i.e. primary care operations, primary care collaborative, quality champions dyad meetings) to engage physicians and providers in quality improvement efforts;
- Cooperating with Sea Mar Community Health Centers to build capacity for quality and value-based care delivery;
- Linking with Greater Lakes Mental Healthcare to expand the array of services available to MultiCare patients, including:
  - Additional access to behavioral and physical health through MultiCare Mobile Integrated Healthcare Van for Greater Lakes patients without primary care;
  - MAT services; and
  - Chronic disease management for target populations with hypertension and obesity.

**Use Improvement Science to Drive Change.** MultiCare will rely on evidence-based approaches to improving and transforming health care. To do this, they will:

- Support MultiCare representatives enrolled with IHI's Improvement Advisor program through Pierce County ACH's Strategic Improvement Team;
- Adopt the "Plan, Do, Study, Act" (PDSA) system strategy for continuous quality improvement; and
- Developing and maintaining performance indicators for staff and infusing these into supervision and change initiatives to help structure and support transformation.

**Adhere to the Transformation Rules of Engagement.** Pierce County's Transformation Rules of Engagement outline the expectations for all partners participating in Pierce County's coordinated transformation effort. While accomplishing the tasks outlined above, partners will be expected to:

- *Put Equity at the Center.* Implement the Institute for Healthcare Improvements (IHI's) Equity guidelines within both organizations and in clinical practices
- *Advance Data Sharing.* Work with other organizations through HIE/HIT solutions and participate in HIE platforms that support sharing across organizations.
- *Move Toward Value:* Start the transition to value based payment arrangements and contracts with managed care organizations
- *Measure:* Collaborate to co-develop metrics and outcomes that drive improvement, with a special focus on the payor lens and an eye toward sustainability.
- *Use Best Practices for Change.* Train staff and implement the use of IHI's Science of Improvement quality improvement model. Develop processes for providers and staff to have dedicated times for improvement activities. Commit to using the Pierce

County ACH WA Portal (and the associated transformation tools and learning community).

- *Enrich & Develop Partnerships.* Commit to partnership development toward “gold status” on the Partnership Accelerator Framework adopted by Pierce County ACH. *Engage Regionally.* Actively engage and collaborate in the larger strategy via Pierce County ACH’s Community-Driven Shared Learning & Action opportunities, including the RHIP (regional health improvement) Council, Provider Integration Panel, Opioid Workgroup, Data and Learning Team, Learning Network, Learning Collaborative, Board of Trustees or Board Committee or other connection points).

Provider Name:	<b>Sea Mar Community Health Centers</b>	Project(s): 2A, 2B, 3A, 3D
Entity-Type:	A Federally Qualified Health Center; a community-based organization committed to providing quality, comprehensive health (i.e. physical health, behavioral health, oral health, pharmacy), human, housing, educational and cultural services	

**Roles & Responsibilities:**

Sea Mar’s role in our regional transformation plan centers on the following:

**Transform the Health System to Support Integration & Whole Person Care.** Sea Mar will partner closely with MultiCare to promote integration and whole-person care models. They will work to help implement strategies that advance bi-directional integration, introduce tools and workflows for improved chronic disease management, improve pain management resources for helping address the opioid crisis, and enhance the use of data for patient-centered care and for population health management. Sea Mar is committed to moving toward a level five (5) or six (6) on the SAMHSA Scale for bi-directional integration of physical and behavioral health.

**Connect the Health System to the Community.** In addition to transformation work within the health system, Sea Mar will help connect health care to the regional infrastructure supported by Pierce County ACH to create a continuum of care. This work will include establishment of care teams and referral pathways to connect patients to social determinants of health resources through enhanced care coordination and the Community HUB, integration of community health worker and peer workforces, and partnering with other community organizations to support community-based care coordination.

**Act as a Community Care Coordinating Agency.** Sea Mar is a Care Coordination Agency (CCA) for the Community HUB within the Pathways pilot and will operate as such during the Demonstration project. Sea Mar is committed to increasing their partnership as the populations expand beyond the pilot.

**KEY STEPS TO IMPLEMENT PROJECTS:**

Sea Mar's regional transformation plan centers on regulatorily permissible models with MultiCare to achieve the following outcomes:

**Advance Bi-Directional Integration & Whole-Person Care.** Sea Mar will work to increase integration and implement and expand whole-person care approaches. To do this, they will partner with MultiCare to support the following tasks:

- Hire a full-time manager to lead and manage their integration strategy, starting with two clinics and then moving to scale and spread;
- Co-locate primary care and behavioral health services in two clinics, integrate a specialist into the primary care settings, and develop care teams;
- Hire up to four behavioral health specialists and integrating into primary care settings;
- Develop workflows that include assessments, initial treatment plan, and continuation of care with specialists if long-term care is required;
- Recruit and train workforce to support the needs of the population and transformation efforts, including various members for care teams;
- Plan and implement a training program on integration and clinical/therapy skills for primary care and behavioral health care staff for continuous and team-based health relationships;
- Expand training opportunities for primary care providers to help increase access;
- Implement the Collaborative Care Model for adult populations, including:
  - establishing behavioral health services as part of whole person care;
  - Assisting primary care providers in providing the essential care for patients with one or more chronic diseases with standard chronic disease management options; and
  - Building communication between specialist providers and primary care providers to increase access and provide efficient care across populations.
- Increase use and effectiveness of patient stated goals documentation in EHR at all primary care sites to increase patient engagement and partnership in their own care;
- Move equitably toward a level five (5) or six (6) on the SAMHSA Scale for bi-directional integration of physical and behavioral health.

**Implement Community Based Care Coordination.** MultiCare and Sea Mar will work together to expand its integrated whole-person care model outside of its own system and establish a continuum of care by connecting to the regional community care coordination infrastructure. To do this, they will:

- Establish a Health Engagement Team (HET) to serve high risk / high cost populations, including: IV drug users, homeless persons with chronic diseases or mental illness and "super utilizers" of care.)
- Create and utilize a patient enrollment and engagement center for patients to improve communication and flow with complex patients;

- Utilize the Community HUB and Pathways to connect patients to community resources and supports;
- Engage two Community Health Workers for Community HUB (Health Engagement Teams / Pathways); scale and spread after initial pilot;
- Utilize technology provided by the Community HUB for continuity of care for clinical and community-based care coordination; and
- Partner with community organizations for chronic disease management and prevention via connections through the HUB

**Operate as a Care Coordination Agency (CCA) for the Community HUB within Pathways.**

Sea Mar is a CCA within the Pathways pilot, and will continue to support Pathways by:

- Hiring and supervising a Community Health Worker workforce;
- Training Community of Health Workers;
- Meeting ACH standards of operation for a CCA;
- Utilizing the CCS platform to manage pathways and coordinate care regionally;
- Following HIPAA standards and ensure risk management;
- Coordinating with Community HUB;
- Attending monthly CCA/HUB meetings
- Supporting maintenance of the community resource pool with the Community HUB;
- Increasing partnership as the populations expand beyond the initial Pathways pilot.

**Improve the Population Health Management Infrastructure.** Sea Mar, along with MultiCare, is committed to helping the region use data to manage population health rather than simply informing transactional patient care and encounters. To do this, they will:

- Establish a population health management system to ensure patients are provided the most appropriate care site for primary and behavioral health needs;
- Increase the level of population health management being done across region to ensure whole-person care;
- Improve panel analytics and reporting functions in the system to help providers more effectively manage their panels;
- Implement/improve a process for reviewing panel level data on patients with chronic disease and/or who are at risk of chronic disease or opioid use disorder; and
- Develop strategies to achieve system level population health aims, then monitor and respond to data to steer execution of the strategy.

**Advance Payment Reform.** Sea Mar will work to advance payment reform in the region by:

- Cooperating with MultiCare to build capacity for quality & value-based care delivery;
- Continue working with Managed Care Organizations (MCOs) on unique payment models;
- Developing additional mechanisms to increase risk in value-based contracts; and
- Participating with the Pierce County ACH Learning Network for trainings and support regarding process changes and requirements associated with value-based care.

**Promote Information Integration.** Sea Mar will work alongside MultiCare to increase information integration in the region by:

- Increasing systems capacity through health information technology and health information exchange;
- Establishing a common electronic health record (EHR) for collaboration in support of bi-directional physical and behavioral health integration, opioid interventions, chronic disease management, and the care continuum;
- Identifying critical providers that need to be engaged common electronic health record (EHR); and
- Transitioning to an integrated (PH/BH) Electronic Health Record Platform to allow data analytics on quality outcomes associated with bi-directional/integrated care.

**Improve Pain Management & Support the Regional Opioid Strategy.** Sea Mar will work to support regional efforts to address the opioid crisis by:

- Use patient panel data and registries to proactively contact, educate and track patients with opioid misuse disorder and/or who are prescribed opioids; and
- Developing, implementing, or improving processes that support continuity of care for all screening, treatment, and follow up needed by patients with opioid use disorder.

**Use Improvement Science to Drive Change.** Sea Mar will support evidence-based approach to change management by enrolling representatives in IHI’s Improvement Advisor program through Pierce County ACH’s Strategic Improvement the use of improvement science to support transformation.

### Partnering Provider Engagement

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

#### ACH Response

**What training and/or technical assistance resources is the ACH facilitating or providing to support partnering providers in implementation from DY 2, Q3 through DY 3, Q4?**

Pierce County ACH offers a robust infrastructure to support partnering providers and community-based organizations, including the following:

1. *A Committee & Workgroup Structure* in service to a Shared Learning & Action model;
2. *A Strategic Improvement Team* that provides technical assistance & coaching;
3. *A Strategic Partnership* with the Institute for Health Improvement (IHI);
4. *Pathways to Population Health (P2PH)* tools & resources;
5. *Pierce County Learning Community*, a web portal with a range of helpful resources;
6. *LIFE QI*, an online “real time” quality improvement platform for all partners;
7. *The Community HUB*, a “care traffic control” center for whole person care;
8. *Whole Person Learning Collaboratives* designed to support implementation;

9. A Population Health Data System used for robust monitoring, feedback, & evaluation;
10. A Co-Designed Regional Roadmap that guides transformation for all partners.

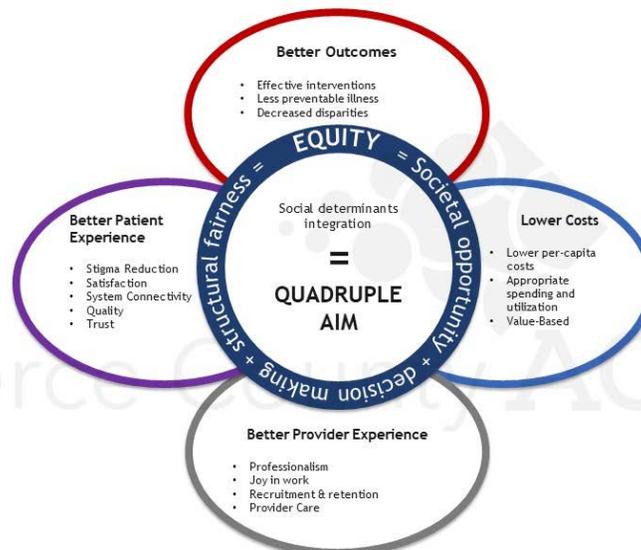
These resources and support strategies are each described in greater detail below.

### Committee & Workgroup Structure to Support Shared Learning & Action

Pierce County ACH has developed a Community-Driven Shared Learning & Action model that targets Community-Clinical Linkages to improve outcomes in the Quadruple Aim Framework (figure below). Resources for provider and community-based training and/or technical assistance are guided by the work of the following committees and workgroups, each of which meets monthly or twice-monthly as needed:

- Provider Engagement Panel (PIP)
- Regional Health Improvement Council (RHIP)
- Community Voice Council (CVC)
- Whole-Person Health Learning Collaboratives
- Integrated Managed Care Learning Network
- Data and Learning Team
- Opioid Taskforce (in partnership with Pierce County Council)
- Various other workgroups that provide the providers and community a space for shared learning, technical assistance and training for providers within the region.

The workgroup structure ensures that all partners have the opportunity to help ensure that the tools and resources created by the region speak to their particular needs.



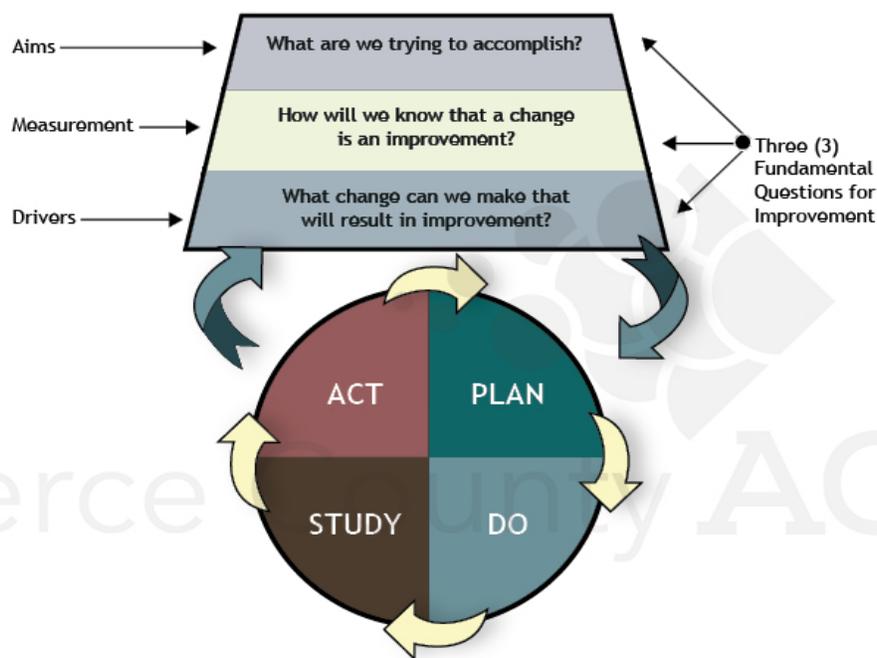
Source: Adapted from Rish Manchanda, HealthBegins & Institute for HealthCare Improvement Updated: 02/27/2019

### Strategic Improvement Team (SI Team)

Pierce County ACH has developed and deployed a *Strategic Improvement Team* that includes

a *Director of Strategic Improvement* and three *Improvement Advisors* grounded in the IHI Model for Improvement (see graphic below). The SI Team provides targeted technical assistance to ACH partners, including in-person and web-based trainings, facilitation, change management, and transformation development. Pierce County ACH’s Improvement Advisors support providers individually and through partnership teams, wherein groups of providers seek collaborative technical assistance. The SI Team also collaborates with Managed Care Organizations (MCOs) to ensure leveraged connectivity and alignment with MCOs technical support opportunities.

In addition to making its own Improvement Advisors available, Pierce County ACH has sponsored two cohorts equaling eight (8) individuals from partnering providers and community-based organizations to attend an intensive 10-month Improvement Advisor Training at the *Institute for Healthcare Improvement (IHI)*.



Source: Adapted from Associates in Process Improvement & Institute for Health Care Improvement

### **Strategic Partnership with the Institute of Healthcare Improvement (IHI)**

Pierce County ACH has committed to a strategic partnership with IHI. The partnership is led by Pierce County ACH’s executives in concert with Dr. John Whittington, a founder of the Triple Aim and Laura Brennan, MSW, faculty for IHI’s 100 Million Healthier Lives. As part of this partnership, Pierce County ACH is able to:

- Have IHI directly support providers and community partners in transformation efforts;
- Adopt tools & resources from IHI that can be made available to all partners;
- Anchor its Strategic Improvement Team’s work in IHI’s model for improvement; and
- Sponsor representatives from partner organizations to receive intensive IHI training.

### **Pioneer Sponsor for the Pathways to Population Health (P2PH)**

Pierce County ACH serves as a champion of the Institute for Healthcare Improvement’s *Pathways to Population Health (P2PH)* movement, which is designed to help accelerate population health improvement efforts within and across health care organizations (see figure below). P2PH includes a variety of tools and resources that can support change efforts within partnering provider and community-based organizations; Pierce County ACH and its Strategic Improvement Teams will encourage partners to utilize these tools and resources, help them regularly assess their progress, celebrate successes and share challenges, and generate shared learnings that can benefit all partners in the region.

### **4 Portfolios of Population Health**



### **Pierce County Learning Community on Washington Portal (WA Portal)**

The WA Portal is a comprehensive resource for all of Pierce County ACH partners. Through this portal, the partnering provider and community-based organization can access the Pierce County ACH Calendar, Webinars, Community Action Events, the Integrated Managed Care (IMC) Learning Network, Virtual Learning Community Blog, links to the Institute for Healthcare Improvement, and Life QI (described below). Providers and Community partners are also able to set up their own team pages to save documents, share resources, and collaborate within a secure discussion space.

### **Life QI**

Life QI is an online “real-time” quality improvement platform for regional partnering provider and community-based organizations. Pierce County ACH has added this resource to the WA

Portal for “one sign-in” option, which assists frontline health and social care staff in running quality improvement (QI) projects. Based around the Science of Improvement methodology promoted by the Institute for Healthcare Improvement (IHI), Life QI supports teams to plan, monitor and report the progress of their improvement projects, as well as connect with other members of the QI community, facilitating collaboration and shared learning.

### **Community HUB**

Pierce County ACH has developed a Community HUB that will be the cornerstone of its strategy to support, scale, and spread comprehensive community-clinical care coordination, transitions, and diversion. The Community HUB connects partners from across the continuum and provides an “air traffic control” methodology, built on evidence-based infrastructure, to provide whole-person care while supporting providers and community-based partners transitioning from fee-for service to value-based payment models.

The Community HUB offers a variety of services to assist ACH partners in transformation. It utilizes the national *Pathways* care coordination model, along with multi-disciplinary Health Engagement Teams (HET), to link Health Homes, First Steps Maternity Support Services, clinical comprehensive case management and care coordination (clinical providers and managed care organizations) to ensure Community-Clinical Linkages supports community-wide care plans for whole-person health. The HUB also sponsors training for the Community Health Worker (CHW) and care coordinator workforce in partnership with Washington State Department of Health, Pathways Community Hub Institute, and Care Coordination Systems.

With the Community HUB as its centerpiece strategy, Pierce County ACH will continue to work closely with managed care organizations, providers and community-based organizations to ensure robust community-based care plans for whole-person health and support providers and community-based partners to improve their care delivery and supports.

### **Whole-Person Care Collaboratives**

Pierce County ACH is developing multiple Learning Collaboratives to support strengths, opportunities and barriers that have been uncovered through assessments and action plans prior to implementation, as well as gaps and risks that may appear after implementation. The intent of the collaboratives is to convene partners with opportunities to come together for targeted focus on improvements and learning that provide successful outcomes at transition and through transformation.

### **Population Health Data System to Drive Regional Health Strategies**

A comprehensive, data-driven population health strategy is critical for achieving and sustaining successful outcomes in the health, quality, and cost spheres. In support of our regional providers and community-based organization partners, Pierce County ACH is searching for a sustainable opportunity to support the care continuum with data compiled and linked from distinct sources including clinical, social determinants of health, financial,

operational, criminal justice, and organizational. This data would be used to help plan together, identify and target population health efforts at key leverage points in the community, monitor and evaluate impact, and understand the total community impact of our collective work across sectors. A uniform, data-driven population health strategy will also help the region build and test effective approaches to spreading our initial work to additional populations, settings, and providers to support scale and spread.

### **Regional Roadmap & Transformation Rules of Engagement**

During the planning phase, Community Providers, Community-based organizations, the Community Voice Council, regional government, the Board of Trustees, and various other workgroups co-designed and developed several “north star” documents to help guide transformation in the region, including a regional strategy, Transformation Rules of Engagement, and an associated regional measure set. These shared documents provide partners a guide for transformation, and also help ensure that collective efforts are aligned with and support regional transformation milestones.

### **How is training and/or technical assistance resources being delivered within the timeframe?**

Training and technical assistance will be delivered through Pierce County ACH’s Community-Driven Shared Learning and Action model. Our communications strategy will ensure standardized tools and transparency around the available opportunities to receive assistance. Specific activities and resources will be delivered through several distinct channels:

**Strategic Improvement Team (SI Team).** The SI Team has expertise in the IHI Science of Improvement – Model of Improvement, which is designed to accelerate improvement work and link to traditional quality improvement tools and resources. The team is an ACH resource available to provide direct assistance to partners.

**Improvement Advisors.** In addition to the ACH’s SI Team, partners can send their own staff to IHI Improvement Advisor Training through an ACH-sponsored training partnership. This allow ACH partner organizations to build their own internal capacity.

**IHI Tools & Resources.** Through our strategic partnership with IHI, a variety of other tools and resources are available for use by Pierce County ACH partners. These tools support local partners in adapting IHI’s evidence-based improvement methodology to their work.

**Team & Workgroup Structure.** Assistance is also available to partners through our active team and workgroup structure, which is designed to support partners’ transformational efforts. Among the teams and workgroups who might help partners:

- A. *The Data & Learning Team*, which can help curate information from the regional data ecosystem and present it to partners in support of transformation;

- B. *The Community Voices Council*, which can bring the wisdom of community residents into the transformation process;
- C. *The Regional Health Improvement Council*, which can help connect improvement efforts to the larger regional strategy for health and health equity;
- D. *The Provider Integration Panel*, which can support implementation of changes related to the move toward integrated whole-person care; and
- E. *Other Workgroups*, including the care coordination advisory group, opioid workgroup, value-based payment workgroup, HIT/HIE workgroup, and workforce workgroup, who are chartered to provide assistance within their respective domains.

**The Integrated Managed Care Learning Network.** This network has been developed for all organizations with an interest in successfully transitioning to integrated managed care, including providers, Managed Care Organizations (MCOs), Behavioral Health Organizations (BHOs), Administrative Services Organizations (ASOs), County Government, the Washington health Care Authority (HCA), and Pierce County ACH. Resources include a shared learning architecture and an Early Warning System to help identify high-risk patients.

**Web-Based Assistance through the WA Portal.** The Pierce County Learning Community, available through the EA portal, is a centralized virtual location from which partners can access a wide range of supports: a calendar of key ACH and community events, the Integrated Managed Care network, a “virtual learning collaborative” blog for sharing ideas and practices, and links to IHI resources. Partners can also access LIFE QI, an online quality improvement platform that supports their efforts to implement and monitor improvement projects and supports partners’ ability to set up their own team pages to save documents, share resources, and collaborate securely.

**Webinars.** Pierce County ACH will host or facilitate topical webinars designed to support partners around key transformation issues. We expect to average at least one such webinar per month.

**Learning Collaboratives & Other In-Person Meetings.** Assistance will also be available through a variety of tailored face to face options. First, Pierce County ACH will support a series of meetings between providers and managed care organizations to support learning, technical assistance, and alignment of integration efforts to the regional strategy. Pierce County ACH will also facilitate a series of *whole person care* learning collaboratives designed to bring key players in the region together to leverage collective wisdom and help one another overcome the challenges inherent in this work. Finally, we expect to provide tailored coaching and one-on-one assistance to partners based on their individual needs and available subject matter expertise.

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

Pierce County ACH has been building relationships with small, medium and large providers and community-based organizations since early 2017, and we are acutely aware of the challenges faced by smaller partners in implementing and supporting change at this scale. Pierce County ACH will extend specific supports to these smaller partners, including:

**Maximizing Opportunities to Pool Efforts & Collaborate.** Pierce County ACH has developed and will maintain a matrix to identify potential partnering and collaboration opportunities across organizations, with a special emphasis on finding opportunities for smaller partners to connect with and leverage work happening elsewhere that aligns with their own efforts. Our goal established a shared learning that links partners with strengths in an area to those with gaps in the same area, eliminating barriers and silos to ensure that our network of partners are working together for the success of all. We employ a strong equity lens when considering cross-organizational partnership opportunities, actively seeking to create partnerships that highlight each partner’s unique strengths and knowledge to the benefit of others.

As part of this effort, we will ensure our Strategic Improvement Team continues to identify areas where smaller partners can participate with others on integration activities and transformation work. By pooling supports when needs are aligned, we can ensure that even smaller providers gain access to the benefits of our SI Team’s work and the other support resources available in our region.

**Capacity Building & Support.** We will support smaller providers & partners with capacity and capability build through the following specific pathways:

- A. Assisting with support for policy and procedure development and deployment;
- B. Linking Improvement Advisors and subject matter experts into smaller organizations to support practice change management and provide tailored one-to-one coaching, training, assistance, and consultation;
- C. Providing individualized technical assistance and core service support for transition activities including operations, billing and workflow; and
- D. Providing technical assistance to implement prescribing guidelines.

**Targeted Subject Matter Support.** We will offer a range of specific subject matter expertise resources that may be of particular value to smaller partners. Subject matter assistance may be delivered via one-to-one coaching, onsite training, group collaboration, evidence-based practices, or through other means as needed. Topics may include, but are not limited to, the following:

- A. Population health management;

- B. Value-based transition support;
- C. Strategies for workforce development;
- D. Community voice and engagement;
- E. Community-Clinical Linkages; and
- F. Embedding Health Equity throughout organizations and their practices.

**Support for Providers.** Transformation work can place enormous strain on providers and staff, and this is often a particular challenge in smaller organizations where fewer specialized roles and supports are available to facilitate the change. Pierce County ACH will support providers in these and other organizations through “Joy in Work” and “Care of the Provider” modules designed to help reduce provider strain and burnout.

**Active Recruitment into Regional Workgroup Infrastructure.** We will continue to actively recruit smaller providers and community-based organizations to engage and share input through our workgroup structure, including our Provider Integration Panel, Regional Health Improvement Council, Data and Learning Team, Behavioral Health and Integrated Managed Care Learning Network, and other workgroups. This will ensure that the needs and priorities of smaller partners remain central to our regional strategy.

**Access to Other Shared Resources.** Finally, smaller partners will have unlimited access to the shared resources available to all partners through the Pierce County Washington Portal, including access to the virtual learning community, team-specific folders, and LIFE QI, the virtual quality improvement tool accessible through the portal. Pierce County ACH also makes an effort to ensure that trainings and materials are available outside traditional business hours so that smaller providers, who may find it more challenging to dedicate portions of their business hours to the learning activities, enjoy convenient access to these resources.

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

Pierce County ACH has been committed to simplifying and streamlining regional efforts to reduce the burden on all partnering organizations.

**Creating Consistent Practices & Platforms for Supporting Change.** Having consistent practices and platforms for change management is critical in simplifying and aligning partnerships, especially for partner such as MCOs who may be working to enact transformation across multiple domains within our region and across multiple ACH regions. Pierce County ACH has taken a number of steps to ensure this happens, including offering a unified methodology, toolkit, and platform to support transformation work through the ACH WA Portal, LIFE QI tool, and other IHI materials and resources. These have been made

available to all providers and partners, even if their transformation efforts are based in regions outside of Pierce County.

**Creating Shared Regional Data Capacity.** Transformational work is fueled by strong data, monitoring, and evaluation that can demonstrate its impact and ensure its long-term viability, but not all partners have in-house data capacity. Pierce County ACH is leading several efforts to help coordinate this need across partners. First, we have worked with our partners to create a set of regional measures to track transformation progress and will provide centralized tracking of progress against those measures so that all partners have access to data that shows how they are doing. Second, we are actively seeking opportunities to build a regional population health data platform that aggregates and connects key population health data from a diverse array of sources, including clinical, public health, social services, public safety, and other social determinants data, and makes that data available for shared community planning, monitoring, and evaluation work. And third, we have convened a *Data & Learning Workgroup* tasked with curating this and other available data, extracting meaning from it, and feeding it into our governance structure so that the appropriate workgroups and partner organizations can leverage it to help make the right decisions to support our regional transformation strategy.

**Creating a Community HUB to Streamline Community Care Coordination.** Pierce County ACH's community HUB streamlines cross-partner coordination through an integrated and shared strategy, IT and data security/privacy support, information exchange standards through the shared community health record, a shared evaluation infrastructure, and support systems for the Community Health Worker and Peer Specialist workforces.

**Creating Common Rules of Engagement for Transformation.** Pierce County ACH's *transformation rules of engagement* were collaboratively designed to create a set of shared standards for transformation work in Pierce County. While they do not prescribe specific approaches, these standards do help outline the basic parameters of transformation across all regional partners, ensuring that the essential elements of the work align and increasing the likelihood that partners will be able to leverage one another's experiences and potentially streamline their own transformation processes.

**Maintaining Structures for Continuing Alignment & Coordination.** Pierce County ACH maintains a workgroup structure that supports continued alignment and coordination across partners, with workgroups dedicated to aligning approaches to finance and contracting, design and implementation of transformation strategies, data and monitoring, support for continuous quality improvement activities, connection with other ACH strategies, and more.

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

Pierce County ACH partners closely with other ACHs to create aligned approaches and shared value, and to reduce the burden of ACH work on partners whose work cuts across ACH regions. We work to coordinate with other ACHs in the following ways:

**Direct Support for other ACHs.** We have and continue to provide direct executive, financial, IT, and HIT/HIE support for Southwest Washington ACH (SWACH) after leadership changes there, including six months of donated services and a number of ongoing contracted services.

**Coordination Around Shared Partners to Reduce Burdens.** We have and will continue to work to coordinate with other ACHs around shared partners in order to reduce the burden of participating in multiple ACH activities. For example, when conducting partner assessments, we coordinated with Healthier Here to do joint assessments for partnering providers with a presence in both regions to reduce the total burden of assessments for those partners. In addition, we have worked to leverage shared technical assistance for ACH partners and MCOs spread across multiple regions to maximize the value of that assistance.

**Coordination & Alignment around Shared Transformation Strategies.** Pierce County ACH participates in a wide range of cross-ACH coordinating activities related to our programmatic work and transformation strategies. For instance, we have a regular sharing calls with North Central ACH and Southwest ACH around clinical transformation and shared our clinical assessment and action plan with all other ACHs. We have sponsored Pierce County Behavioral Health Providers to attend site visits in North Coast ACH to promote alignment and sharing of best practices, regularly share learnings with Southwest ACH and North Central ACH regarding financial integration of managed care, and maintain bi-directional sharing of business practices and transformation efforts with several other ACHs, including Better Health Together and Healthier Here. For ACHs implementing the Pathways program, we maintain ongoing partnership and coordination around multiple aspects of implementation including strategy, clinical linkages, IT, and data security/privacy issues; we have also worked to create an aligned evaluation approach across the participating regions.

**Resource Sharing.** We share resources with a number of other ACHs to support one another, including transformation planning resources, tools, best practices, and more. We have business associate agreements in place that allow us to share data between ACHs in the interest of common planning and alignment of efforts.

**Regular Meetings with other ACHs.** We maintain close relationships with the leadership of other ACHs, including regular calls and in-person meetings between executive directors, a weekly ACH huddle, a bi-weekly meeting of ACH program leads, monthly meetings with other ACHs around finance, and others. We also directly engage with other ACHs through direct conversations between staff and leaders and on-site joint work sessions between ACH teams. In at least one case, executives from Pierce County ACH and North Central ACH jointly represent ACH interests in a monthly ACH/HUB clinical Transformation Meeting.


**Partnering Provider Management**

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

**ACH Response**

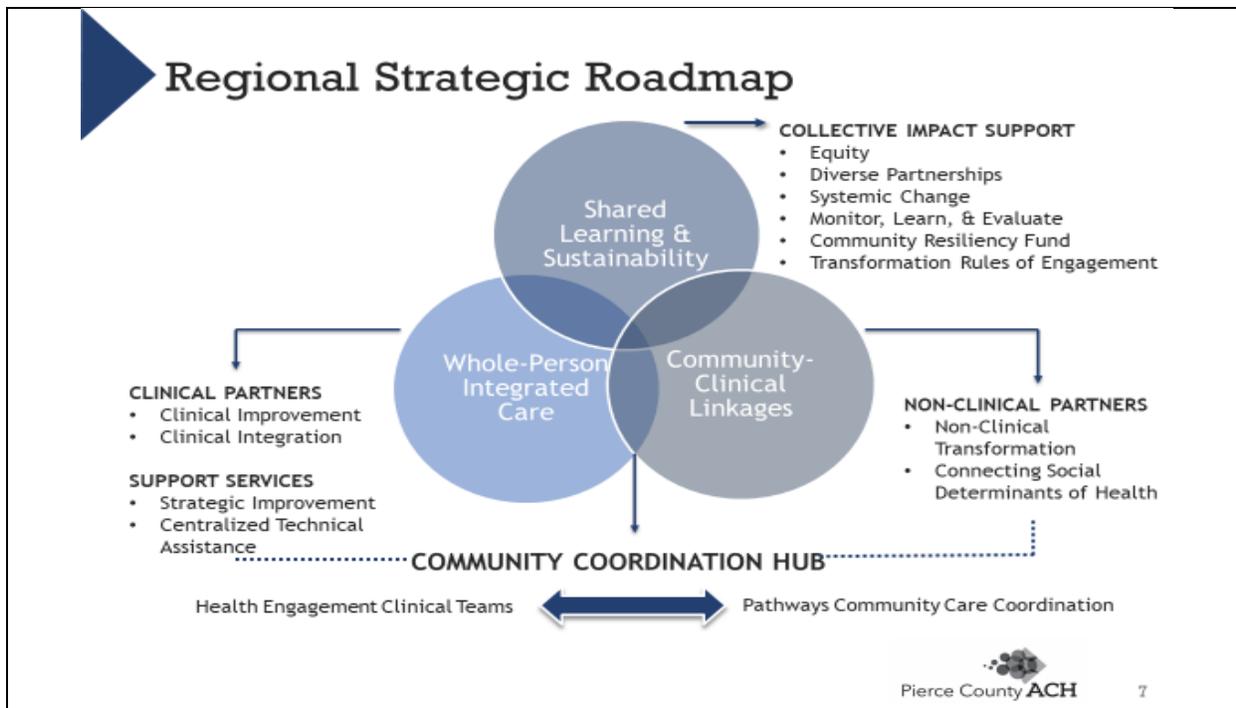
Responses must address both traditional and non-traditional Medicaid providers and cover the following:

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

**Overview of Strategy.** Pierce County is transforming across care settings using improvement science methodology to implement key change ideas and standards of care for:

- Whole person integrated care;
- Care Coordination that supports Community-Clinical Linkages;
- Patient Outcomes;
- Provider Experiences; and
- Access to Quality Care.

To accomplish this, we have developed a *Strategic Roadmap* and accompanying *Action Plan* designed to catalyze and spread the change we are seeking in our community. Our roadmap is designed to structure the implementation of principles codified in our *Transformation Rules of Engagement*, overlaid with an equity lens, to build strong partnerships and a healthy community to support and promote health and health resiliency for everyone in our region.



Pierce County ACH’s expectation of a clinically transformed system incorporates the following change concepts that stimulate specific, actionable steps for improvement:

- *Lay the foundation* through engaged leadership, evidence-based improvement strategy, and health information technology;
- *Build relationships* with patients through empanelment and enduring, team-based healing relationships;
- *Change care delivery* with organized, evidence-based care and person/family centered engagement that centers on the whole person; and
- *Reduce barriers* by enhancing access to a full spectrum of supports and deploying community-based care coordination to enhance whole-person integrated care.

**Partner Expectations.** With this as our transformation vision, we are inviting physical, behavioral health, and substance use disorder providers into a binding improvement agreement that reflects our community’s collective transformation vision. Our goal is to secure agreements with partners representing at least 90% of the regional Medicaid population. The overarching requirements (see Partnership Continuum below) for partners entering into agreements include:

- *Submit a Plan.* Build a model for transformation and submit Workplans and budgets outlining how they will use ACH funds and internal resources to execute change grounded in the Strategic Roadmap and Transformation Rules of Engagement
- *Commit the Time.* A 3-year binding agreement with Pierce County ACH;

- **Authentically Engage the Community.** Include feedback from those with lived experience into workplan development (via the Community Voice Council);
- **Put Equity at the Center.** Leadership endorses and supports the implementation of health equity as a strategic priority; partnerships are formed with external organizations that advance equity and address social determinants of health, with Pierce County ACH assisting to facilitate partnerships
- **Share the Learnings.** Participate in Whole Person Care Collaborative; appoint a dedicated liaison or Improvement Advisor to work with the ACH
- **Use Best Practices for Change.** Commit to using the Pierce County ACH WA Portal (and the associated transformation tools and learning community);
- **Report Progress & Demonstrate Improvement.** Quarterly reporting to Pierce County ACH with a demonstration of steady improvement, with use of our regional improvement science resources to support efforts
- **Move toward Value.** Ensure that 90% of contracts are in some level of Value-based payment by the end of the contract term
- **Join the Movement.** Actively engage and collaborate in the larger strategy via Pierce County ACH's Community-Driven Shared Learning & Action opportunities, including the RHIP (regional health improvement) Council, Provider Integration Panel, Opioid Workgroup, Data and Learning Team, Learning Network, Learning Collaborative, Board of Trustees or Board Committee or other Pierce ACH related connection points)

## Pierce County ACH Partnership Continuum

CATEGORY A: Direct Partner Payments & ACH Care Coordination Service	CATEGORY B: ACH Services and Partner Capacity Investments	CATEGORY C: Collective Learning & Improvement System
<p><b>Whole Person Integrated Care</b> Based on decision making criteria partners are invited into a negotiation process to result in a three-year binding agreement accountable to supporting the achievement of MTP goals.</p> <p><b>Eligible Partners:</b> Clinical Partners (in partnership with non-clinical organizations)</p> <p><b>ACH Investments (Direct Partner Payments):</b></p> <ul style="list-style-type: none"> <li>• Monetary investment;</li> <li>• Dedicated ACH staff support</li> <li>• Tools and resources for improvement</li> <li>• Implement/support Whole Person Care Collaborative</li> <li>• Evaluation</li> </ul> <p><b>Required Deliverables:</b></p> <ul style="list-style-type: none"> <li>• 3-year binding agreement with ACH</li> <li>• Submit budget for use of funds and internal resources to execute workplan</li> <li>• Quarterly reporting to ACH</li> <li>• Partner with external organizations in Category B that advance equity and address social determinants of health (matchmaking)</li> <li>• Include feedback from those with lived experience into workplan development (via the Community Voice Council)</li> <li>• Dedicated project liaison with ACH</li> <li>• Participation in Whole Person Care Collaborative</li> <li>• Leadership endorses/supports the implementation of health equity as a strategic priority</li> </ul> <p><b>Required Partner Outcomes:</b></p> <ul style="list-style-type: none"> <li>• Develop a model for clinical transformation</li> <li>• Demonstrate improvement in performance measures on state and regional measure set</li> <li>• Value based payment contracts covering 90% of Medicaid</li> </ul>	<p><b>Community HUB Care Coordination</b> Based on RFP/Catalyst process partners are/were invited to participate in the development of the Community HUB (pathways/HET) for target populations to sustain and scale across the care continuum.</p> <p><b>Eligible Partners:</b> Community Based Organizations Clinical and Non-Clinical Partners (i.e. EMS, Social Services)</p> <p><b>ACH Investments (Direct Partner Payments):</b></p> <ul style="list-style-type: none"> <li>• Pay for performance/outcomes connected to Community HUB</li> <li>• Training CHWs/Peers (pathways)</li> <li>• Training for Health Engagement Team (HET)</li> <li>• Community HUB platform/data exchange solution</li> <li>• Evaluation</li> </ul> <p><b>Required Deliverables:</b></p> <ul style="list-style-type: none"> <li>• Hire and supervise CHW workforce (Pathways)</li> <li>• Completion of CHW training(pathways)</li> <li>• Completion care team workforce development (HET)</li> <li>• Meet ACH standards of operation</li> <li>• Utilize CCS platform</li> <li>• Follow HIPAA standards and ensure risk management</li> <li>• Coordinate with HUB</li> <li>• Attend monthly CCA/HUB meetings</li> <li>• Support maintenance of community resource pool</li> <li>• Partner with Category A and B partner for deep community-based care coordination</li> </ul> <p><b>Required Partner Outcomes:</b></p> <ul style="list-style-type: none"> <li>• Demonstrate improvement in regional measure set</li> <li>• Close pathways</li> </ul>	<p><b>Capacity Building &amp; Community-Clinical Linkages</b> Partners who are essential to addressing social determinants of health services will be supported in capacity building and partnership development.</p> <p><b>Eligible Partners:</b> Community Based Organizations and Clinical and Non-Clinical Partners (i.e. Housing, Transportation, Food, Social Services)</p> <p><b>ACH Service Offerings (Regional/Direct Partner Investments):</b></p> <p><b>Integrated Managed Care:</b></p> <ul style="list-style-type: none"> <li>• Partner investments for cash flow stabilization during financial integration transition</li> <li>• IMC Learning Network</li> <li>• Whole Person Care Collaborative</li> <li>• Capacity-building and sustainability <ul style="list-style-type: none"> <li>◦ Science of Improvement tools/resources</li> <li>◦ Tailored coaching</li> <li>◦ Shared Services/Technical consulting support</li> <li>◦ Early Warning System</li> </ul> </li> </ul> <p><b>Partnership Matchmaking &amp; Capacity Building</b></p> <ul style="list-style-type: none"> <li>• Map community assets: map the unique contributions that each partner in the region can make in service of achieving the goals, including listening to those with lived experience through the Community Voice Council</li> <li>• Support partnerships between CBOs and care delivery partners from Category A to meet goals and use those assets in both traditional and nontraditional ways (i.e. equity)</li> <li>• Community Based Learning Collaborative: Tailored coaching and technical assistance to ensure that CBO partners have improvement skills and supports</li> </ul> <p><b>Partner Expectations:</b></p> <ul style="list-style-type: none"> <li>• Partners are invited to participate in one or more ACH offered services &amp; shared learnings</li> <li>• IMC partners to share financial billing data and be a member of the IMC Learning Network</li> <li>• CBO partners that make a match are required to share partner agreements/deliverables and participate in a learning collaborative.</li> </ul>
<p><b>CATEGORY D – Community Resiliency Fund for Social Impact Investing</b></p> <p><b>SUSTAINABILITY &amp; ECONOMIC VITALITY:</b> The Community Resiliency Fund (CRF) is the vehicle for planning and making collective investments to improve health and health equity in our community, then capturing and reinvesting the shared value created by those investments to sustain &amp; spread change.</p>		

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

We have been working to develop a rigorous set of indicators and accountability measures for partnering providers and community-based organizations. Although our list of metrics is not yet finalized, we have attached a summary of our preliminary list below. The metrics are broken into three sections:

- *Regional Quality Improvement Measures.* These measures focus on assessing impacts on key quality indicators, including patient/family experiences, provider/staff satisfaction, and key indicators of high-quality care derived from administrative data.
- *Process & Implementation Measures.* These measures focus on assessing whether partners have implemented specific elements derived from our Roadmap and Transformation Rules of Engagement, such as equity trainings, use of our regional quality improvement toolkit, or implementation of evidence-based screening for social determinants of health.
- *Pay for Reporting & Pay for Performance Measures.* These measures map to the P4R and P4P measures used by HCA to assess ACH performance; we expect that the work our partners do will positively impact these measures.

Specific measure concepts within each section are detailed in the attached spreadsheet; however, these represent only our preliminary concepts. The ACH is going to continue working with our partners and providers to identify an initial subset of measures from this attachment that we would want to develop and monitor initially. In addition, Pierce County ACH is working with the Institute for Healthcare Improvement to develop a regionalized dashboard to monitor the progress of this Implementation Plan at a strategic level. We expect to refine these measurement concepts over the coming months.



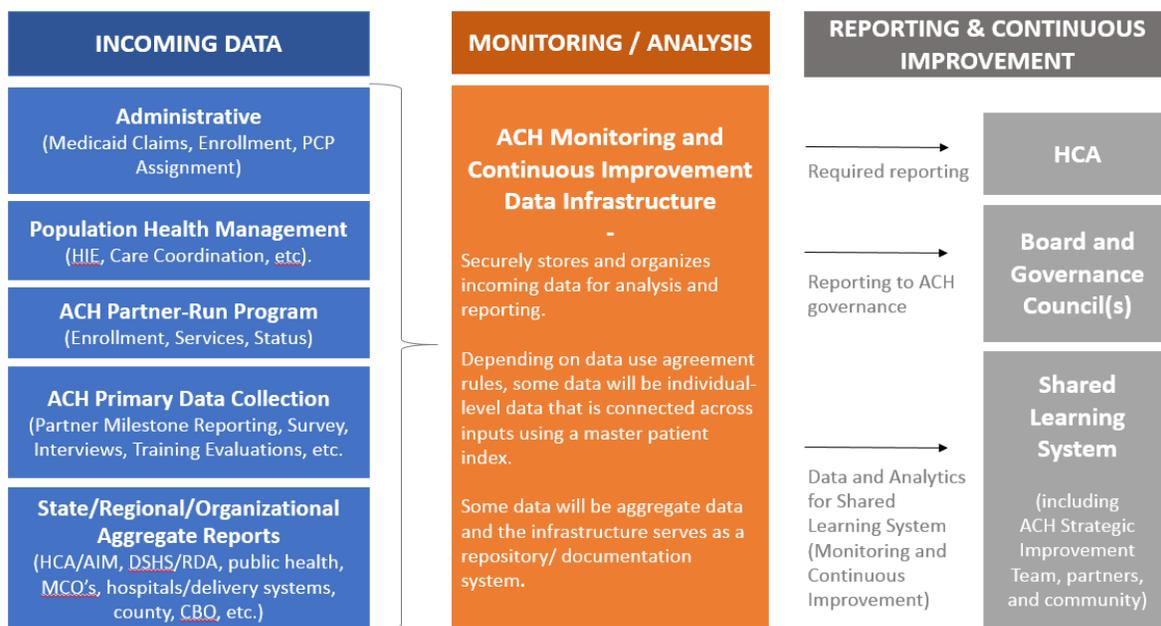
**What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?**

**Overall Data Strategy.** Pierce County ACH is committed to making data a centerpiece of our work via a Community-Driven Shared Learning and Action infrastructure. We will use data to strategize together, support development and implementation, optimize the impact of our programs, support the spread of programs beyond their initial focus populations to support regional efforts as broadly as possible, and evaluate the total impact of our transformation

across the communities we serve. Our overall data strategy includes a *performance monitoring and continuous improvement* program and a *population health management analytics system*, each further described below.

**Performance Monitoring & Improvement Program.** Pierce County ACH will maintain a robust data program to support performance monitoring and quality improvement activities for our partners. We will aggregate and connect a range of data inputs, including administrative data, population health management data from our shared community health record platform, programmatic data collected by the ACH as part of its activities, primary data collection collected for evaluation and monitoring purposes, and other reports from regional, state, or other organizational partners such as MCOs or public health. A data vendor will aggregate and connect these data inputs and use them to support required reporting to HCA, internal reporting to our ACH governance structure, and specific use cases within our shared learning system to support monitoring and continuous improvement (figure below).

### Pierce County ACH Monitoring and Continuous Improvement System



**Data Into Action – the Learning & Action Infrastructure.** We recognize that making data available is key, but that using the data to actually inform clinical practice or change how a patient’s care is managed requires more than just putting data in front of people. For this reason, our data streams will be fed into a *learning and action infrastructure* designed to consider and curate the available data, work with partners to understand what the data mean, and plan together on how to overcome barriers or improve results over time. Key elements of our approach to turning data into action include:

- **Strategic Improvement Team.** Our SI team will work closely with partnering organizations to help them understand their data and develop action plans to continually improve their scores.
- **ACH Workgroups & Leaders.** Our workgroup structure will receive data to help inform decisions about the collective work contained within their respective charters. Our ACH leaders will use the data to set strategy, monitor progress, and build toward long-term sustainability plans grounded in empirical evidence of impact.
- **Project Engagement Dashboards.** In addition to partner-specific feedback, Pierce County ACH is working with IHI on the development of a *project and engagement dashboard*, which will monitor the health of our multiple project workstreams. These dashboards will include a special focus on understanding the provider experience as part of our transformation efforts.
- **Program Evaluation & Impact Analytics.** We will work closely with CORE (the Center for Outcomes Research & Education) on program evaluation and data analytics that combine and leverage all of our data inputs, as well as adding new primary data collection in service to our evaluation needs that can be subsequently integrated into our data ecosystem and used to support continuous improvement efforts.
- **MCO & Provider Partnerships.** We will work closely with providers and Managed Care Organizations on multiple data collaboration opportunities. We will use data together to support implementation and evaluation of Pathways, the Community Hub, and other ACH activities, and partner to explore sustainability models that are grounded in the data we acquire over time.
- **Early Warning System.** Pierce County ACH is and will continue to coordinate with the Health Care Authority and Pierce County Human Services on an *Early Warning System* to monitor the implementation of Integrated Managed Care in the county.
- **Care Coordination/Community Health Record.** Finally, we will use data collected via our contracted partnership with *Care Coordination Systems (CCS)* to ensure the Community HUB can provide “care traffic control” across partners in support of our transformation vision. Frequent review of performance indicators from this system will enable Pierce County ACH to ensure our central strategy – improved clinical-community care coordination in service to whole-person care -- is producing the anticipated outcomes.

**Population Health Management Analytics and Processes.** In addition to monitoring, reporting, and evaluation, Pierce County ACH will work closely with MCOs, providers, and our evaluation and analytic partners to leverage our data assets in service to the development of better *regional population health management* strategies. We anticipate this work will involve, for example:

- **Exploring Variation.** Examining data by demographics, Medicaid rate categories or eligibility groups, and other characteristics to identify performance gaps or potential equity issues.

- **Exploring Common Populations.** Understanding how high risk or challenging populations in one sector overlap with similarly challenging populations in other sectors to better target cross-sector integration efforts at points of maximum impact.
- **Assessing “Total Risk.”** Understanding the interplay between *clinical* and *social* risk factors as drivers of quadruple aim outcomes within health care and other sectors, allowing resources to be targeted at the most critical drivers of poor outcomes.
- **Assessing Interdependency of Outcomes.** Understanding how outcomes in one sector (e.g. health care costs) are associated with outcomes in another sector (e.g., housing stability) to help formulate collective impact strategies that are positioned for optimal impact across sectors.
- **Illuminating High-Leverage Root Causes.** Identifying common risks or root causes that jointly predict poor outcomes across multiple systems in the region, setting the stage for high-leverage joint investments that ripple across sectors to improve everyone’s outcomes; and
- **Exploring Promising Strategies.** Understanding how strategies such as empanelment and integrated whole-person care may help mitigate the impact of risk factors and impact outcomes over time.

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

Pierce County ACH will continue to support partnering providers and community-based organizations throughout the implementation by providing a variety of resources through the Strategic Improvement (SI) Team. The SI Team utilizes subject matter expertise and the science of improvement to emphasize innovation and rapid-cycle testing (Plan, Do, Study, Act or PDSA) to produce learning about which variations and situations will yield improvements.

Pierce County ACH’s commitment to the partnering providers and community-based organizations will ensure that providers can rapidly improve and adjust if a project or plan is not progressing as expected. Pierce County ACH will ensure that Improvement Advisors are readily available to provide support and resources to ensure gaps, barriers and risks to meeting project milestones are uncovered throughout the implementation period. Improvement Advisors will coach or bring in additional subject matter expertise to encourage providers individually and as part of partnership or collaborative team to adjust and modify practices to achieve success.

### Alignment with Other Programs

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

## ACH Response

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

The *Transformation Rules of Engagement*, developed by the region for the region, explicitly call for aligning and leveraging resources for learning as providers are integrating Primary Care into Behavioral Health settings and/or integrating Behavioral Health into Primary Care settings. Specific measures we are taking to facilitate that alignment include:

- **Staying Connected.** Pierce County ACH continually seeks to keep abreast of work and learnings provided by state agencies, Washington State Hospital Association (WSHA), Washington State Medical Association (WSMA), Washington Association of Community & Migrant Health Centers (WACMHC) and numerous other state associations and regional networks sharing inputs for the benefit of transitioning providers. We also maintain close connections with other ACHs to ensure broader alignment of efforts.
- **Building on Existing Efforts.** Current bi-directional integration occurring in Federally Qualified Health Centers and health systems within the region are supported through Pierce County ACH's Provider Integration Panel, Strategic Improvement Team, and via one-on-one learnings and capacity building. Our data and learning infrastructure ensures that results are shared across the region and that existing efforts are transparent to all, helping encourage alignment and avoid duplication.
- **Strategic Improvement Team.** Our SI Team, working through the Pierce County ACH/ Washington Portal, gathers and disseminates resources from the Healthier Washington Practice Transformation Support Hub, Qualis, University of Washington AIMS Center, and SAMSHA in support of regional providers working on integration. This ensures those providers can align with existing evidence-based models (Collaborative Care Model, Bree Collaborative) that support practice transformation.

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

We ensure alignment of our opioid work in the following ways:

- **Working at the Fore.** Pierce County ACH is supporting the Pierce County Council as a co-lead organization for the county Opioid Taskforce; we are partnering and contracting with the Tacoma/Pierce County Health Department in multiple aspects of this work with a focus on stigma reduction efforts.
- **Staying Connected.** Pierce County ACH participated on an Opioid Community Panel with United States Senator Patty Murray, the Tacoma Pierce County Health Department, and local community members, and is actively engaged in a workgroup with CHI at a state system level on their highly successful prescribing reduction strategies. We maintain

active connections to multiple strategic improvement engagements with providers in the county to develop and/or support opioid plan development going forward and are in alignment with and reinforcing prescribing guidelines of the Washington State Hospital Association and the Washington State Medical Society across our region.

- **Disseminating Guidelines & Convening Partners.** Pierce County ACH is ensuring the Opioid Prescribing Guidelines, including updates, are readily available and shared with our providers and community-based organizations through our Strategic Improvement Team's work and our communications strategy through the Behavioral Health Learning Network. We also co-designed an ACH/State Agency/Tribal Opioid Summit focused on information sharing and ongoing strategy coordination.
- **Monitoring & Reporting.** Pierce County ACH is building out a Hub and Spoke Model for monitoring and data reporting around opioid indicators in our region.

**For ACHs implementing Project 2B: How does the ACH align referral mechanisms and provider engagement strategies with the Health Homes and First Steps Maternity Support Services program?**

Pierce County ACH has worked diligently with Health Homes and First Steps Maternity Support Services program providers to ensure streamlined referrals and warm handoffs to support clients without duplication of services. In the Community HUB, for Pathways, an example mechanism includes requirements for collaboration and documented engagement between clinical case managers and community health workers (CHW) to ensure continuity of care working closely with Step by Step (high level of referrals and engagement). Another example is the opportunity for the Community HUB to train Health Homes coordinators in Pathways model to ensure community-clinical linkages as requested by CHI Franciscan in their Health Connections program. We have had and continue to pursue conversations with various state agencies (i.e. HCA, DOH, DSHS, DEL) to ensure alignment with these standardized programs.

**What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?**

Many MCOs, health systems, and providers in our region have their own care coordination and case management programs in place. Pierce County ACH collaborates closely with these partners to ensure the Community HUB supports but does not duplicate the complex case management, intensive care coordination and established protocols, working to enhance and augment those efforts through use of peer support specialists or other HUB resources without replicating their essential character.

**How is the ACH's approach aligned with MCO care coordination contract requirements?**

Pierce County ACH has been meeting with MCOs since last year regarding community-based care coordination seeking to understand opportunities for Pathways and the Community HUB could support their contract requirements. Progress has been made with some MCOs and additional work is underway. All MCOs in the region are engaged in the Pathways Pilot in our region, which is a centerpiece project operating under the Community HUB. We anticipate and are actively pursuing alignment between our plans to sustain and spread the HUB and MCOs' care coordination contracting requirements.

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

Pierce County ACH has been meeting with state (i.e. Department of Health, DSHS) and regional agencies (i.e. public health, health systems, clinical providers, community-based organizations) to ensure alignment with programming that currently exists within the region and state, such as the *Stanford Living Well with Chronic Conditions* model and additional chronic disease prevention programming. There continues to be communication to align action plans with evidence-based practices throughout the region building upon partnerships to ensure equity and reduce silos and ensure no duplication.

**For ACHs implementing Project 2C**

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

**For ACHs implementing Project 2D**

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

**For ACHs implementing Project 3B**

- How do the ACH's partnering providers align with and avoid duplication of Maternal Support Services? How will the project strengthen or expand current implementation of Home Visiting Models?
- What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve access to high quality reproductive and maternal/child health care?

For ACHs implementing Project 3C

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

**Regional Readiness for Transition to Value-based Care**

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

**ACH Response**

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

**VBP Readiness Assessments:** The current-state, HIE/HIT, and billing readiness assessments that our partners all completed during the planning process identified capacity-gaps and barriers they face in moving forward with value-based payments. In response, we have designed our Action Plans template to target the identified gaps and are working individually with our partners to help them identify strategies and tactics to address those challenges.

**MCO Alignment:** Pierce County ACH is actively pursuing conversations and work sessions with MCOs in the region to identify quality and outcome metrics that would be commonly included in future contracts. Once we have identified these metrics, we will include assessments of our impacts on those metrics in our evaluation and monitoring plans, so we can use the results to move toward value-based payment arrangements built on them.

**Technical Assistance around VBP:** The Strategic Improvement Team at Pierce County ACH has designed its shared learning collaboratives around issues and change management practices that are common to our partners around value-based payment transitions. Partners that are moving into a binding agreement with the ACH are committing to active participation in a shared learning collaborative as one of the performance milestones for incentive payments. Pierce County ACH is also making deep regional investments to provide technical assistance resources to our partners by:

- Bringing in subject-matter expertise for shared learning opportunities;
- Building and expanding the role of the Improvement Advisors to work with partners individually on quality improvement methods and measurement; and
- Providing technical assistance with qualitative and quantitative financial analysis to better understand impacts of moving from a fee-for-service environment to alternative payment methods.

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

In addition to the Improvement Advisors that are part of the ACH's Strategic Improvement

Team, Pierce County ACH is investing in building capacity within our region by sponsoring representatives from our partner organizations to complete the IHI Improvement Advisor Professional Development training. This is an intensive, ten-month practicum where quality improvement and change management skills are learned. By investing in these “practice champions” and providing them with project management tools and shared resources, we are building a culture of improvement within our partner organizations that can be spread internally and throughout the region.

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

Explain how the region is advancing HIT/HIE objectives.

### ACH Response

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

**Example One.** Pierce County ACH has asked OneHealthPort to attend meetings of our Board of Directors and Provider Integration Panel to share information about their services and the information exchange needs of Pierce County providers. ACH staff are meeting with OneHealthPort in September to identify two to three specific use cases that we can invest in to further support both the use of OneHealthPort and broader information exchange in the county. Lastly, the ACH has become a trading partner with OneHealthPort and is coordinating on how best to utilize that service.

**Example Two.** Pierce County ACH participates in a county workgroup focused on services that Collective Medical Technologies (CMT) provides (both EDIE and Pre-Manage) that brings together providers across multiple sectors including clinical, social services, emergency management services, public health, and county human services teams. Pierce County ACH is working with other ACHs statewide to define common investments that could be made, along with Pierce County-specific investments to support the timely exchange of information that CMT provides through multiple services.

**Example Three.** Pierce County ACH is heavily involved with MultiCare and Sea Mar on an effort to standardize their ability to share clinical data to facilitate broad coordination between these two large systems across the state, including in 96 Sea Mar clinics.

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

Pierce County ACH takes part in multiple partnership meetings and discussions with federal and state partners. A large part of our ACH strategy is to align with the state direction to

both partner and invest in services provided by OneHealthPort and to coordinate additional Health Information Exchange investments, such as Collective Medical Technologies, with other ACHs in the state.

We are actively seeking a strategy that is responsive to our partner's key needs. Thus, there is currently no settled strategy with a defined investment -- instead, we are working with clinical partners to identify their needs, then will determine technology solutions to address those needs. With that said, Pierce County ACH is leveraging the Community Health Record, along with shared care planning capabilities of the Care Coordination Systems platform, in alignment with Pathways and Community HUB work.

### Technical Assistance Resources and Support

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

#### ACH Response

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

Pierce County ACH has invested in the following outside resources for technical assistance and supplementing internal capacity:

- *Institute for Healthcare Improvement.* Our strategic partnership with IHI enhances our ability to active change in the region by applying state-of-the-art tools in support of our partner's efforts. Partners include Senior Faculty, John Whittington, MD (co-founder of the Triple Aim); Faculty, Laura Brennan, MSW (100 Million Healthier Lives, Subject Matter Expert on Community Engagement) and others on the IHI Faculty.
- *Uncommon Solutions.* This consulting firm serves as a strategic partner for Pierce County ACH and assists with community partnerships, policy and legislative connections, and information technology services.
- *CORE.* The Center for Outcomes, Research, and Education (CORE) provides data analytics, program monitoring and evaluation services, and strategic assistance across multiple aspects of our work.
- *Point B Consulting.* Point B provides project management expertise.
- *DH.* This partner has been engaged to provide expertise and support for public relations, communications, advertising, ACH branding, website communications and strategic development
- *Tacoma Pierce County Health Department.* TPCHD has been engaged to provide training to internal ACH staff, community health workers working in the Community HUB (Pathways) and community partners in equity, cultural humility and anti-racism.

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

Pierce County ACH would like to see additional technical assistance provided to contracted data partners and ACH staff on program evaluation and data strategies for the ACH and partnering providers in the county region. We believe there is substantial amount to be gained by everyone if data and evaluation approaches can be coordinated across regions.

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

Pierce County ACH remains open to learning from the implementation experience of other ACHs in all aspects of this work and is willing to share learnings from work within the Pierce County region with other ACHs, including:

- Technical assistance from Pierce County ACH's strategic alliance with Institute for Healthcare Improvement (IHI), including invitations to join community learning events, access to resources including population health pathways, equity roadmap, improvement science, and numerous additional resources;
- Sharing of resources with interested ACHs through the Pierce County ACH / Washington Portal tool;
- Continued shared learnings for early adopter (SWACH) and mid-adopter (NCACH) regions;
- Continued shared learnings with BHT on community resiliency efforts;
- Continued shared learnings with all ACHs adopting Pathways community-based care coordination and Community HUBs, including Health Engagement Teams;
- Continued shared learnings with ACHs going through integrated managed care transition in 2019;
- Continued conversations through shared learnings with ACHs regarding tribal affairs;
- Continued shared learnings and leverage resources regarding equity and cultural sensitivity training;
- Continued shared learnings with ACHs on workforce issues;
- Continued shared learnings on with ACHs value-based payment supports;
- Continued shared learnings with ACHs on transformation efforts partnerships with statewide sector organizations;
- Continued shared learnings with ACHs regarding public-private partnerships;
- Open to shared learnings with other ACHs on population health strategies;
- Continued shared learnings with ACHs to efficiently support providers in shared regions (flexible and numerous opportunities); and
- Continued shared learnings with ACHs regarding governance and operational improvements.

Pierce County ACH Metrics

Indicator	Metric	Description	Target	Measure Steward	Granularity	Frequency	Reporting Source	Data Source	Reporting Data	P4P	P4R	ACH Rep
<b>Quality Improvement Measures</b>												
Patient/family experience	CAHPS Composite: Satisfaction with Care (clinical & group, hospital)			AHRQ	Site?	Semi-Annual	Partner	CAHPS?	Num/ Den/ Rate			Y
	Leapfrog as another option	Big systems - hospitals										
Patient/family experience	CAHPS Care Coordination			AHRQ	Site?	Semi-Annual	Partner	CAHPS?	Num/ Den/ Rate			Y
Patient/family experience	CAHPS Provider Communication			AHRQ	Site?	Semi-Annual	Partner	CAHPS?	Num/ Den/ Rate			Y
Patient/family experience	CAHPS Timeliness of Care			AHRQ	Site?	Semi-Annual	Partner	CAHPS?	Num/ Den/ Rate			Y
Patient/family experience	CAHPS Helpful Staff			AHRQ	Site?	Semi-Annual	Partner	CAHPS?	Num/ Den/ Rate			Y
Provider/ Staff experience	Provider/ Staff Satisfaction	Proposed definition: Percent of providers/ clinicians/ staff reporting high or very high satisfaction		TBD: http://www.ih	Site?	Semi-Annual	Partner	?	Num/ Den/ Rate			Y
% Shared care plan	Shared Care Plan	Proposed definition: Percent of patients (with specific diagnoses?) who have a shared care plan documented in their medical record; Any requirement around updating it or is it just if they have it at any point?		TBD: https://www.a	Site?		Partner	EHR/ Life QI?	Num/ Den/ Rate			Y
% One Key Question	One Key Question	Proposed definition: Percent of women of reproductive age (*15-44) who had an outpatient visit during the quarter / measurement year who were asked one key question (as evidenced by response documented as structured data in their medical record)		TBD: http://www.co	Site?		Partner	EHR	Num/ Den/ Rate			Y
% SBIRT	Alcohol & Drug Misuse (SBIRT)	Proposed Definition: Percent of patients (ages 12+?) who had an outpatient visit in the quarter/ measurement year and received one or more screening, brief intervention, and referral to treatment		TBD: http://www.st	Site?		Partner	EHR	Num/ Den/ Rate			Y
% Well child visits	Well Child Visits - 3-6 years	Percent of patients ages 3-6 years who had one or more well-child visit with a primary care provider during the measurement period	10% gap to goal	NCQA HEDIS	Site?		Partner	EHR	Num/ Den/ Rate	Y		Y
% Well child visits	Well Child Visits - 15 months	Percent of patients 15 months old who had the recommended number of well-child visits with a primary care provider in their first 15 months of life	10% gap to goal	NCQA HEDIS	Site?		Partner	EHR	Num/ Den/ Rate	Y		Y
Comprehensive Diabetes Care	Diabetes: HbA1c Control	Percent of patients ages 18-75 with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement period was greater than 9.0% (poor control)		NCQA HEDIS	Site?		Partner	EHR	Num/ Den/ Rate			Y
Comprehensive Diabetes Care	Diabetes: Blood Pressure Control	Percent of patients ages 18-75 with diabetes (type 1 and type 2) whose most recent blood pressure reading was <140/90		NCQA HEDIS	Site?		Partner	EHR	Num/ Den/ Rate			Y
Controlling High Blood Pressure	Controlling High Blood Pressure	Percent of patients ages 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement period		NCQA HEDIS	Site?		Partner	EHR	Num/ Den/ Rate			Y
Depression Screening	Depression Screening and Follow-up for Adolescents & Adults	Percent of patients ages 12+ who were screened for clinical depression using a standardized tool, and, if screened positive, who received appropriate follow-up care.		CMS (NQF 0418)/ NCQA HEDIS	Site?		Partner	EHR	Num/ Den/ Rate			Y
Patient Volume?	Medicaid Enrollees Served	Proposed description: Number of unique Medicaid Enrollees served by clinic/site/org in measurement period. (Include individuals for whom claim was not submitted?)		ACH	Site/ Org		Partner	EHR/ Admin	Num/ Den/ Rate			Y
<b>ACH Partner Process &amp; Implementation Measures</b>												
PCMH-A	Level of medical home at practice/ clinic site	The PCMH-A is intended to help sites understand their current level of "medical homeness" and identify opportunities for improvement	TBD	Qualis Health	Site	Semi-annual	Partner	Partner Reporting	Subscale score/ overall score?			Y
Provider/ Staff Experience	TBD	Options: ACH could field 3-5 item provider satisfaction survey or partners could submit responses from their own surveys	Maintain or improve baseline rates?	TBD	Site? Individual?	Annual?	Partner	Partner Reporting	Num/ Den/ Rate			Y
VBP Survey	Completion of VBP survey	Proposed Definition: Has your organization completed HCA's VBP survey? (alternative: Build questions into ACH reporting?)	100% of partners complete	HCA	Org	Annual	Partner	HCA? (or build into partner reporting?)				
Quality Improvement - Participation	Life QI Use	Proposed Definition: Number of staff/ providers using Life QI	100% of partners participate?	N/A	Site? / Org?	Semi-Annual	ACH?	Partner Reporting	Number			Y
Quality Improvement - Training	QI Model Training	Proposed Definition: Number/ percent of staff/ providers at participating sites trained on QI model	N/A	N/A	Site?	Semi-Annual	Partner	Partner Reporting	Num/ Den/ Rate			Y
Patient Engagement	Patient Engagement Communication Plan	Proposed Definition: Does the clinic/site/practice/org have a plan for engaging patients?	100% of partners have a plan	N/A	Site? / Org?		Partner	Partner Reporting	Yes/No			Y
Patient Engagement	Shared Treatment Plan	Proposed Definition: Does the clinic/site/practice have a process for integrated treatment plans that are accessible to all providers?		N/A	Site?		Partner	Partner Reporting	Yes/No			Y
(Is this about training or participation?)	BH Integration Training	Proposed definition: Number/ percent of staff trained on integration and clinical/therapy skills for primary care and behavioral healthcare staff (or # of staff participating in learning network?)		N/A	Site? / Org?		Partner	Partner Reporting	Num/ Den/ Rate			Y
Evidence-Based Screening	Screening tools	Proposed Definition: List evidence-based screening implemented for the following conditions: diabetes, obesity, cardiovascular disease, pulmonary disease, cancer, SDOH (multiple choice list)		N/A	Site?	Semi-Annual	Partner	Assessment?	Yes/No			Y
Health Literacy	Health Literacy Review Process	Proposed Definition: Does your organization have a process to review the health literacy level of patient communications and materials?		N/A	Site? / Org?	Annual?	Partner	Partner Reporting	Yes/No			Y

Culturally Appropriate Communications	Cultural & Linguistic Review Process	Proposed Definition: Does your organization have a process to review cultural and linguistic appropriateness of patient communications and materials?		N/A	Site? / Org?	Annual?	Partner	Partner Reporting	Yes/No			Y
Care Coordination	Pathways Referrals	Proposed Definition: Does your organization refer to Pathways for [insert target populations?] [Do we want number of referrals?]		N/A	Site? / Org?	Semi-Annual	Partner	Partner Reporting	Yes/No			Y
Health Equity - Training	Trauma-Informed Care Training	Proposed definition: Number/ percent of staff trained on trauma-informed care		N/A	Site? / Org?	Semi-Annual	Partner	Partner Reporting	Num/ Den/ Rate			Y
Health Equity - Training	Cultural & Language Diversity Training	Proposed definition: Number/ percent of staff trained on culturally & linguistically appropriate care delivery		N/A	Site? / Org?	Semi-Annual	Partner	Partner Reporting	Num/ Den/ Rate			Y
Health Equity - Training	Health Literacy Training	Proposed definition: Number/ percent of staff trained on health literacy		N/A	Site? / Org?	Semi-Annual	Partner	Partner Reporting	Num/ Den/ Rate			Y
Health Equity - Training	Motivational Interviewing Training	Proposed definition: Number/ percent of staff trained on motivational interviewing		N/A	Site? / Org?	Semi-Annual	Partner	Partner Reporting	Num/ Den/ Rate			Y
Level of Integration	SAMHSA Levels of Integration	Proposed Definition: Use IPAT tool or other to determine level of integration?			Site?	Semi-Annual	Partner	Partner Reporting	TBD			Y
Health Equity	Demographic Data Collection	Proposed Definition: Does your org have systems in place to collect demographic information from patients? (multiple choice options of demographic data, maybe to focus on REAL+D?)			Org	Annual	Partner	Partner Reporting	TBD			Y
Health Equity	Demographic Data Plan	Proposed Definition: Does your organization have a plan to use demographic data to advance health equity? Describe.		CLAS	Org	Annual	Partner	Partner Reporting	Yes/No; Narrative			Y
Health Equity	Anti-Discrimination	Proposed definition: Has your organization adopted a public policy prohibiting all forms of discrimination?	100% of partners have policy		Org	Annual	Partner					
Health Equity	Culturally & Linguistically Appropriate Workforce	Proposed Definition: Does your org have policies in place to ensure that your staff has the cultural and linguistic capacity to meet the needs of the population you serve? Describe.		CLAS	Org	Annual	Partner	Partner Reporting	Yes/No; Narrative			Y
Opioid Decision Support	EHR interface with PMP	Proposed definition: Does your organization's EHR have a direct interface with the Prescription Monitoring Program (PMP)?	Baseline: 12% 2019: 25% 2020: 50% 2021: 75%		Org	Semi-Annual	Partner	Partner Reporting	Yes/No			Y
<b>Pay-for-Reporting Measures (P4R)</b>												
MeHAF	Level of physical and behavioral health integration at practice/ clinic site	The Maine Health Access Foundation (MeHAF) developed the SSA tool to assess levels of primary and behavioral care integration. The SSA tool focuses on two domains: 1) integrated services and patient and family services and 2) practice/organization. Each domain has nine characteristics to rate on a scale of 1 to 10 depending on the level of integration or patient-centered care achieved.		HCA	Site	Semi-Annual	Partner (clinical)	HCA Template	Number (score for each row of MeHAF questionnaire)			Y
Opioid Guidelines	Providers trained on guidelines for prescribing opioids for pain	Practices and clinic sites conduct trainings in a variety of ways. What proportion of the clinicians participating in Project 3A at your practice sites have undergone training on opioid prescribing guidelines? These guidelines could include AMDG guidelines, 6 Building Blocks guidelines, CDC guidelines or others.		HCA	Site	Semi-Annual	Partner (clinical)	HCA Template	Percent of providers			Y
Opioid Guidelines in EHR	Practice/clinic site level measure of whether site has EHRs or other systems offering clinical decision support for opioid prescribing guidelines	Does the practice/clinic site offer clinical decision support for opioid prescribing guidelines through an EHR or through another system? These guidelines could include AMDG guidelines, 6 Building Blocks guidelines, CDC guidelines or others.		HCA	Site	Semi-Annual	Partner (clinical)	HCA Template	Y/N (drop down)			Y
OUD Treatment Providers	Practice/clinic site level measure of whether mental health and substance use disorder providers deliver acute care and recovery services to people with opioid use disorders (OUDs)	What systems, if any, are in place to ensure people with opioid use disorders (OUDs) are connected to the acute care and recovery services they need?		HCA	Site	Semi-Annual	Partner (clinical)	HCA Template	Select from response options			Y
ED Naloxone	Emergency department has protocols in place for providing overdose education, peer education or take home naloxone to individuals seen for opioid overdose	Does the ED site have protocols in place to offer overdose education and take home naloxone for individuals seen for opioid overdose?		HCA	Site	Semi-Annual	Partner (clinical)	HCA Template	Select from response options			Y
CBO MAT Access	CBO site is an access point in which persons can be referred for MAT	Does the CBO site have protocols in place to offer refer people with opioid use disorders to providers of medication-assisted treatment?		HCA	Site	Semi-Annual	Partner (CBO)	HCA Template	Y/N (drop down)			Y
CBO Syringe Exchange	CBO site is a syringe exchange	Did your CBO receive technical assistance to organize or expand a syringe exchange program?		HCA	Site	Semi-Annual	Partner (CBO)	HCA Template	Select from response options			Y
<b>Pay-for Performance Measures (P4P)</b>												
ED Utilization	All Cause Emergency Department (ED) Visits per 1000 Member Months	The rate of Medicaid enrollee visits to emergency department per 1000 member months, including visits related to mental health and chemical dependency. Separate reporting for age groups 10-17, 18-64, and 65+.	1.9% improvement over baseline	HCA	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate		Y	
Antidepressant Medication Management	Antidepressant Medication Management	The percentage of Medicaid enrollees 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.	10% gap to goal	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate		Y	
Access to Care	Child and Adolescents' Access to Primary Care Practitioners	Percent of children enrolled in Medicaid who had a visit with a primary care provider.	10% gap to goal	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate		Y	

Diabetes Care	Comprehensive Diabetes Care: Eye Exam (retinal) performed	Percentage of Medicaid enrollees 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	10% gap to goal	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Diabetes Care	Comprehensive Diabetes Care: HbA1c Testing	Percentage of Medicaid enrollees 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year	10% gap to goal	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Diabetes Care	Comprehensive Diabetes Care: Medical attention for nephropathy	The percentage of Medicaid enrollees 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	10% gap to goal	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Follow-up after ED visit for alcohol or other drug dependence	Follow-up After Discharge from ED for Alcohol or Other Drug Dependence	The percentage of discharges for Medicaid enrollees 18 years of age and older who had a visit to the emergency department with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence. Two rates are reported: 7-day & 30-day	1.9% improvement over baseline	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Follow-up after ED visit for mental health	Follow-up After Discharge from ED for Mental Health	The percentage of discharges for Medicaid enrollees 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health. Two rates are reported: 7-day & 30-day	1.9% improvement over baseline	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Follow-up after hospitalization for mental illness	Follow-up After Hospitalization for Mental Illness	The percentage of discharges for Medicaid enrollees 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: 7-day & 30-day	1.9% improvement over baseline	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Inpatient Hospitalizations	Acute Hospital Utilization	For members 18 years of age and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year reported by Surgery, Medicine, and Total	1.9% improvement over baseline	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Asthma Medication Management	Medication Management for People with Asthma (75% compliance)	The percentage of Medicaid enrollees 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	10% gap to goal	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Access to Mental Health Services	Mental Health Treatment Penetration (broad)	Percent of Medicaid enrollees with a mental health service need who received at least one qualifying service during the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years	1.9% improvement over baseline	DSHS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
High Dose Opioid Prescriptions	Patients on high-dose chronic opioid therapy by varying thresholds	Measure specifications in development. Among Medicaid enrollees, percent of chronic opioid therapy patients receiving doses: >50 mg. MED in a quarter, doses >90 mg. MED in a quarter.	1.9% improvement over baseline	HCA	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Concurrent opioid and sedative prescriptions	Patients with concurrent sedatives prescriptions	Measure specifications in development. Among Medicaid enrollees receiving chronic opioid therapy, what percent had more than 45 days of Sedative Hypnotics/ Benzodiazepines/ carisoprodol/ barbiturates dispensed in the quarter.	1.9% improvement over baseline	HCA	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Homelessness	Percent Homeless (Narrow Definition)	Percent of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes "homeless with housing" ACES living arrangement code	1.9% improvement over baseline	DSHS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Hospital Readmissions	Plan All-Cause Readmission Rate	The proportion of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days among Medicaid enrollees ages 18-64 years old.	1.9% improvement over baseline	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Statin Therapy	Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	Percentage of male Medicaid enrollees 21 to 75 years of age and female Medicaid members 40 to 75 years of age during the measurement year who were identified as having clinical ASCVD who were dispensed at least one high- or moderate-intensity statin medication.	1.9% improvement over baseline	NCQA HEDIS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Access to SUD Treatment Services	Substance Use Disorder Treatment Penetration	The percentage of Medicaid enrollees with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting by age groups: 12-17 years and 18-64 years.	1.9% improvement over baseline	DSHS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			
Access to Opioid Use Disorder Treatment Services	Substance Use Disorder Treatment Penetration (Opioid)	Percent of Medicaid enrollees with a diagnosis of opioid use disorder who have a substance use service need who received at least one qualifying service during the measurement year. Reported separately for adults and for children.	1.9% improvement over baseline	DSHS	ACH	Quarterly	HCA	Claims	Num/ Den/ Rate	Y			

