



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

July 31, 2018

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Semi-Annual Report Information and Submission Instructions

Purpose and Objectives of ACH Semi-Annual Reporting

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

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

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

Reporting Requirements

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

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

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

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

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

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

Key Terms

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

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

Semi-Annual Report Submission Instructions

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

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

File Format

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

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

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

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

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

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

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

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

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

Semi-Annual Report Submission and Assessment Timeline

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

ACH Semi-Annual Report 1 – Submission and Assessment Timeline			
No.	Activity	Responsible Party	Timeframe
1.	Distribution of Semi-Annual Report Template and Workbook to ACHs	HCA	March 30, 2018
2.	Overview of Semi-Annual Report Template	HCA/IA	Apr 9, 2018

3.	Publish pre-recorded webinar with additional information about the Semi-Annual Report assessment	IA	Apr 2018
4.	Submit Semi-Annual Reports	ACHs	July 31, 2018
5.	Conduct assessment of reports	IA	Aug 1-25, 2018
6.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Aug 25-30, 2018
7.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Aug 26-Sept 14, 2018
8.	If needed, review additional information within 15 calendar days of receipt	IA	Sept 10-29, 2018
9.	Issue findings to HCA for approval	IA	TBD

Contact Information

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

ACH Contact Information

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

ACH Name:	Pierce County ACH
Primary Contact Name	Alisha Fehrenbacher
Phone Number	(253) 370-9242
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E-mail Address	Meg@piercecountyach.org

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

The following terms are used throughout the document in abbreviated form:

BH	Behavioral Health
BOT	Pierce County ACH Board of Trustees
CBO	Community-based Organization
CCA	Care Coordination Agency
CHW	Community Health Worker
CORE	Center for Outcomes Research and Education (Providence Health and Services)
CVC	Community Voices Council (Pierce County ACH)
DLT	Data and Learning Team (Pierce County ACH)
EHR	Electronic Health Record
HCA	Health Care Authority
HET	Health Engagement Team
HIT/HIE	Health Information Technology/Health Information Exchange
IHI	Institute for Healthcare Improvement
IMC	Integrated Managed Care
IT	Information Technology
MCO	Managed Care Organization
MSS	Maternal Support Services
OBP	Outcome-based Payment
ODD	Opioid Use Disorder
PIP	Provider Integration Panel (Pierce County ACH)
PMP	Prescription Monitoring Program
RHIP	Regional Health Improvement Plan Council (Pierce County ACH)

SAMHSA	Substance Abuse and Mental Health Services Administration
SI	Strategic Improvement
SBIRT	Screening, Brief Intervention and Referral to Treatment
SUD	Substance Use Disorder
TPCHD	Tacoma/Pierce County Health Department
VBP	Value-based Payment

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

1. Milestone 1: Assessment of Current State Capacity **M**

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

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

Yes	No
X	

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

ACH Response:

Not Applicable

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

ACH Response:

In March – June 2018, Pierce County ACH fielded the following assessments with partnering providers:

- Health System/Clinical Organization Assessment
- Community-based Organization (CBO) Assessment
- Health Information Technology/Exchange (HIT/HIE) Assessment
- Community Voice Survey
- Behavioral Health (BH) Billing and Information Technology Toolkit Assessment (Qualis)

The assessments were fielded separately to allow the ACH to tailor items to specific audiences.

Health System/Clinical Organization Assessment

Pierce County ACH fielded a Health System and Clinical Organization Assessment, designed to collect information about partnering providers' current capacity, needs, and readiness to implement Medicaid Transformation efforts. Information from the assessment is being used to:

- Inform ACH of current gaps in the regional health system
- Identify areas of investment to minimize the gaps and achieve the goals of Medicaid transformation
- Introduce a framework for systems transformation within primary care practices, behavioral health clinics, and community-based organizations for a continuum of whole-person care
- Assess the current state of partnering organizations
- Support organizations who complete the assessment in developing an Action Plan for participation in the Medicaid Transformation Project over the next 3 years

The assessment asked respondents about their capacity, needs, and gaps related to the following change concepts: engaged leadership; empanelment for population health management; quality improvement strategy; continuous and team-based healing relationships; organized, evidence-based care; person-family engagement and experience; enhanced access; care coordination; value-based payment; and whole-person care (behavioral health and oral health integration). The assessment was developed by Pierce County ACH with support from the Center for Outcomes Research and Education (CORE). The Provider Integration Panel (PIP) and Regional Health Improvement Planning (RHIP) Council reviewed the assessment survey and provided input on language and terminology, fielding approach, and content.

The assessment was distributed as an online survey to 25 physical and behavioral health organizations across the county. Of those, 19 organizations completed the Clinical Organization Assessment, including 8 that provide physical health services, 17 that provide mental health services, and 12 that provide SUD treatment. Partners were asked to complete the assessment on behalf of their organization by June 15, 2018. CORE completed a draft assessment summary report in late June. The draft report was shared with ACH governance groups in July 2018. The final report will be provided in August 2018.

Assessment key findings include:

- Consistent, strong support for Behavioral Health integration including implementation of evidence-based guidelines, care coordination and referrals among Behavioral Health providers and high levels of engagement
- Key differences exist between Physical Health and Behavioral Health (Mental Health and Substance Use Disorder) providers
- Workforce as a key barrier for transformation efforts, with staff shortages the greatest barrier to Behavioral Health (78%) and oral health integration (67%). Provider and staff turnover are the most frequently cited workforce barriers (90%)
- High provider commitment to quality improvement methods

Health Information Technology / Exchange (HIT/HIE) Assessment

Pierce County ACH distributed a Health Information Technology / Exchange Assessment to partnering providers in April 2018 and gave organizations two months to complete the survey. The assessment was completed by 24 partnering providers, with respondents providing services to the majority of Medicaid enrollees in the region. The respondents were a diverse group: 11 participants provide Physical Health services, 13 provide Mental Health services, and 12 provide Substance Use Disorder (SUD) treatment services.

The survey covered the following sections:

1. Electronic Health Records (EHRs)
2. Health Information Exchange
3. Telehealth and Mobile Applications
4. Population Health Management Systems
5. Other technologies and data sources including health registries and direct/fax data exchange.

The assessment was executed by CORE, and a final summary of the results was delivered to the ACH in late June. Key findings included:

- SUD partnering providers have the biggest gaps in HIE/HIT capacity and functionality
- Prescription Monitoring Program (PMP) use in the region is low with only 29 percent of respondents reporting using the service, although 62 percent of all respondents and 100 percent of SUD partnering providers report that they would like to implement a PMP interface in the next 18 months
- Only 33 percent of partnering providers have implemented a Population Health Management System
- Data exchange largely occurs manually via fax
- Partnering providers are looking to the ACH for assistance, primarily via funding, training and education, and IT support/technical assistance in order to increase their HIE/HIT adoption

Over the summer, the ACH is forming sub-groups of the Data and Learning Team (DLT) and partnering providers to discuss and propose strategies to the Pierce County Board of Trustees (BOT) and address the gaps shared above.

Community-Based Organizational (CBO) Assessment

Pierce County ACH completed an extensive assessment of CBOs throughout the County. The purpose of the assessment was to:

1. Assess the current state of community-based organizations in supporting whole-person care and Medicaid Transformation
2. Inform Pierce County ACH of gaps in regional health, community, and social services
3. Identify areas in which the Pierce County ACH should invest to reduce the gaps and achieve the goals of Medicaid Transformation
4. Introduce a framework for systems transformation within community-based organizations for a continuum of whole-person care
5. Support organizations who complete the assessment in developing an Action Plan for potential participation in the Medicaid Transformation Project

Multiple stakeholders provided input on the development of the assessment itself. Pierce County ACH utilized regional, community-based organization partners, including social services, emergency response, housing, and public health providers. CORE assisted in the design and development of the assessment.

Additionally, a high-level overview of the assessment was presented to the Regional Health Improvement Plan (RHIP) Council, a cross-sector group of leaders and community members who understand the programs and services within the region. During the monthly meeting in May, RHIP Council members provided essential input. They stressed the need for the assessments to be aligned with the cultural and language norms of social services agencies and that it not place an undue burden on the respondents.

CBOs were asked to provide basic information about their organization such as a description of their mission, services offered, people served, staff, etc. The rest of the assessment asked questions about Pierce County ACH's four engines of system change and transformation: Community-Clinical Linkages, Continuous Improvement, Population Health Management and Community-based Care Coordination. In addition to these drivers of change, we asked questions about the change concepts Pierce County ACH has embedded in all of our work:

1. Engaged leadership
2. Quality improvement strategies
3. Building continuous relationships
4. Evidence-based care and/or promising practice
5. Authentic person/family engagement
6. Reducing barriers to care
7. Health equity

Pierce County ACH sent the assessment to CBOs who indicated their intent to partner with Pierce County ACH by submitting a letter of interest last fall and completing their registration in the Washington Financial Executor portal. In addition, potential partners were also sent the assessment.

The Human Service Coalition, Health Systems and government partners also sent the assessment to key stakeholders. For those who had questions or were unsure if they should participate, ACH staff members were available to talk with them about the assessment and the planning process. Those who chose to become new partners were directed to register with the Washington Financial Executor. All those who were registered received a \$5,000 payment for their participation in the planning efforts.

In total, 31 CBOs completed the assessment. Key findings from the assessment summary report include:

- Community-Based Organizations want to partner with health systems. CBOs expressed a desire for stronger partnerships with the region's health systems, emphasizing shared planning and goal-setting above resource sharing or governance activities. Organizations reported high levels of commitment and buy-in from both leadership and staff
- Data capacity varies among organizations. Organizations collect a wide range of demographic and screening data, but this differs on a program-by-program basis. Organizations often lack the ability to link internal data or analyze it comprehensively. Some respondents recommended assessing process improvement and data management capacity at the program rather than organizational level
- Time, budget, and workforce are key barriers. These factors hinder ability to partner with health systems, engage in process improvement, and evaluate impact. Some organizations reported that they currently possess tools or data infrastructure that is underutilized because of staffing constraints

Community Voice Survey

In joint-partnership, the Community Health Worker Collaborative of Pierce County and Pierce County ACH's Community Voice Council (CVC) developed and administered a Community Voice Survey to better understand what motivates people in their communities to be healthy or prevents good health. (The CHWCPC advocates for the Community Health Worker (CHW) workforce to have a critical role in health reform, systems change, and community advocacy.)

Surveys were given to low-income community members who represent a wide variety of vulnerable communities, including people who identify as African American, African, Asian, Eastern European, homeless, Latinx, LGTBQ, Native American. Other included those who have a behavioral health or substance use disorder or chronic disease, and those living in a rural part of the county. One note: after completion of analyzing the survey results, Pierce County ACH will update the categories of respondents to include those who may have been missed.

Responses to the survey were due June 30, 2018. More than 140 surveys were returned. In July, CVC members will review the survey results. The results will inform the criteria used to evaluate the Health Systems and CBOs' Phase 1 Action Plans and the development of their Phase 2 Action

Plan template. The CVC will recommend the criteria to Pierce County ACH staff and Board members so that it may be included in their evaluation of the Phase 1 Action Plans and the development of the Phase 2 Action Plans.

BH Billing and IT Toolkit Assessment (Qualis)

Under the direction of the Provider Integration Panel (PIP), a structured learning and support initiative called the Integrated Managed Care (IMC) Learning Community was created. Using the Qualis Billing and IT Toolkit, a self-assessment template was sent to 17 Behavioral Health partners who provide mental health services and/or SUD treatment for Medicaid populations, as well as BH providers not yet engaged with ACH work. Eleven assessments were returned. Support needs were aggregated to help guide the training and support plan. Preliminary findings include:

- 6 BH organizations are in multiple ACHs
- 4 need historical data from the departing Behavioral Health Organization (BHO)
- 3 use paper charts only
- 9 are upgrading or implementing new EHR's
- 6 do not have a complete Data Transition Plan

The transition support most requested in priority order includes: information systems; billing operations; BHO sunset; staffing; IT support; and contingency planning.

In its beginning stage, Behavioral Health providers were convened by a peer representative from the PIP to discern the needs of BH providers for the IMC transition. Based on this input, the ACH will conduct monthly webinars through December 2018 with topics of interest generated by the Behavioral Health providers. The webinars will be produced and recorded, with a 24-7 option of accessing training and support. Each webinar will allow for peer-to-peer sharing of challenges and further support needs of Behavioral Health providers. Payers including MCOs, the Behavioral Health Organization, and HCA are included as collaborative stakeholders with the ACH to address the support needs of Behavioral Health providers.

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

ACH Response:

Fielding assessments and the formation of Action Plans are dynamic processes undertaken in partnership between the ACH and partnering providers. A majority of the assessments were due in mid-June, therefore Pierce County ACH continues work with its data partner CORE to analyze, report out and respond to assessment results. Some assessment results are still being analyzed and summarized at the time of this Semi-Annual Report.

As the assessment summary reports become available, they are being used to inform project

planning and implementation for each project area, and are also part of a larger, more comprehensive quality improvement and continuous learning capacity that the ACH provides across its portfolio. To highlight some of our key assessment learnings to date, the examples illustrated below show how the assessment and ACH responses or “mitigation strategies” are nested within a larger sequence of actions that deepen the learning collaborative approach to technical assistance, allows reporting for milestones, and sharpens the overall evaluation planning.

The following examples highlight how assessment findings are informing ACH decisions and priorities:

- A strong foundation for Behavioral Health Integration exists in the region and partnering providers are eager to engage in technical assistance and shared learning in advance of the arrival of IMC on January 1, 2019. A strong majority of partnering providers share implemented, evidence-based clinical guidelines and have care teams for populations with behavioral health diagnoses. This finding has led the ACH to further prioritize its IMC Learning Community and seek full engagement from all regional BH providers, in partnership with Pierce County government.
- Partners demonstrate a strong commitment to quality improvement. The majority of organizations (58%) track clinical quality metrics on a monthly basis, and 95% of organizations incorporate quality improvement into their mission, vision, and/or values. This finding has led the ACH to emphasize the availability and value of the Strategic Improvement Team and Improvement Advisors, making them available for technical assistance on any issue of interest to partnering providers.
- Use of the PMP is low among partnering providers in Pierce County. Only 29% of respondents have a PMP interface built into their EHR systems, and only 40% access the PMP independent of their EHR. Interest in PMP interface is high, however, and 62% of all respondents - and 100% of SUD partnering provider respondents - would like to implement a PMP interface within their EHR systems in the next 18 months. This finding has led the ACH to prioritize raising this issue with the Pierce County Opioid Taskforce and elevate PMP usage as a priority for action planning with partnering providers.
- Few Clinical or Health System partners currently have formal processes to refer to a Community Health Worker (11%) and CBOs are eager to partner with Health Systems. This finding has led the ACH to further prioritize community-clinical linkages and the development of the Pierce County ACH “Community HUB”, a system for community-based care coordination that utilizes Community Health Workers and links to the Pathways model. Assessment results highlight the opportunity to scale and sustain these operations and provide value and benefit throughout the region and to additional populations.

The ACH used the Health Systems/Clinical Organizations Assessment as a first step to launch into the action planning phase and to inform the development of subsequent Action Plans individualized by partnering provider.

The initial assessment summary for the HIT/HIE has also been created. For the summary report, the organization responses and reported findings by provider type were aggregated based on the services an organization provides (Physical Health, Mental Health, and SUD treatment). Key findings across respondents and questions were highlighted. In addition to the summary report, aggregate responses for each question and full responses for each organization were both shared. These question responses are being leveraged by ACH staff to dig deeper into key findings from the assessment.

The DLT reviewed the HIT/HIE Assessment report in the June monthly meeting. DLT members were asked to review the full report and provide comments to Pierce County ACH. Additionally, the ACH is forming sub-groups of the DLT over the summer with partnering providers to discuss and propose strategies to the Pierce County Board to address the gaps identified in the survey.

Although the results of the Community Voice Assessment have not been compiled yet, development of the assessment will assist with implementation. Part of CVC's development of a community engagement system is growing deep trust with community members. Too often community members provide information and never learn the results or what was done with their information. This concern was expressed in the planning process. To maintain trust with the people who were surveyed, CVC and the Community Health Worker Collaborative of Pierce County will bring the results of this survey back to the communities with whom they worked.

On a similar note, the CBO Assessment also provided a communication- and relationship-building tool for the ACH to new, potential partners. In working with the Human Service Coalition, Health Systems and government partners, potential partners were referred to the ACH. For those organizations that had questions or were unsure about participation, ACH staff members were available to talk with them about the assessment and the planning process. These meetings provided new networking and partnering opportunities to a broader audience.

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

ACH Response:

Pierce County ACH is partnering with 31 CBOs which have completed the Pierce County organizational assessment. On average, 63% of the clients they serve are Medicaid eligible and include people who are homeless or at risk of being homeless, transitioning from criminal justice systems, in recovery, immigrant, disabled, and experiencing food insecurity. Most of the CBOs that completed the assessment have internal policies that promote equity. Some preliminary statistics about partnering provider CBOs include:

- 62% have policies and procedures that require clients and their families to be engaged in decision-making about their care

- 47% have quality improvement activities. Among those that collect demographic data, more than 50% of the partnering providers collect data regarding gender, age, race, ethnicity, and primary language
- 72% routinely measure client satisfaction.
- 73% have staffing diversity plans that address recruitment and retention of staff, contractors, and/or Board members.
- Most partnering provider CBOs have equity-related staff training requirements, including equity cultural and language diversity (73%), cultural humility (59%), social determinants of health (52%), stigma reduction (42%), and trauma-informed care (41%).

The assessment also revealed a robust human service community where 90% of partnering providers are committed to reducing barriers to care for our most vulnerable populations. CBO partnering providers spanned the spectrum of services, from information and referral to emergency medical assistance, and neighborhood associations. Most are advocates for the people they serve. The vast majority (82%) provide direct services, including care coordination, case management, job training, and counseling. Nearly 50% offer home-based services. More than 66% of the organizations surveyed serve people who are homeless or at risk of being homeless, people with behavioral health conditions, substance use disorders, chronic illness, and those who frequently use hospital emergency departments.

Another example of a community asset is the Tacoma/Pierce County Health Department (TPCHD), which has been a part of national health equity efforts since 2014. One of their staff members was a trainee in the first cohort of the National Health Equity Awaken Leadership Institute. He is identified as a national leader in health equity work and is now a mentor and guide for new participants.

The TPCHD was also an awardee of the Public Health Center for National Innovations. They are a member of a learning community that is discerning how to build healthy communities through public health innovations that empower community members and build equity. In addition, TPCHD has worked to create an organizational culture where difficult equity conversations are the norm. They require all staff to attend a day-long training on racial inequities. They also provide a training on cultural humility for all their front-line staff. Finally, they provide health equity technical assistance to Pierce County organizations to help them develop a Health Equity Plan to operationalize equity within their setting.

Pierce County ACH intends to partner with TPCHD to operationalize health equity and integrate these definitions into our Phase 2 Action Plans for both Health Systems and CBOs.

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

ACH Response:

Some of the steps Pierce County ACH have taken to address health equity include:

1. Utilizing the Board-adopted Health Equity Framework as a tool to support conversations, Action Plan development and incentive planning across the ACH

governance structure, partnerships and national and statewide stakeholders. This has allowed Pierce County ACH to better understand the regional capacity and partner norms around health equity, institutional racism and trauma-informed approaches to care.

2. Developing a deep partnership with:
 - a. The Institute for Healthcare Improvement (IHI), where much of the health equity framework was adapted.
 - b. The CVC partnered with and funded the Community Health Worker Collaborative of Pierce County (CHWCPC) to develop and administer the Community Survey. The CHW Collaborative’s members are CHWs from across Pierce County who work together to advocate for the CHW workforce to have a critical role in health reform, systems change, and community advocacy.
3. Sending several of our key leaders to national forums to further explore how equity is and will be imbedded into Action Plans.
4. Scheduling several workshops to bring in some national experts, including the co-founder of the Triple Aim, John W. Whittington, MD, to design learning collaboratives with equity tracks. This will include both normative and policy/systems improvements for individual Medicaid Transformation Project participants and regional skills building.
5. Partnering with TPCHD to further operationalize health equity and integrate these definitions into our Phase 2 Action Plans for both Health Systems and CBOs.
6. Given the high rates of disparities for Maternal Child Health outcomes in Pierce County among the African American community, the ACH is partnering with Department of Health for funding to support hiring Community Health Workers for the Community HUB who have specific expertise working with this population.

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

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

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

Yes	No
X	

2. If the ACH checked “No” in item B.1, provide the ACH’s rationale for not identifying common gaps, opportunities, and strategies for statewide health system capacity

building. Describe the steps the ACH will take to complete this milestone. If the ACH checked “Yes,” respond “Not Applicable.”

ACH Response:

Not Applicable

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

ACH Response:

The following progress and strategies have been identified during the reporting period for each Domain 1 focus area:

VBP Progress

- Established strong relationship and partnership with county government to stand up IMC Learning Community and provide technical assistance and best practices for VBP to assist Behavioral Health Organizations in the transition to IMC on January 1, 2019
- Fielded Phase 1 Action Plans and Assessments from Clinical partners with content related to VBP readiness and adoption

Strategy Identified: Support partnering providers in building readiness for increased levels of VBP adoption

Workforce Development Progress

- Stood up Strategic Improvement Team including hiring a “Director for Strategic Improvement” and two “Improvement Advisors” to provide technical assistance and expertise to partnering providers for clinical transformation, including addressing workforce barriers identified in assessment results
- Launched live operations of Community HUB, including expansion of Community Health Worker workforce. Establishing regional software and infrastructure to build financial and operational sustainability
- Fielded Phase 1 Action Plans and Assessments from partnering providers with content related to workforce development needs and barriers
- The CHW Collaborative is increasing the Science of Improvement capacity through supporting partners in the IHI IA Professional Development program and virtual QI essentials
- The ACH has been working closely with the Department of Health to develop and

implement a CHW workforce development strategy that builds on the recommendations of Healthier Washington’s CHW Taskforce.

Strategy Identified: Support partnering providers to better address barriers to workforce development as identified by assessment results

Population Health Management:

- Launched live operations of Community HUB and established a regional software platform and future interface for community-level Population Health Management with focus on social determinants of health and care coordination
- Fielded Phase 1 Action Plans and Assessments from partnering providers with content related to Population Health Management system capacity

Strategy Identified: Increase regional capacity among clinical and CBO partnering providers for Population Health Management systems

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

ACH Response:

VBP:

Results of the Health Systems/Clinical Organization Assessment indicate a majority of partnering providers expect their proportion of Medicaid patients and level of adoption of VBP in contracting to increase in the coming 12 months. The barriers to further adoption most commonly cited include lack of interoperable data systems, lack of access to comprehensive data on patient populations and lack of availability of timely patient/population cost data. These results correspond to those reported in earlier surveys and related in the Project Plan.

Based on these ongoing assessment findings for VBP, Pierce County ACH has adjusted its Domain 1 strategies in the following ways:

- Disseminated recent assessment findings throughout the community via governance groups and public opportunities to coalesce stakeholders around addressing barriers to further VBP adoption, serving as “convener, educator and developer of regional strategy”
- Prioritized provider access to regional HIT/HIE resources capable of providing partnering providers with further population and cost data
- Further prioritized visibility and reach of IMC Learning Community including technical assistance for Behavioral Health providers with contracting and pricing for services, standardized billing and reporting workflows and processes, and developing payment models for specialty services

- Working with MCO's to develop payment models for Community HUB, based on clinical and quality outcomes, shared savings and community and health system investment to link social determinants of health and clinical services across a continuum of care and allow for braided funding to create a sustainable community asset into the future

Workforce Development:

According to the Health Systems/Clinical Organization Assessment, workforce issues are a key barrier to transformation. Staff shortages were identified as key barriers to behavioral health integration (78% of partnering providers reporting) and oral health integration (68% of partnering providers reporting). Provider/staff turnover was the most frequently-cited workforce barrier (90% of partnering providers reporting.) In addition, only half of Physical Health partnering providers reported hiring Community Health Workers or other Peer Specialists, whereas 92% of Substance Use Disorder partnering providers and 82% of Mental Health serving organizations responded affirmatively. Barriers to further employment of Community Health Workers or Peer Specialists included funding uncertainty (85%) and finding qualified candidates (77%). Based on the preliminary assessment findings for workforce development, Pierce County ACH has adjusted its Domain 1 strategies in the following ways:

- Disseminated recent assessment findings throughout the community via governance groups and public opportunities to coalesce stakeholders around addressing common needs for the “identification of a necessary workforce”
- Further prioritized strategies for “Improving Joy in Work” as the Strategic Improvement Team provides technical assistance to partnering providers
- Work to engage with local Pierce County Workforce Development Council and other statewide resources for consultation given recent assessment results and “consideration and prioritization of statewide and regional innovations”
- Prioritize support for and creation of a robust Community Health Worker workforce through scale and spread of the Community HUB model, including Pathways
- Support interested partnering providers in building out plans for expanding local residency programs in the formation of Phase 2 Action Plans during Fall, 2018

Population Health Management Systems:

Results of the HIT/HIE Assessment indicate Population Health Management system capacity is low in Pierce County, with only 33% of respondents reporting the use of a Population Health Management system. Roughly half (54%) reported the use of registries for various client populations or conditions. For Population Health Management, Pierce County ACH has adjusted its Domain 1 strategies in the following ways in response to these assessment findings:

- Disseminate recent assessment findings throughout the community via governance groups and public opportunities to coalesce stakeholders around addressing barriers to further Population Health Management System use

- Further prioritize visibility and reach of IMC Learning Community including technical assistance for Behavioral Health providers with empanelment and network adequacy and developing common quality definitions and measurements
- Analysis of assessment results by DLT governance body to provide recommendations for action going forward

Further engage Strategic Improvement Team and Improvement Advisors with partnering providers to identify opportunities for population health management approaches in daily operations

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

ACH Response:

At the current time, Pierce County ACH does not require additional support from the state. However, Pierce County ACH considers its state partners key drivers for systems transformation, building community/clinical linkages, and achieving sustainability. Close collaborations exist with the State Department of Health on CHW workforce development, practice transformation, community engagement, e-learning through the Washington Portal, chronic disease, and opioid prevention and mitigation. The Department of Social Health and Services continues to be a partner in co-designing community/clinical linkages via the Community HUB, specifically for the dual-eligible populations, with a focus on transitions of care. In addition, partnerships continue with the Department of Early Learning to better understand how to integrate home visiting programs into the overall transformation plan for the region. Finally, the HCA remains an essential partner on the programmatic side for MSS, Health Homes, and Community-Based Care Coordination. A series of workshops was recently held with the three sister agencies to ensure alignment of programs and resources for whole-person, community-based health. These conversations resulted in agreements to move forward as partners in a pilot for Health Engagement Team (HET) under the Community HUB model.

Pierce County ACH appreciates the consistent willingness of state staff to participate in either scheduled or ad-hoc discussions. Having state partners attend ACH meetings, the bi-weekly Development Council calls, Data and HIT/HIE calls, the Pierce County IMC Learning Community, along with all the other programmatic issues that come up consistently provides much value. Pierce County ACH is grateful for the partnership and assistance.

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

For this milestone, the ACH should either:

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

Or,

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

1. Medicaid Transformation Approaches and Strategies

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

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

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

2. Target Populations

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

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

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

3. Expansion or Scaling of Transformation Strategies and Approaches

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

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

1. Transformation Strategies and Approaches

Pierce County ACH is implementing a portfolio approach, fusing all project areas together and incentivizing partnering providers to engage in transformational activities through the formation of Action Plans. The specific approaches employed for Project 2A comes directly from the Pierce County ACH Rules of Engagement, a set of strategies and approaches designed in collaboration with Pierce County ACH’s governance bodies and embedded within the Action Plans. The Rules of Engagement includes setting a goal for level of integration along a continuum of the SAMHSA scale, allowing for incremental transformation from minimal collaboration to full collaboration over the course of the Medicaid Transformation Project. Partnering providers, both clinical and non-clinical, commit to the activities they select and implement the Action Plan starting January 1, 2019 with updates in subsequent years. The following activities are outlined for project area 2A and the evidence-based strategy chosen is the Collaborative Care model:

Transformation Activities Required of Clinical ACH Partnering Providers:

(as taken from the Pierce County ACH Phase 1 Action Plan template)

Partnership Accelerator Framework:

- Identify actions, policies and initiatives to advance along spectrum of partnerships continuum (financial incentives provided in funds flow framework)

Health Equity Accelerator Framework:

- Identify actions, policies and initiatives to advance along spectrum of health equity continuum (financial incentives provided in funds flow framework)

Engaged Leadership:

- Assign behavioral and primary care integration project to a multi-disciplinary team

Quality Improvement Strategy:

- Choose a formal model for quality improvement to drive systems changes for Behavioral Health/Physical Integration (IHI Model for Improvement recommended)

Sustainable Business Operations:

- For Behavioral Health partnering providers, develop a plan to transition to IMC payment model
- Develop a plan to transition to VBP arrangements

Person/Family Engagement:

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- Utilize the Pierce County ACH's CVC for Phase 1 Action Plan feedback

Transformation Activities for Selection by Clinical ACH Partnering Providers:

Empanelment:

- If co-located, test and implement the integration of behavioral health and physical health care panel management
- If not co-located, test and implement a standard process for sharing registries, gaps in care, and patient population outcomes across physical and behavioral health organizations

Continuous and Team-based Healing Relationships:

- Define team roles including those who support patients directly or indirectly and communicate roles to patients
- Plan and implement a training program on integration and clinical/therapy skills for primary care and behavioral healthcare staff
- Assess training needs of care team and implement a training plan with emphasis on stigma reduction, trauma-informed care, cultural and language diversity, health literacy, and motivational interviewing
- Integrate Community Health Workers or Peer Specialists in the care team

Organized, Evidence-based Care

- Identify level of integration using the SAMHSA/HRSA Center for Integrated Health Solutions Six Levels of Integration
- Provide Collaborative Care Model Attestation
- Achieve provider-level Collaborative Care model certification
- Identify 2 or more validated screening tools to adopt for behavioral health conditions, and/or substance use disorder
- Develop the process for sharing the care plan within and/or across organizations
- Define high-risk populations with behavioral health conditions and/or co-occurring chronic disease, and assure continuity of care/treatment between behavioral and physical healthcare providers

Person/Family Engagement:

- Develop/implement or improve process for engaging patients in decision making in the plan of care

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- Provide self-management support at every visit through goal setting, action planning, and follow-up
 - Obtain feedback from patient/family about their healthcare experience. Use this information for quality improvement
 - Review how the organization communicates with patients for culturally-appropriate and/or health literacy-level communication
 - Integrate Community Health Workers for person/family engagement
- Enhanced Access:*
- Promote and expand access by assuring established patients have 24/7 access to their care team via phone, email, telehealth, and/or in-person visits
 - Provide scheduling options that are patient- and family-centered and accessible to all patients
 - Integrate usage of Community Health Workers/Peer Support Specialists in the care team (i.e. ensuring appointments are kept)
 - Implement telehealth programs that enhance access
- Care Coordination:*
- Develop/implement or improve follow-up with patients upon discharge from emergency department, urgent care or hospital
 - Partner with CBOs for innovative care transitions (i.e. EMS, Community Paramedicine, Community Health Workers)
 - Partner with CBOs for innovative diversion strategies (i.e. criminal justice, jails, county, Crisis Triage Center, Mobile Community Intervention Response Team)
 - Participate in Health Information Exchange platforms that support sharing across organizations
 - Develop document referral, care plan exchange and follow-up processes with key ‘Medical Home Neighborhood’ organizations, which may include specialty care, dental services, pharmacies, EMS, schools, criminal justice system and CBOs
 - Implement referrals to the Pierce County ACH Community Pathways HUB
 - Become a Care Coordination Agency (CCA) for the Pierce County ACH Community Pathways HUB. Determine target populations of interest.

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	<p><u>Transformation Activities Required for Non-Clinical ACH Partners:</u></p> <p>CBOs action planning framework uses a systems-change approach to support a transformed health system and changed care delivery by strengthening the link between community and clinical systems and reducing barriers to care. They are required to:</p> <ul style="list-style-type: none"> • Identify target population • Identify how proposed project design aligns with the Pierce County ACH projects (e.g., prevention and management of behavioral health challenges, chronic conditions and/or opioid misuse) and connects with health systems • Implement a process to engage clients and, where appropriate, family members in decision-making • Reduce barriers to care • Partner with health systems who serve the identified target population • Develop quality improvement and evaluation processes and metrics • Develop and implement actions, policies, and initiatives to advance partnerships with Health Systems and promote health equity
<p>1. Target Populations</p>	<p>Medicaid beneficiaries (children and adults) with a diagnosed behavioral health disorder (approximately 82,000 individuals, about half of whom also have a co-morbid chronic health condition), or those at risk for behavioral health conditions, including mental illness and/or substance use disorder. Health system partners have the option of further defining their population in the formation of their Action Plan.</p>
<p>2. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>Clinic partners will update their Action Plan on an annual basis, in consultation with the ACH, thus allowing for sustainability, spread, and ongoing process improvement for increasing levels of integration.</p> <p>In advance of the transition to IMC on January 1, 2019, Pierce County ACH launched an IMC Learning Community where the ACH is convening stakeholders in a shared learning approach to prepare for the regional transition in funding for Behavioral Health services. Members who choose to join the Network are encouraged to take the Qualis Billing and IT Self-Assessment. An in-person kickoff event took place in June and the Learning Community now convenes monthly, interactive learning webinars geared toward preparing partnering providers for the shift to IMC. The webinars cover a</p>

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wide range of topics including presentations from providers who have pioneered this transition in other counties, presentations from MCO's outlining their approach, and shared space to discuss tactical work, barriers, and challenges towards IMC transition. One-on-one consultation for contracting and analysis of quality measures, technical IT support, billing processes, and workflow analysis is available as technical assistance through the ACH as needed.

Planning for scaling of the Community HUB model for care coordination will occur over the course of 2018 and connect several other programs and workstreams to the software platform as the Community HUB. These include establishing a deeper level of care coordination partnering with Health Systems and operationalizing multi-disciplinary HET. These teams will work in collaboration with existing services, such as Health Homes and MSS, to assure successful engagement in care and services for persons not currently engaged and identified as high-cost and rising-risk, including those with behavioral health diagnoses or risk factors.

Finally, Pierce County ACH is finalizing an evaluation and monitoring plan with CORE that will provide ongoing and rigorous monitoring of key implementation and outcome markers related to this project. We are committed to using data from this monitoring and evaluation system in support of the Learning Community activities. To support our efforts to scale and spread our transformation strategies, we will target additional efforts or resources at places or populations where the data suggest implementation challenges may exist. We expect monitoring and evaluation of our work associated with this project to begin in Fall 2018.

Project 2B: Care Coordination

1. Transformation Strategies and Approaches

During the planning phase, Pierce County ACH and its governance bodies committed to the Community HUB, including the Pathways Model, to fulfill an anchor strategy of improving community-clinical linkages and better aligning community care coordination efforts in our region. By serving as the HUB, Pierce County ACH provides a centralized platform for Health Information Exchange, and implements an outcomes-based approach to coordination of care, supported by a robust software platform and detailed analytics. Pierce County ACH is pursuing national certification as a Pathways HUB, assuring fidelity to the model, including actively assessing all participant risk factors and working from all 20 standard Pathways to better address challenges and needs, particularly in the areas of Social Determinants of Health.

In March 2018, Pierce County ACH launched live operations as the Community HUB for Pierce County. The launch included securing a contract for the cloud-based Care Coordination Systems software platform and establishing contractual relationships and related agreements with four Care Coordination Agencies to hire a cohort of 8 Community

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Health Workers and participate in implementation. Additionally, Pierce County ACH engaged Blue Orange, a compliance firm to advise on matters of HIPAA and security during implementation and ongoing operations. All Community Health Workers and their Supervisors attended two weeks of in-person training provided by the Pathways Community HUB Institute (PCHI), including an extended practicum period at their home sites. Work with clients began immediately following completion of the training. Finally, an evaluation plan specific to this Phase One Pilot is in place with data partners, CORE.

CCA partners include:

- Community Health Care: A Federally-qualified Health Center (FQHC) with operations throughout Pierce County
- Hope Sparks: A partnering provider of pediatric behavioral health and other support services to children and families
- Korean Women's Association: A CBO working with diverse communities across Pierce and neighboring counties
- Sea Mar Community Health Centers: An FQHC with operations throughout Pierce County and multiple counties in Western Washington

Pierce County ACH provided baseline financial support to these partners for the initial phases of implementation, with guaranteed ACH support decreasing over 2018 while their financial risk increases with 100% of earnings dependent on performance in closing Pathways and earning Outcome-based Payments (OBP's) by December 2018. Overall agency performance is reviewed with administrative staff and leadership on a periodic basis to assure fiscal monitoring and continued maximum performance. Upon launching, a period of sustained engagement took place with providers also serving the target population, including MSS and Nurse Family Partnership. This engagement resulted in bi-directional referral networks and collaboration among multiple programs, innovations that continue today. With 8 Community Health Workers and an average case load of 30 women, the program intends to engage a rolling total of 250 women at any one time. Current referral totals have reached over 100 and more than 750 Pathways have been initiated. MSS and other providers with frequent contact with the target population, have signed agreements as referral partners and received log-in information to consent clients and input their referral information directly into the system, instantly populating client data the HUB staff to use to refer out to CCA partners.

The cohort of Community Health Workers and their Supervisors gather on a weekly basis with Pierce County ACH Community HUB staff to troubleshoot issues, perform process improvement activities and receive presentations on

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	<p>various community resources and programs of potential benefit to clients. Pierce County ACH staff, including the Clinical HUB Manager, meet individually with CCA Supervisors to review performance and provide clinical quality improvement feedback and education. The Care Coordination Systems software platform includes robust reporting capabilities. Pierce County ACH monitors metrics through a weekly Key Performance Indicator report to assure positive trends for individual CHW performance and overall HUB operations.</p> <p>Successful launch and implementation of the Phase One Pilot offers Pierce County ACH and its partners the opportunity to establish operations for subsequent scaling and sustaining to other populations and settings. Pierce County ACH HUB staff have quickly grown their expertise working in the software system and effectively implementing the Pathways model in collaboration with partners. The learnings gained from the pilot will facilitate regional systems transformation in the future.</p>
<p>2. Target Populations</p>	<p>The Phase One Pilot of Community HUB targets pregnant women and their newborn children enrolled in or eligible for Medicaid, residing in Pierce County and with one of the following risk factors:</p> <ul style="list-style-type: none"> • A Behavioral Health diagnosis or concern • Active substance use, including tobacco • A prior or current pregnancy complication including low birth weight, premature birth, or fetal death <p>Services are provided to pregnant women and their newborn children until 2 months postpartum when they may qualify for Infant Case Management and the second well-child check should be completed. Community Health Workers encourage engagement with all eligible services throughout pregnancy and after birth, including MSS, Early Head Start and others. Community Health Workers also assure continuity of care and engagement in other support services for participants as they transition out of the Pathways pilot. The period of service duration exists for the purposes of service uniformity and evaluation necessary for the Phase One Pilot.</p>

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<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>Planning for scaling of the Community HUB model will occur over the course of 2018 and connect several other programs and workstreams to the software platform as the Community HUB. These include establishing a deeper level of care coordination partnering with Health Systems and operationalizing a multi-disciplinary HET. These teams will work in collaboration with existing services, such as Health Homes and MSS, to assure successful engagement in care and services for persons not currently engaged and identified as high-cost and rising-risk.</p> <p>Pierce County ACH is also finalizing an evaluation and monitoring plan with CORE that will provide ongoing monitoring of key implementation and outcome markers related to this project. Data from this monitoring and evaluation system will support the expansion and scaling of our approaches by helping identify challenges and allowing us to “smart-target” additional efforts or resources at places or populations where implementation or spread is encountering challenges. We expect monitoring and evaluation of work related to this project to begin in Fall 2018.</p>
<p>Project 2C: Transitional Care</p>	
<p>1. Transformation Strategies and Approaches</p>	<p>Not Applicable</p>
<p>2. Target Populations</p>	<p>Not Applicable</p>
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>Not Applicable</p>
<p>Project 2D: Diversion Interventions</p>	

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1. Transformation Strategies and Approaches	Not Applicable
2. Target Populations	Not Applicable
3. Expansion or Scaling of Transformation Strategies and Approaches	Not Applicable

Project 3A: Addressing the Opioid Use Public Health Crisis

1. Transformation Strategies and Approaches	<p>Pierce County ACH is implementing a portfolio approach fusing all project areas together and incentivizing partnering providers to engage in transformational activities through the formation of Action Plans. The specific approaches employed for Project 3A come directly from the Pierce County ACH Rules of Engagement, a set of strategies and approaches designed in collaboration with Pierce County ACH’s governance bodies and embedded within the Action Plans. Partnering providers, both clinical and non-clinical, commit to the tactics they select and implement the Action Plan starting January 1, 2019. The following tactics are outlined for project area 3A:</p> <p><u>Transformation Activities Required of ACH Clinical Partnering Providers:</u> (as taken from the Pierce County ACH Phase 1 Action Plan template)</p> <p><i>Partnership Accelerator Framework:</i></p> <ul style="list-style-type: none"> • Identify actions, policies and initiatives to advance along spectrum of partnerships continuum (financial incentives provided in funds flow framework) <p><i>Health Equity Accelerator Framework:</i></p> <ul style="list-style-type: none"> • Identify actions, policies and initiatives to advance along spectrum of health equity (financial incentives provided
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in funds flow framework)

Engaged Leadership:

- Assign Opioid Misuse Disorder Treatment to a multi-disciplinary team

Quality Improvement Strategy:

- Choose a formal model for quality improvement to drive systems changes for Opioid Misuse Treatment (IHI Model for Improvement recommended)

Sustainable Business Operations:

- For Behavioral Health partnering providers, develop a plan to transition to IMC payment model
- Develop a plan to transition to VBP arrangements

Person/Family Engagement:

- Utilize the Pierce County ACH's CVC for Phase 1 Action Plan feedback

Activities for Selection by Clinical Partnering Providers:

Empanelment:

- Test and implement a standard process for reviewing panel level data on patients with Opioid Misuse Disorder and/or patients who are prescribed opioids
- Use panel data and registries to proactively contact, educate and track patients with Opioid Misuse Disorder and/or patients who are prescribed opioids
- For non-co-located partnering providers, test and implement a standard process for integrated treatment plans that are accessible to all providers
- Develop, implement or improve processes that support continuity of care for all screening, treatment and follow-up needed by patients who have Opioid Misuse Disorder

Continuous and Team Based Healing Relationships:

- Define team roles including those who support patients with Opioid Misuse Disorder or who are prescribed opioids. Communicate roles to patients
- Assess training needs of care team and implement a training plan with emphasis on stigma and trauma reduction, trauma-informed care, cultural and language diversity, health literacy, motivational interviewing and

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Opioid Misuse Disorder treatment and prevention

- Provide training opportunities for Medically-assisted Treatment for partnering providers and care team members
- Consider integration of Community Health Workers or Peer Specialists in the care team

Organized, Evidence-Based Care

- Implement Guidelines on Prescribing Opioids for Pain and Substance Use During Pregnancy, (SAMHSA)
- Implement Washington State Medical Director's Group Interagency Guidelines on Prescribing Opioids for Pain
- For Emergency Departments, Implement Washington Emergency Department Opioid Prescribing Guidelines
- Integrate Decision Support Tools in the EHR
- Implement validated substance use screening such as SBIRT including evaluation for Medically Assisted Treatment
- Register providers with the PMP
- Integrate PMP with the EHR
- Evaluate appropriateness of co-prescribing Naloxone for pain patients

Person/Family Engagement:

- Develop/implement or improve process for engaging patients in decision making in plan of care
- Provide self-management support at every visit through goal setting, action planning and follow-up
- Obtain feedback from patient/family about their healthcare experience and use this information for quality improvement
- Review how the organization communicates with patients for culturally appropriate and/or health literacy-level communication
- Integrate Community Health Workers for person/family engagement

Enhanced Access:

- Promote and expand access by assuring established patients have 24/7 access to their care team via phone, email telehealth, and/or in-person visits
- Provide scheduling options that are patient- and family-centered and accessible to all patients

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- Integrate usage of Community Health Workers/Peer Support Specialists in the care team (i.e. ensuring appointments are kept)
- Implement telehealth programs that enhance access

Care Coordination:

- Develop/implement or improve follow-up with patients upon discharge from Emergency Department, urgent care or hospital
- Partner with CBOs for innovative care transitions (i.e. EMS, Community Paramedicine, Community Health Workers)
- Partner with CBOs for innovative Diversion strategies (i.e. criminal justice, jails, county, Crisis Triage Center, Mobile Community Intervention Response Team)
- Participate in Health Information Exchange platforms that support sharing across organizations
- Develop document referral, care plan exchange and follow-up processes with key ‘Medical Home Neighborhood’ organizations, which may include specialty care, dental services, pharmacies, EMS, schools, criminal justice system and CBOs
- Implement referrals to the Pierce County ACH Pathways through the Community HUB
- Become a CCA for the Pierce County ACH Community HUB. Determine target populations of interest.

Community Based Organizations:

CBOs action planning framework uses a systems-change approach to support a transformed health system and changed care delivery by strengthening the link between community and clinical systems and reducing barriers to care. They are required to:

- Identify target population
- Identify how proposed project design aligns with the Pierce County ACH projects (e.g., prevention and management of behavioral health challenges, chronic conditions and/or opioid misuse) and connects with health systems
- Implement a process to engage clients and, where appropriate, family members in decision-making,

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- Reduce barriers to care,
- Partner with health systems who serve the identified target population,
- Develop quality improvement and evaluation processes and metrics,
- Develop and implement actions, policies, and initiatives to advance partnerships with health systems and promote health equity

Community-Level Opioid Leadership Role:

Pierce County ACH serves as a regional leader and convener for opioid policy on a community level. Local stakeholders in the county including the county council, county Human Services, the Tacoma/Pierce County Health Departments, MCO's, providers across physical/behavioral/substance-abuse settings, and provider administrators came together to form the Pierce County Opioid Task Force which is co-led by the ACH. This group developed an impressive slate of draft strategies successfully vetted at a Pierce County Opioid Summit in early 2018. The ACH is working closely with TPCHD to support the work of this task force. The next meeting is scheduled for July 18 and next steps include forming action teams by sector and issue to pursue work in smaller groups.

2. Target Populations

In Pierce County, there are 34,517 Medicaid beneficiaries who use opioids (defined as members with at least one opioid prescription). Nearly 90 percent of those members do not have a cancer diagnosis. Twenty percent are defined as heavy opioid users and 18 percent are chronic opioid users. The preliminary target population includes: Medicaid beneficiaries who use opioids, particularly those with OUD who are not receiving medication assisted therapy (MAT). In each of the four categories of focus, Pierce County ACH will target the following groups:

- Prevention: Approximately 180,000 Medicaid beneficiaries receiving care through partnering providers will receive broad prevention efforts, such as education and prescribing guidelines. Within that group, focus will be on people at risk of transitioning from appropriate use of opioids to chronic use, including the roughly 34,000 Medicaid enrollees with an opioid prescription.
- Treatment: Approximately 6,500 Medicaid beneficiaries with OUD.
- Overdose Prevention: Medicaid beneficiaries with an opioid prescription who are evaluated for a naloxone co-prescription, including approximately 6,870 Medicaid beneficiaries who have high- dose prescriptions, and 6,890 chronic opioid users; and the approximately 2,812 people who inject heroin and do not have ready access to

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	<p>treatment or are not ready for recovery.</p> <ul style="list-style-type: none"> Recovery: Medicaid beneficiaries in recovery, with a focus on those at risk for relapse, including the roughly 500 beneficiaries who receive MAT with buprenorphine, 1,075 who receive MAT with methadone, and those who have recently completed inpatient treatment.
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>Clinic partners will update their Action Plan on an annual basis, in consultation with the ACH, thus allowing for sustainability, spread, and ongoing process improvement for addressing the opioid public health crisis.</p> <p>Pierce County ACH launched a Community HUB pilot with an initial target population of pregnant women to increase community-clinical linkages through implementation of a central software infrastructure and risk-based interventions for resources and referrals by Community Health Workers. A review of pregnant women already engaged with the program showed 19 out of 111 (17%) reported current or past opioid involvement. Future plans to scale and sustain these efforts include targeting opioid-involved individuals specifically as a target population in DY3, as indicated in the Project Plan.</p> <p>Pierce County ACH is also finalizing an evaluation and monitoring plan with CORE that will provide ongoing monitoring of key implementation and outcome markers related to this project. Data from this monitoring and evaluation system will support the expansion and scaling of our approaches by helping identify challenges and allowing us to “smart-target” additional efforts or resources at places or populations where implementation or spread is encountering challenges. We expect monitoring and evaluation of work related to this project to begin in Fall 2018.</p>
<p>Project 3B: Reproductive and Maternal/Child Health</p>	
<p>1. Transformation Strategies and Approaches</p>	<p>Not Applicable</p>

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2. Target Populations	Not Applicable
3. Expansion or Scaling of Transformation Strategies and Approaches	Not Applicable
Project 3C: Access to Oral Health Services	
1. Transformation Strategies and Approaches	Not Applicable
2. Target Populations	Not Applicable
3. Expansion or Scaling of Transformation Strategies and Approaches	Not Applicable
Project 3D: Chronic Disease Prevention and Control	
1. Transformation Strategies and Approaches	Pierce County ACH is implementing a portfolio approach fusing all project areas together and incentivizing partnering providers to engage in transformational activities through the formation of Action Plans. The specific tactics employed for Project 3D come directly from the Patient Centered Medical Home Model and the Pierce County ACH Rules of Engagement, a set of strategies and approaches designed in collaboration with Pierce County ACH’s governance bodies and embedded within the Action Plans. Partnering providers, both clinical and non-clinical, commit to the tactics they select and implement the Action Plan starting January 1, 2019, with updates in subsequent years.

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Pierce County ACH's Chronic Disease Prevention and Control Project will be focused on implementation of Wagner's evidence-based Chronic Care Model across care settings for targeted populations based on partnering provider Action Plans that will set the populations. The project is centered on the following drivers of change: Adoption of Pierce County ACH's Transformation Rules of Engagement ensuring consistent guidelines across regional partners; implementation of Chronic Disease Self-management (CDSM) interventions; provision of support for effective complex care and disease management for targeted populations (scaling and spreading as interventions begin to work in the initial targeted populations); utilization of Community Voice Council, PIP and RHIP Council.

Clinical partners will be held accountable to the following change concepts: engaged leadership; empanelment for population health management; quality improvement strategy; continuous and team-based healing relationships; organized, evidence-based care; person-family engagement and experience; enhanced access; care coordination; value-based payment; and whole-person care with a focus on the following priority populations outlined below. Each demonstration participant will be incentivized through milestone payments to work with the non-clinical partners for Chronic Disease Prevention and Mitigation.

Health equity has been a foundational element of Pierce County ACH's design and planning and individuals facing the greatest health disparities inform the assessment of priorities. Partnering providers are being held accountable to addressing and maintaining equity in their delivery of services and interventions. Pierce County ACH's Community Care HUB, that includes Pathways, is a critical asset for the successful pursuit of improved health outcomes for individuals at risk for chronic disease. The following tactics are outlined for project area 3D where Pierce County ACH selected Wagner's Chronic Care Model as the evidence-based approach:

Transformation Activities Required of ACH Clinical Partnering Providers:

(as taken from the Pierce County ACH Phase 1 Action Plan template)

Partnership Accelerator Framework:

- Identify actions, policies and initiatives to advance along spectrum of partnerships continuum (financial incentives provided in funds flow framework)

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Health Equity Accelerator Framework:

- Identify actions, policies and initiatives to advance along spectrum of health equity continuum (financial incentives provided in funds flow framework)

Engaged Leadership:

- Assign a Chronic Disease Management project to a multi-disciplinary team

Quality Improvement Strategy:

- Choose a formal model for quality improvement to drive systems changes for Chronic Disease Management (IHI Model for Improvement recommended)

Sustainable Business Operations:

- For Behavioral Health partnering providers, develop a plan to transition to IMC payment model
- Develop a plan to transition to VBP arrangements

Person/Family Engagement:

- Utilize the Pierce County ACH's CVC for Phase 1 Action Plan feedback

Transformation Activities for Selection by ACH Clinical Partnering Providers:

Empanelment:

- Implement/improve a process for reviewing panel-level data for patients with chronic disease and/or who are at risk for chronic disease
- Use panel data and registries to proactively contact, educate and track patients with chronic disease

Continuous and Team Based Healing Relationships:

- Define team roles including those who support patients with diabetes either directly or indirectly and communicate roles to patients
- Assess training needs of care team and implement a training plan with emphasis on stigma and trauma reduction, trauma-informed care, cultural and language diversity, health literacy, motivational interviewing and Opioid Misuse Disorder treatment and prevention
- Provide training opportunities for Medically-assisted Treatment for providers and care team members

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- Consider integration of Community Health Workers or Peer Specialists in the care team

Organized, Evidence-Based Care

- Implement Guidelines for Prescribing Opioids for Pain and Substance Use During Pregnancy (SAMHSA)
- Implement Washington State Medical Director's Group Interagency Guidelines on Prescribing Opioids for Pain
- Implement Washington Emergency Department Opioid Prescribing Guidelines for emergency departments
- Integrate Decision Support Tools in the EHR
- Implement validated, substance use screening such as Screening, Brief Intervention and Referral to Treatment (SBIRT), including evaluation for Medically-assisted Treatment
- Register providers with the PMP
- Integrate PMP with the EHR
- Evaluate appropriateness of co-prescribing Naloxone for pain patients

Person/Family Engagement:

- Develop/implement or improve process for engaging patients in decision making in plan of care
- Provide self-management support at every visit through goal setting, action planning and follow-up
- Obtain feedback from patient/family about their healthcare experience and use this information for quality improvement
- Review how the organization communicates with patients for culturally appropriate and/or health literacy-level communication
- Integrate Community Health Workers for person/family engagement

Enhanced Access:

- Promote and expand access by assuring established patients have 24/7 access to their care team via phone, email telehealth, and/or in-person visits
- Provide scheduling options that are patient- and family-centered and accessible to all patients
- Integrate usage of Community Health Workers/Peer Support Specialists in the care team (i.e. ensuring appointments are kept)

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- Implement telehealth programs that enhance access

Care Coordination:

- Develop/implement or improve follow-up with patients upon discharge from emergency department, urgent care or hospital
- Partner with CBOs for innovative care transitions (i.e. EMS, Community Paramedicine, Community Health Workers)
- Partner with CBOs for innovative diversion strategies (i.e. criminal justice, jails, county, Crisis Triage Center, Mobile Community Intervention Response Team)
- Participate in Health Information Exchange platforms that support sharing across organizations
- Develop document referral, care plan exchange and follow-up processes with key “Medical Home Neighborhood” organizations, which may include specialty care, dental services, pharmacies, EMS, schools, criminal justice system, and CBOs
- Implement referrals to the Pierce County ACH Community HUB
- Become a CCA for the Pierce County ACH Community HUB. Determine target populations of interest.

In addition, by serving as the HUB, Pierce County ACH provides a centralized Care Traffic Control with a platform for Health Information Exchange and implementing an outcomes-based approach to coordination of care, supported by a robust software platform and detailed analytics. Below is a set of tactics specific to implementation of the Community Care HUB.

Care Traffic Control

- Assess regional care coordination efforts and identify and recruit partners and stakeholders for community HUB that includes HET (clinical care coordination, transitions, and diversion) linked with Pathways (Social Determinants of Health)
- Identify and develop technology platform to facilitate cross-system coordination and information sharing, and develop a process for data governance
- Develop community-wide processes and norms for care coordination
- Implement community HUB to facilitate Health Information Exchange with additional data streams

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Health Engagement Team

- Pilot HET model for persons and families who need deep, community-based, team-based care coordination for priority populations outlined below
- Identify HET pilot target population. Potentially to focus on opioid, chronic disease, dual diagnosis, and long-term care target populations
- Conduct request for proposal (RFP) process to identify key health systems and community-based partners for HET pilot
- Build technology infrastructure, such as adapting HUB technology platform for HET pilot and connecting to provider EHR systems

Transformation Activities Required for Non-clinical ACH Partners:

CBOs action planning framework uses a systems-change approach to support a transformed health system and changed care delivery by strengthening the link between community and clinical systems and reducing barriers to care. They are required to:

- Identify target population
- Identify how proposed project design aligns with the Pierce County ACH projects (e.g., prevention and management of behavioral health challenges, chronic conditions and/or opioid misuse) and connects with Health Systems
- Implement a process to engage clients and, where appropriate, family members in decision-making
- Reduce barriers to care
- Partner with Health Systems who serve the identified target population
- Develop quality improvement and evaluation processes and metrics
- Develop and implement actions, policies, and initiatives to advance partnerships with health systems and promote health equity

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2. Target Populations

Pierce County ACH has used a multi-phase process to identify target populations for this project. With the support of CORE and Pierce County ACH’s DLT Workgroup, council members were asked to identify populations according to need and potential impact. Based on the assessments and data, these set of priority populations with multiple chronic care conditions were identified for Pierce County:

- Adults with diabetes (particularly Type 2)
- Children and adults with obesity
- Children and adults with asthma/chronic obstructive pulmonary disease (COPD)
- Adults with hypertension and cardiovascular disease

Targeted populations are chosen by partnering providers and outlined in Action Plans. Additional populations will be considered in later years as interventions prove successful.

3. Expansion or Scaling of Transformation Strategies and Approaches

The leading approach Pierce County ACH will undertake to advance the communities’ work in chronic disease prevention and control occurs through the deployment of Pierce County ACH’s Strategic Improvement team utilizing the principles of science of improvement, shared learning and building improvement capabilities through in-house Improvement Advisors and capacity-built within the community of partnering providers.

Partnering providers will update their Action Plan on an annual basis in consultation with the ACH, thus allowing for sustainability, spread, and ongoing process improvement of chronic disease management and mitigation.

Pierce County ACH launched a Community HUB pilot to increase community-clinical linkages and care coordination through use of central software infrastructure and referral system. Future planning includes reaching chronic disease populations specifically in DY3.

Pierce County ACH is also finalizing an evaluation and monitoring plan with CORE that will provide ongoing monitoring of key implementation and outcome markers related to this project. Data from this monitoring and evaluation system will support the expansion and scaling of our approaches by helping identify challenges and allowing us to “smart-target” additional efforts or resources at places or populations where implementation or spread is encountering challenges.

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We expect monitoring and evaluation of work related to this project to begin in Fall 2018.

Please refer to attachments “Pierce County ACH.SAR1.Attachment 1. 7.31.18.pdf” and “Pierce County ACH.SAR1.Attachment 2. 7.31.18.pdf” for copies of the Clinical and non-Clinical Phase 1 Action Plan templates.

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

ACH Response:

Pierce County Accountable Community of Health is building a transformation strategy that ensures whole-person health and health equity for all as a foundational value and common outcome for the entire community. Using the Quadruple Aim framework (based on the tenets of the Triple Aim), the ACH's goal is to improve health, increase the quality of care and services in the community, lower costs of care by removing waste and paying for value, and support providers to prevent burnout and maintain a sustainable workforce. Pierce County ACH strives to invest in prevention, keep residents healthy at every stage of life, and help them build strong families with high-health resiliency.

Whole-person Integrated Care: Pierce County ACH expects to achieve whole-person integrated delivery of care for 80% of the Medicaid population while focusing our efforts on the entire regional Medicaid population. The effective system of care will be responsive, person-centered, and will improve health outcomes and quality of life for the previously outlined target populations resulting in the following clinical outcomes for demonstration partners:

- Deepened capacity and expanded skills related to continuous quality improvement
- Expanded infrastructure and resources (i.e. workforce, HIT/HIE, VBP contracts) to support system transformation that addresses chronic care prevention and treatment
- Increased adoption of Value-based contracts
- Bolster provider capacities to enhance care collaboration
- Build internal capacity and capabilities to fully implement the Patient Centered Medical Home Model and key change concepts
- Increased provider and CBO linkages with the expectation these partnerships will become part of the infrastructure and an accepted way of doing business within the Chronic Care Model
- Transformed clinic practices moved from volume-to-value

These outcomes will occur by supporting most of the providers in our region. The Strategic Improvement Team is utilizing a variety of process improvement and change management strategies to support practices in making sustainable change. The Strategic Improvement Team will continue to support partnering providers with performance management tools. These tools will provide a roadmap for the expansion of internal capacity and capability building to achieve established success measures and outcomes through the transformation period and beyond to implement systemic changes for the population at large.

Community-Clinical Linkages: Pierce County ACH expects to increase population health and population health care coordination through deep community clinical linkages, resulting in the following outcomes:

- Achieved care traffic control, continuity of care, and performed-based payments for care coordination and engagement through the establishment of a robust regional Community HUB
- Deepened partnerships across health systems and the community at local, regional, and state levels, with aligned focus for target populations and population health improvement efforts
- A shared learning infrastructure for community-clinical partners and community members across the region that results in identification and response to policy and systems barriers to health and wellbeing
- Enhanced and aligned community resources that are focused on addressing the Social Determinants of Health for individuals and populations facing the greatest health disparities

Shared Learning & Sustainability: We will have a strong and diverse set of cross-sector partnerships aligning and pooling resources for large-scale social impact investing, authentic community engagement, and a robust data and learning infrastructure for long-term transformation and collective improvement. Results will include:

- Enhanced and aligned community resources that are focused on addressing the Social Determinants of Health for individuals and populations facing the greatest health disparities
- Fully operational Community Resiliency Fund to support equity and to fill gaps in the community that address Social Determinants of Health
- A robust community engagement system that partners with those who have lived experience
- Participatory evaluation plan to study collective impact and identify opportunities for shared savings, shared investment, cost avoidance, and pay-for-performance approaches for key transformation initiatives

D.

M

Milestone 4: Identification of Partnering Providers

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

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

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

Section 2: Standard Reporting Requirements

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

ACH-Level Reporting Requirements

A. ACH Organizational Updates

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

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

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

ACH Response:

Pierce County ACH is in compliance with all elements of A.1.c. requirement except for securing tribal/IHS/UIHPs membership on the governing body. The staff and leadership have worked diligently over the past year to secure representation without success. The ACH has included the tribes within the region in all governing correspondence in action planning efforts. Pierce County ACH will be submitting a formal request to discuss possible Action Plan development from the

Puyallup Tribe by the middle of August in the hope of beginning a dialogue, likely in coordination and partnership with Pierce County government. For more information, please see Section B. Tribal Engagement and Collaboration.

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

	Yes	No
Changes to Key Staff Positions during Reporting Period	X	

Insert or Include as an Attachment: Organizational Chart

Please refer to “Pierce County ACH.SAR1.Attachment 3. 7.31.18.pdf” for a copy of the Organization and Governance Chart.

B. Tribal Engagement and Collaboration

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

Tribal Engagement and Collaboration Activities for the Reporting Period					
Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Tribal Liaison Connection	April 18, 2018	Jeanne McMinds, Molina Healthcare & Adam Aaseby	2	Doing outreach with the Puyallup Tribe	Working on the ground in multiple tribal communities
ACH Tribal Liaison Standing Meeting	May 4, 2018	All ACHs & HCA Tribal	17	How to engagement Tribal members	This is a standing meeting/webinar. It will be every two-weeks until implementation/ projects plan

Tribal Engagement and Collaboration Activities for the Reporting Period

Activity Description	Date	Invitees	Attendees	Objective	Brief Description of Outcome / Next Steps
Tribal Engagement with the ACH	June 25, 2018	Pierce County Human Services	4	Better engage Tribal members	

To date, Tribal engagement and collaboration in Pierce County ACH have been limited, even though Pierce County ACH makes all good faith efforts to engage. The county has two Tribal governments: the Puyallup and the Nisqually. The Nisqually Tribe has focused an ongoing engagement with Cascade Pacific Action Alliance. The second tribe in the county is the Puyallup Tribe. The ACH made some initial invitations to the Puyallup and Nisqually to join the BOT at the establishment of the organization, but to date, those board seats remain unfilled.

The ACH has recently joined the HCA-led ACH Tribal Work Group meeting to facilitate a shared understanding of how each ACH is coordinating with our local Tribal Governments. The ACH is also beginning a coordination effort with the Pierce County Tribal Liaison as another example of the deep partnership between the ACH and the county. Lastly, the ACH is connecting with Tribal Liaisons using MCO's to coordinate further outreach efforts.

The ACH will be submitting a formal request to discuss possible Action Plan development from the Puyallup Tribe by the middle of the summer in the hope of beginning a dialogue, likely in coordination and partnership with Pierce County.

Project Reporting Requirements

C. Project Status Update

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

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

- *The ACH secured Memoranda of Understanding (MOUs), change plans, or other agreements with partnering providers.*
- *Partnering providers have completed training on project interventions.*

- *We have held monthly shared learning opportunities throughout the governance structure.*
- *Partnering providers have adopted and/or are using project tools/protocols.*
- *All X number of demonstration partners are using the assessment. Action Plan tools and reporting mechanism outlined by the HCA.*
- *The ACH has invested in and/or provided technical assistance for partnering providers.*
- *The ACH has invested in and/or implemented new resources for project management (e.g. IT advancements).*
- *New services are being offered/provided to Medicaid beneficiaries.*

ACH Response:

Project Status Update			
Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
IHI Improvement Advisor Professional Development Program: Sponsoring partner staff for 12-month Intensive training on the Science of Improvement to increase regional capacity for change management in implementation of projects	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	3 additional Improvement Advisors attending next wave of program—2 from partnering providers and 1 Pierce County ACH staff
QI Essentials Virtual Training: 6-week training through IHI on Model for Improvement	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Completed. No next steps
Clinical Organization Assessment Facilitation: Staff Improvement Advisors helped partners complete assessment	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Completed. No next steps

Project Status Update			
Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Phase 1 Action Plan Facilitation: Improvement advisors facilitated partners' leadership teams in completion of the Phase 1 Action Plan template	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Completed. Facilitation of final action plan and binding letter of agreement
IMC Learning Community Stakeholder Meeting: Convened MCO's, BHO, HCA, Qualis to discuss aligning support for BH providers in IMC payment model transition	BH Integration Opioid Epidemic	Y	Ongoing engagement with IMC Learning Community
IMC Learning Community BH Provider Meeting: ACH convened BH partners to identify BH partner needs in the IMC transition and contribute to the IMC Learning Community Kick-Off agenda	BH Integration Opioid Epidemic	Y	Facilitation of contracts training and available technical assistance for Pierce County BH providers
IMC Learning Community Kick-Off: Half-day live event to bring all sectors involved in IMC payment model transition together. MCO's shared timeline of tasks; panel (MCO's, HCA, BHO) answered questions from BH providers	BH Integration Opioid Epidemic	Y	Completed. Monthly webinars and training events
Pierce County (virtual) ACH Learning Network: Developed Learning Network page within the WA-Portal. Includes training calendar; discussion threads; tools and resources. First team is IMC Learning Community	BH Integration Opioid Epidemic	Y	Promotion of virtual space for partner usage

Project Status Update			
Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Life QI: Web-based subscription that uses the Model for Improvement and serves as a project management tool—tracking Plan-Do-Study-Act (PDSA) cycles and measures	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Promotion, subscription and orientation of partners to use of web-based tool
Governance Bodies & Community Meetings: Engaged robust governance structure with monthly meetings of BOT and relevant sub-committees, the PIP, RHIP Council, CVC and DLT	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Ongoing meeting facilitation per governance structure
Clinical & CBO Phase 1 Action Plans to Partners: Phase 1 Action Plans were sent to potential Clinical and Community-based Organizations	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Completed. Facilitation of final Action Plan and Binding Letter of Agreement
Project Management & Structure Implemented: External consultant is contracted to build and manage project work and structure	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Ongoing. Project Management as needed
Community HUB: Two-week, face-to-face Community HUB training offered by the Community HUB Institute	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Completed. Further training facilitation as needed for scaling with additional Care Coordination Agencies
Community HUB: Community HUB live operations launched March 19	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Completed. Ongoing operations

Project Status Update			
Key Activity	Associated Project Areas	Is activity progressing as expected? (Y/N)	Next Steps
Community HUB: Pathways weekly gatherings of Community Health Workers, Supervisors and guest presenters	BH Integration Opioid Epidemic Chronic Disease Care Coordination	Y	Ongoing meeting facilitation in support of operations

Some of the larger activities Pierce County ACH has been working on:

- IMC Learning Community – as part of the overall IMC project plan, Pierce County ACH developed a structured learning and support initiative which convenes all major stakeholders, including Behavioral Health and SUD providers, MCO’s, Pierce County, HCA, Optum, and Beacon. The group will meet regularly to share best practices, bring subject matter experts to the table, and work through issues and solutions. Data and metrics will be gathered by the ACH and its partner, CORE, and will be shared regularly with the group, which also functions as the on-the ground Early Warning System (EWS) workgroup. A smaller IMC Stakeholder Workgroup comprised of the MCO’s, selected Behavioral Health providers, Pierce County Behavioral Health, and the ACH Strategic Improvement Team develops the agendas, reviews and approves the metrics to be tracked for the EWS, and escalates issues that need to be reported to the Pierce County Oversight Board.
- Direct technical assistance is offered to providers from the Strategic Improvement Team of the ACH and expert consultants brought in by the ACH. The team brings change management expertise and direct support to assist providers in completing the Qualis Behavioral Health Agency Self-Assessment and develop an Action Plan utilizing the Qualis toolkit.
- Centralized billing and business office support will be leveraged through a shared services model. This model allows for the region to invest in a shared technology platform and will centralize and standardize the billing processes and workflows for smaller providers who do not have the resources or internal know-how to adopt technology and add administrative functions necessary to effectively transition to the new payment model.

For a summary of the assessments and action plans partner organizations have completed, please refer to attachment “Pierce County ACH . SAR1. Attachment 4. 7.31.18.pdf”.

Portfolio-Level Reporting Requirements

Partnering Provider Engagement

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

ACH Response:

Pierce County ACH has partnered for various specific activities with other ACHs. These partnerships include:

- Direct executive, financial, IT, and HIT/HIE support for Southwest ACH. Much of this support will be ongoing and contracted
- Coordination of HIT/HIE assessment with Healthier Here. This included sending only one assessment to six shared partnering providers ACHs to lessen the administrative burden on partnering providers, along with structuring our surveys with similar questions. We also shared our survey questions and format with the HCA and other ACHs to use as a model
- Ongoing partnership and coordination on the multiple aspects of the Pathways implementation including strategy, clinical linkages, IT and data security/privacy, and program evaluation with all six ACHs that are implementing this service

This is in addition to participating in the following regularly scheduled meetings:

- Monthly ACH Executive Director's meetings
- Weekly ACH huddle
- Weekly Development Council calls
- Bi-weekly ACH Program Leads
- Monthly MTP Finance meetings
- MVP Action Team meetings
- Bi-weekly Data Leads
- Monthly ACH Convenings
- Monthly Program/QI ACH Staff Meeting

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

ACH Response:

ACH expectations for partnering provider engagement in support of transformation activities includes a two-pronged approach. The expectations of partnering providers were presented at the February PIP and RHIP Council monthly meetings using a Funds Flow Map. Partnering providers that chose to engage with the ACH in transformation activities received incentive payments for completion of HIT/HIE and Organization Assessments and for completion of the

Phase I Action Plan. In addition, most partnering providers have representatives on the ACH BOT and/or RHIP Council and/or the PIP. These governance groups have expectations of participation and regular attendance for monthly meetings where feedback and guidance from partnering providers is received by ACH staff.

Partnering providers who wish to engage and access incentive funding with Pierce County ACH in support of transformation activities must complete a multi-step process known as the “Partner Action Plan.” This plan includes:

1. Submit contact information for initial Regional Inventory (Completed)
2. Submit initial Letter of Intent (Completed)
3. Complete relevant portfolio of assessments, including Clinical/Health Systems, HIT/HIE, and CBO (Completed)
4. Complete Phase 1 Action Plan (Completed)
5. Complete Phase 2 Action Plan (Fall, 2018)
6. Submit Binding Letter of Agreement (Late Dec 2018)
7. Participation in relevant governance bodies and activities of the ACH (On-going)

Those partnering providers that complete the above steps become eligible to access incentive funding for 2018. Participation in relevant governance bodies and activities of the ACH includes adherence to ACH policies for regular attendance and engagement.

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

ACH Response:

Outreach to partnering providers during the reporting period took place via reviewing an initial partner inventory to assure providers serving Medicaid populations were represented and engaged for assessments and Action Plan development, particularly on the Behavioral Health side. The ACH cross-walked online regional directories of providers and the BHO provider network to reach out to Behavioral Health providers that had not previously engaged. At least one Substance Use Disorder provider was reached in this way and the ACH staff met with their CEO and clinical director to orient the organization to the ACH work and incentivized activities.

Barriers identified included a lack of understanding or knowledge of the ACH Medicaid Transformation Project and/or a lack of staff time on the part of smaller organizations to engage with these activities. In addressing these barriers and engaging partnering providers critical to transformation success, the ACH offered onsite or virtual facilitation by staff (Improvement Advisors) to lead partner teams through completion of both the Organization Assessment and

Phase I Action Plan templates. Thirteen organizations requested and received this assistance from the ACH. In addition, ACH leadership met with partners critical to the success of this work multiple times, with the goal of increased understanding of each business model and the development of discussions regarding how best to support them in the transformation work.

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

ACH Response:

Under the direction of the PIP, a structured learning and support initiative called the IMC Learning Community was created. Using the Qualis Billing and IT Toolkit, a self-assessment template was sent to 17 Behavioral Health partners that provide mental health services and/or SUD treatment for Medicaid populations, as well as Behavioral Health providers not yet engaged with ACH work. Eleven assessments were returned, and support needs were aggregated to help guide the training and support plan. Preliminary findings include:

- 6 BH organizations are in multiple ACHs
- 4 need historical data from the departing Behavioral Health Organization (BHO)
- 3 use paper charts only
- 9 are upgrading or implementing new EHR's
- 6 do not have a complete Data Transition Plan

The transition support most requested in priority order includes: information systems; billing operations; BHO sunset; staffing; IT support; and contingency planning.

In its beginning stage, Behavioral Health providers were convened by a peer representative from the ACH PIP to discern the needs of BH providers for the IMC transition. Based on this input, monthly webinars to be offered through December 2018, will include topics of interest generated by the Behavioral Health providers. The monthly webinars will be produced and recorded, offering a 24-7 option of accessing training and support. Each webinar will allow for peer-to-peer sharing of challenges and further support needs of BH providers. Payers including MCOs, the BHO, and HCA are included as collaborative stakeholders with the ACH to address the support needs of BH providers.

E. Community Engagement

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

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

Community Engagement Activities for the Reporting Period							
Activity Description	Date	Objective	Target Audience	Associated Project Areas	Owner ²	Brief Description of Outcome	Attendance Incentives Offered? (Y/N)
Bates Dental Clinic: Low cost dental service and a community resource	4/18/18	To present Pathways to the Bates Dental staff and discuss how the Community Health Worker can refer clients to their dental program	Bates Dental Staff	Oral Health	Reyneth Morales	Became a referral partner for the Community HUB	No
Black Infant Health	6/12/18	Educate pregnant women and their families about pregnancy and infant health	Multiple care providers and community members	Care Coordination	Lizet Chavez	Made a connection with the group that meets every month and collaborate on how they can help educate the public	No
Pierce County Community Health Worker Collaborative	2/25/18	Networking among Community Health Workers in Pierce County	Multiple care providers and community members	Care Coordination	Lizet Chavez	Partnership with the ACH to increase awareness and encourage community engagement in Pierce County	Yes
Comprehensive Life Resources Homeless Outreach	5/23/18	Present to the Comprehensive Life Resource Homeless staff	Comprehensive Life Resource staff	Care Coordination	Reyneth Morales	Became a referral partner for the Community HUB	No
Community Voice Council	1/9/18 2/6/18 3/6/18 4/3/18 5/1/18 6/5/18	To be a guiding council to the ACH and to provide feedback regarding the barriers and needs for each community in Pierce County	Community members	Care Coordination	Lizet Chavez	To have community engagement in the decision-making process of the Medicaid Transformation Project	Yes
First 5 Fundamentals	2/7/18 3/7/18 4/4/18	Gathering with organization	Community member	Child Development	Lizet Chavez	Became a member of the coalition to aid in	No

² Examples of Owner may include: ACH, Project Partner, Consultant Company Name, Trainer Name, etc.

	5/2/18 6/6/18	servicing young children and parents				child development education and outreach	
Catholic Community Services Chronic Homeless Service Team Coalition	6/8/18	Providers servicing homeless population-resource sharing	Community Member	Care Coordination	Lizet Chavez	Provided information to Homeless Case Managers regarding becoming a potential referral for their pregnant clients	No
Leaders in Women's Health	3/14/18	Working strategically with other organizations to think about training, education and early outreach in the African American and medical communities	African American women at higher risk for breast cancer	Prevention	Reyneth Morales	Partnership with the ACH to increase awareness and encourage community engagement in Pierce County	No
Maternal Child Outreach Team (MCOT)	5/9/18 6/26/18	To connect pregnant women to Medicaid or material support service for a healthy baby and have early linkages	TPCHD Staff	Care Coordination	Linsey Singleton	To provide early connection and reduces risk factors through partnership with the Pathways HUB	No
Perinatal Collaborative	9/22/17 12/11/17 3/12/18 3/27/18 6/11/18	Form a collaborative for all care providers serving pregnant women, mom and infant, and child development	Multiple care providers and community members	Care Coordination	Lizet Chavez	Promote Pathways program as a potential resource for clients	No
Pierce County MSS Providers	2/8/18 4/18/18 5/9/18 5/11/18 6/14/18	First Steps is a program that helps low-income, pregnant women get the health and social services they may need. It covers a variety of services for pregnant women and their infants. First Steps is available as soon as a woman knows she is pregnant. Uses Washington Apple Health (Medicaid). First Steps services include medical, enhanced, drug and alcohol and other services	Multiple care providers	Care Coordination	Linsey Singleton	To partner with all MSS providers and agency to the Pathways program and to provide community-clinical linkages	No
Reach Center Community	5/4/18	To promote different resources in Pierce	Pregnant Women	Maternal and Child Health	Reyneth Morales	To assist the client with resource and help	No

Resource Fair & Baby Shower		County for the pregnant population				navigating through the complex medical system	
TPCHD	4/20/18 5/9/18	Offered Pathways 101 presentation to the staff of the TPCHD	Multiple care providers	Care Coordination	Kyle Davidson/ Reyneth Morales /Linsey Singleton	TPCHD is to partner with Pierce County ACH Pathways team to develop a community-wide outreach and marketing strategic plan	No
City of Tacoma Mental Health Collaboration	6/19/18	Coalition for Mental Health case managers/administrators	Mental Health providers	Bi-Directional Integration	Lizset Chavez	Presented as potential resource for pregnant women with behavioral health concerns	No
Community Collaboration Case Management Pre-Manage Workgroup	6/7/18	Collaborative for medical and EMS care providers focusing on helping high utilizers and prevent high emergency department use	High Utilizers	Diversion	Lizset Chavez	Presented as potential resource for pregnant women and high utilizers. Potential referral partner with an opioid treatment center	No
Asian American Counseling Treatment Services	5/15/18	To bring healing, hope, and recovery to the entire community, by first focusing on those recently immigrated and delivering quality treatment for all suffering with gambling and substance use disorders as well as families torn apart by domestic violence and mental illness	Asian, Asian-American, Immigrants, mental health and addicted residents	Mental Health	Elizabeth Clark & Emerita Espinoza	CHW outreach to establish relationship and inform about Pathways Program	No
Asian Pacific Cultural Center	4/9/18	Non-profit cultural center that serves as an interactive cultural crossroads between local and international communities	Asian/ Pacific Islander	Community Services	Johanna Trader	CHW outreach to establish relationship and inform about Pathways Program	No
Associated Ministries/Coordinated Entry	5/18/18	Coordinated entry to screen homeless families, individuals, and unaccompanied youth/young adults for eligibility into housing services	Homeless/At risk	Diversion	Elizabeth Clark & Emerita Espinoza	CHW outreach for resource to pregnant women population	No

Baby Catchers and Beyond	5/8/18	OB/GYN Clinic	Medical Provider	Care Coordination	Krizia Chimal	To refer pregnant clients to the Pathways HUB for further care coordination	No
Bates Technical College	4/21/18	Technical College	Students	Education	Johanna Trader	CHW outreach to establish relationship and inform about Pathways Program	No
Carnet of Puget Sound	5/10/18	Provides an evidence-based education program for parenting skills, men's program available, maternity and baby supplies including diapers, clothes, layettes, bottles, and food	Pregnant Women	Maternal and Child Health	Ash Martinez	CHW outreach for resource to pregnant women population	No
Carol Milgard Breast Center	6/21/18	Non-profit, patient-centered breast imaging center offering sustainable breast health services to women in Pierce County	Women/ African American Community	Prevention	Suzanne Pak	CHW outreach to establish relationship and inform about Pathways Program	No
Catherine's Place	4/5/18	Women Support Center committed to addressing needs of women who are materially poor, in transition, or facing the daily challenges associated with poverty, loss, violence, immigration and illness	Women	Community Services	Krizia Chimal	CHW outreach to establish relationship and inform about Pathways Program	No
Catholic Community Services	4/16/18	Non-profit organization providing community services such as food, transportation, housing, and financial assistance	Community Member	Community Services	Krizia Chimal	CHW outreach to establish relationship and inform about Pathways Program	No
Center for Childhood Safety	4/25/18	Program hosted by Mary Bridge-MultiCare to prevent unintentional childhood injury through health education, community partnerships, and best-practice prevention strategies	Community Member	Prevention	Krizia Chimal	CHW outreach to establish relationship and inform about Pathways Program	No

Center for Multicultural Health	4/20/18	Promote the health and well-being of diverse communities--including individuals from communities of color, individuals with limited English proficiency, immigrants and refugees--through innovative health advocacy, health promotion, disease prevention, and immigrant and refugee service programs	Multiple Care providers, Immigrant-Refugee population	Prevention	Johanna Trader	CHW outreach to establish relationship and inform about Pathways Program	No
CHI St Joseph Birthing Center	5/20/18	Social Worker for mothers in the birthing center who are at-risk due to SUD/opioid use or transitioning from jail	Pregnant Women/ SUD	Maternal and Child Health/ Opioid/ Transition	Elizabeth Clark & Emerita Espinoza	To refer pregnant clients to the Pathways HUB for further care coordination	No
CHI St Joseph Women's Health	5/28/18	OBGYN	Medical Provider	Care Coordination	Elizabeth Clark & Emerita Espinoza	To refer pregnant clients to the Pathways HUB for further care coordination	No
Lakewood schools	4/20/18	Community services and resource support through education/schools for children and families	Students and Families	Care Coordination	Krizia Chimal	To present on Pathways Model and educate the community on a new care coordination service in Pierce County	No
Community Partnerships for Transitional Services	5/11/18	Re-entry Services and planning with surrounding agencies	Incarcerated individuals and their families	Transition	Elizabeth Clark & Emerita Espinoza	To present on Pathways Model and educate the community on a new care coordination service in Pierce County	No
Community Youth Services	4/2/18	Youth Shelter	Homeless Youth/ Unaccompanied Minors	Homeless	Krizia Chimal	To present on Pathways Model and educate the community on a new care coordination service in pierce county	No
Court Resource Center	5/10/18	Re-entry services for justice involved or formally incarcerated	Formerly-incarcerated Individuals and their Families	Transition	Elizabeth Clark & Emerita Espinoza	To present on Pathways Model and educate the community on a new care coordination	No

						service in Pierce County	
Step by Step	6/19/18	Maternal Support Services for at-risk pregnant women connections to ACH and Community HUB and funding obstacles; questions to state about MSS funding issues and opportunities for future	At-risk pregnant women	Care Coordination ; Transitions; Workforce Development	Alisha	Collaboration opportunities ACH, Community Partner, HCA, Governor's Office and legislator	No

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

ACH Response:

By launching live operations for the Community HUB, Pierce County ACH has undertaken the following efforts to reach out to populations with limited proficiency in English:

- Marketing materials in multiple languages are under development. On-going tracking of other languages identified by Community Health Workers when engaging new clients
- Care Coordination Agencies are responsible for assuring culturally and linguistically appropriate services are provided to clients while HUB staff monitor compliance with HUB policies
- Within the current Pathways Community Health Worker cohort, there are 5 bilingual Community Health Workers and three supervisors with proficiencies in English, Spanish, and Korean

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

ACH Response:

Pierce County ACH is aware of underrepresented community groups and has focused on identifying those groups and the challenges they face. As many Medicaid enrollees may contend with various other agencies promoting similar services, Pierce County ACH is working to build trust as a new agency serving clients within underrepresented communities. Some strategies to identify challenges are as follows:

- One of the first challenges the Pierce County ACH addressed was to identify

underrepresented communities that require our focus. To identify these communities, the ACH requested the CVC review its representation per ethnicity, age, and geography and add members where there were perceived gaps

- Pierce County ACH encouraged CCA partners to prioritize hiring staff from underrepresented communities. The current cohort of 8 CHWs and 4 CHW Supervisors includes members of the Hispanic/Latinx, African American, and Asian Pacific Islander communities. Weekly meetings of the CHW cohort are designed to include discussions regarding the challenges clients face and includes outside presenters from CBOs or community coalitions who serve underrepresented populations. They provide education on challenges and interventions, and resources to increase positive health outcomes.
- Implementation of the Community HUB offers the means to address the challenges inherent in engaging underrepresented communities. Pathways HUB staff plan to leverage feedback from the community survey to expand existing efforts to reach out to Community-based Organizations or other community coalitions working with underrepresented communities.
- Another challenge occurred with some service agencies regarding perceived duplication of services. For example, some Pathways clients were unaware of their eligibility for MSS services. Pierce County ACH now has a bi-directional referral policy in place for MSS referrals and the partnerships and collaborations are growing. This solution was developed when representatives of MSS agencies approached Pathways staff with concerns about potential duplication of services and hesitation making referrals into the HUB. Two of the Pathways Care Coordination Agencies are also MSS providers and assisted in advocating Pathways and MSS jointly provide services to clients by coordinating efforts. MSS agencies provide medical interventions and education through nurses and other staff while Pathways CHWs provides resource information and care coordination to address the Social Determinants of Health. Currently, clients are more aware of which MSS agency is on their care team. In addition, their Pathways CHW assists with accessing other community services and resources during their pregnancy.
- Pierce County ACH conducted a community survey developed by the Community Voice Council and the Community Health Worker Collaborative of Pierce County. The purpose of the survey was to identify the barriers communities face when obtaining medical care or care coordination. To promote deeper discussions within communities, both the CVC and CHWCPC tapped into their established relationships and networks. Based on the feedback, the ACH will identify barriers or challenges communities face in Pierce County when navigating the health system.

Health Equity Activities

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

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

ACH Response:

During implementation of the Community HUB, Pierce County ACH and its CCA partners reviewed data showing pronounced disparities in infant mortality rates for communities in Pierce County and across Washington State. (According to a Department of Health report with data from 2011-2015, African American and Native American babies suffer twice the infant mortality of their white peers.) The ACH encouraged these agencies to consider prioritizing the hiring of Community Health Workers from communities experiencing disparities and entered a conversation with the Department of Health to seek ways to partner and support those efforts. The Department of Health responded with a grant to the Korean Women's Association to support hiring a CHW with expertise in the African American community. With the full support of the ACH, the Korean Women's Association hired a total of 3 Community Health Workers, an increase from earlier planning. Other agencies likewise responded by hiring CHWs with deep expertise from communities experiencing disparities. The decision to expand this capacity in implementation resulted directly from equity considerations.

The ACH has incorporated health equity throughout its Funds Flow Methodology to incentivize and reward organizations who are building equity into their organizational culture, and improving how they deliver care to the community. The Waiver and Investment Committee developed the methodology for distributing funds to partners in 2018. This plan includes an Equity Accelerator Pool for partners who submit an Action Plan that demonstrates readiness to participate in strategies promoting health equity, stigma reduction, anti-racism and "equity-focused care". Allocations will be dependent on the depth of equity-oriented improvement efforts imbedded into the organization's Action Plan and organizational strategy. The distribution plan (aka Funds Flow Guiding Principles) were adopted by the BOT.

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

ACH Response:

Through its partnership with CORE and other partners such as the TPCHD, and Department of Health, the ACH will continue to provide regionally-specific qualitative and quantitative data to all of its governance structures with input from the DLT and allowing for cross-sector voices to be heard in prioritizing health equity issues. Evaluation plans for all ACH project activities include formative evaluation methods (such as qualitative interviews of participants and

stakeholders) and quantitative monitoring and analysis of claims and other outcome-based data. In each case, the plan is deeply informed by the need to support and assess the work in the context of its impact on entrenched disparities and health equity issues in the region.

By prioritizing health equity into its Funds Flow Methodology and shared-learning Action Plans with partnering providers, the ACH assures health equity issues retain high priority and visibility throughout the Medicaid Transformation and the work undertaken by all. Examples include the publication of a story by ACH's Communications Team profiling the CHW hired by Korean Women's Association, highlighting her expertise in the African American community and referencing data on disparities in birth outcomes. Through communications and strategic focus, the ACH assesses and prioritizes health equity issues.

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

ACH Response:

During the first six months of this planning year, the ACH educated members of its governance structure including the RHIP, PIP, CVC, and BOT on sources of data and assessment tools available for prioritizing community health equity issues, including those available through the local TPCHD. The ACH then adapted a Healthy Equity Accelerator Tool from IHI into Phase 1 Action Plans for partnering providers as a model to support organizational approaches to prioritizing health equity, including data collection.

The Funds Flow Guiding Principles developed by the Waiver and Investment Committee and adopted by the BOT, includes equity as a primary driver for distribution of funds. The Equity Accelerator Pool is designated for partners who submit an Action Plan demonstrating readiness to participate in strategies promoting health equity, stigma reduction, anti-racism and "equity-focused care". Allocations are dependent on the depth of equity-oriented improvement efforts embedded into the organization's Action Plan and organizational strategy and outlined by the Health Equity Accelerator Tool.

The ACH will monitor the use of health equity tools through compilation and evaluation of Phase 1 Action Plans. These plans will transition into Phase 2 Action Plans and eventual binding Letters of Intent in the fall of 2018. Progress towards operationalizing principles and practices around health equity will be monitored, tracked and incentivized for partnering providers as they move through action planning and into implementation.

G. **Budget and Funds Flow**

B

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

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

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

Yes	No
X	

If the ACH checked “Yes” in item G.1, have all audit findings and questions been appropriately resolved? If not, please briefly elaborate as to the plan to resolve. If the ACH checked “No” in item G.1, respond “Year Ended December 31, 2017

ACH Response:

Please refer to attachment “Pierce County ACH.S AR 1.Attachment 5. 7.31.18.pdf” for our

2017 Financial Audit. There were no further findings or questions.

* Pierce County ACH is audited annually. Therefore 2018 audited financial statements are not available at this time.

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

ACH Response:

Not Applicable

2. Design Funds

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

3. DY 1 Earned Incentives

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

4. Integration Incentives

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

- a. Describe how the ACH has prioritized, or will prioritize, integration incentives to assist Medicaid behavioral health providers transitioning to fully integrated managed care. Include details on how Medicaid behavioral health providers and county

government(s) have or will participate in discussions on the prioritization of these incentives.

ACH Response:

Through the Waiver and Investments Committee and BOT, Pierce County ACH prioritized integration incentives to Behavioral Health providers by investing in the following strategic areas:

- IMC Learning Community – As part of the overall IMC project plan, Pierce County ACH developed a structured learning and support initiative that convenes all major stakeholders, including Behavioral Health and SUD providers, MCOs, Pierce County, HCA, Optum, and Beacon. The group will meet regularly to share best practices, bring subject matter experts to the table, and work through issues and solutions. Data and metrics will be gathered by the ACH and its partner, CORE, and will be shared regularly with the group, which also functions as the on-the-ground Early Warning System (EWS) workgroup. A smaller IMC Stakeholder Workgroup comprised of the MCOs, selected Behavioral Health providers, Pierce County Behavioral Health, and the ACH Strategic Improvement Team develops the agendas, reviews and approves the metrics to be tracked for the EWS, and escalates issues that need to be reported to the Pierce County Oversight Board.
- Direct technical assistance is offered to providers from the Strategic Improvement Team of the ACH and expert consultants brought in by the ACH. The team brings change management expertise and direct support to assist providers in completing the Qualis Behavioral Health Agency Self-Assessment and develop an Action Plan utilizing the Qualis toolkit.
- Centralized billing and business office support will be leveraged through a shared services model. This model allows for the region to invest in a shared technology platform and will centralize and standardize the billing processes and workflows for smaller providers that do not have the resources or internal know-how to adopt technology and add administrative functions necessary to effectively transition to the new payment model.
- Participating member of the Integration and Oversight Board. Membership of this County Executive’s developed board will consist of members of the County Council, Executive, ACH, HCA, and the provider community. The following list of responsibilities is taken from the Integration and Oversight Board charter document:

POWERS OF THE BOARD, HCA, AND PCACH.

In consultation with the PCACH, the Board and HCA shall collaborate on Pierce County’s implementation of Integrated Managed Care, and shall include

responsibility for:

- (a) Alignment and standardization of MCO contracting, administrative functions, IT, data sharing, and other processes to their respective providers to minimize administrative burden at the provider level to achieve outcomes;*
- (b) Monitoring implementation of Integrated Managed Care in the regional service area, including design of an early warning system to monitor ongoing success to achieve better outcomes and make adjustments to the delivery system as necessary;*
- (c) Developing regional coordination processes for capital infrastructure requests, local capacity building, and other community investments;*
- (d) Identifying, using, and building on measures and data consistent with, but not limited to, RCW 70.320.030 and 41.05.690, for tracking and maintaining regional accountability for delivery system performance;*
- (e) Convening appropriate task forces to provide clinical, data sharing, and other needed expertise, or may confer with and rely on the expertise of provider groups and the PCACH; and*
- (f) Preserving, financing, and enhancing the crisis and justice-related systems through an administrative service organization or other local organization approved by the Board.*

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

ACH Response:

A governance structure exists with the Waiver and Investment Committee for integration incentives to be allocated in a similar manner to project funds, using the same Funds Flow Guiding Principles. The BOT approved allocating half of the integration funds to Pierce County to be distributed at the direction of the Pierce County Oversight Board. This Board is appointed by the County Executive and includes payers, Behavioral Health providers, and the CEO of Pierce County ACH.

The remaining funds will be allocated according to the priorities as described in 4.a. above to assist providers currently contracted with the BHO to provide Medicaid services who will be transitioning to the IMC model.

5. Total Medicaid Transformation Incentives

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



August 27, 2018

Dear Ms. Fehrenbacher:

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

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

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

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

Thank you,
Myers and Stauffer LC

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

Request for Supplemental Information

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

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

Milestone 3: Define Medicaid Transformation Evidence-based Approaches, Promising Practices, Strategies, and Target Populations. Medicaid Transformation Approaches and Strategies - For each project area the ACH is implementing, the ACH should provide: (1) A description of the ACH's evidence-based approaches or promising practices and strategies for meeting Medicaid Transformation Toolkit objectives, goals and requirements.

- 1. Independent Assessor Question:** Please confirm all areas of the response provided for Project 3D on pages 39-45 of the report are correct. The section on evidence-based approaches, for example, focuses on opioid use disorder as listed in Project 3A and the Chronic Care Model is not listed. If incorrect, please provide the corrected information.

ACH Response:

Below is the updated content for the Chronic Disease Prevention and Control. A majority of the content is the same; however, the **highlighted sections** were corrected to properly reflect the focus on the Chronic Care.

Project 3D: Chronic Disease Prevention and Control

1. Transformation Strategies and Approaches

Pierce County ACH is implementing a portfolio approach fusing all project areas together and incentivizing partnering providers to engage in transformational activities through the formation of Action Plans. The specific tactics employed for Project 3D come directly from the Patient Centered Medical Home Model and the Pierce County ACH Rules of Engagement, a set of strategies and approaches designed in collaboration with Pierce County ACH's governance bodies and embedded within the Action Plans. Partnering providers, both clinical and non-clinical, commit to the tactics they select and implement the Action Plan starting January 1, 2019, with updates in subsequent years.

Pierce County ACH's Chronic Disease Prevention and Control Project will be focused on implementation of Wagner's evidence-based Chronic Care Model across care settings for targeted populations based on partnering provider Action Plans that will set the populations. The project is centered on the following drivers of change: Adoption of Pierce County ACH's Transformation Rules of Engagement ensuring consistent guidelines across regional partners; implementation of Chronic Disease Self-management (CDSM) interventions; provision of support for effective complex care and disease management for targeted populations (scaling and spreading as interventions begin to work in the initial targeted populations); utilization of Community Voice Council, PIP and RHIP Council.

Clinical partners will be held accountable to the following change concepts: engaged leadership; empanelment for population health management; quality improvement strategy; continuous and team-based healing relationships; organized, evidence-based care; person-family engagement and experience; enhanced access; care coordination; value-based payment; and whole-person care with a focus on the following priority populations outlined below. Each demonstration participant will be incentivized through milestone payments to work with the non-clinical partners for Chronic Disease Prevention and Mitigation.

Health equity has been a foundational element of Pierce County ACH's design and planning and individuals facing the greatest health disparities inform the assessment of priorities. Partnering providers are being held accountable to addressing and maintaining equity in their delivery of services and interventions. Pierce County ACH's Community Care HUB, that includes Pathways, is a critical asset for the successful pursuit of improved health outcomes for individuals at risk for chronic disease. The following tactics are outlined for project area 3D where Pierce County ACH selected Wagner's Chronic Care Model as the evidence-based approach:

Transformation Activities Required of ACH Clinical Partnering Providers:

(as taken from the Pierce County ACH Phase 1 Action Plan template)

Partnership Accelerator Framework:

- Identify actions, policies and initiatives to advance along spectrum of partnerships continuum (financial incentives provided in funds flow framework)

Health Equity Accelerator Framework:

- Identify actions, policies and initiatives to advance along spectrum of health equity continuum (financial incentives provided in funds flow framework)

Engaged Leadership:

- Assign a Chronic Disease Management project to a multi-disciplinary team

Quality Improvement Strategy:

- Choose a formal model for quality improvement to drive systems changes for Chronic Disease Management (IHI Model for Improvement recommended)

Sustainable Business Operations:

- For Behavioral Health partnering providers, develop a plan to transition to IMC payment model
- Develop a plan to transition to VBP arrangements

Person/Family Engagement:

- Utilize the Pierce County ACH's CVC for Phase 1 Action Plan feedback

Transformation Activities for Selection by ACH Clinical Partnering Providers:

Empanelment:

- Implement/improve a process for reviewing panel-level data for patients with chronic disease and/or who are at risk for chronic disease
- Use panel data and registries to proactively contact, educate and track patients with chronic disease

Continuous and Team Based Healing Relationships:

- Define team roles including those who support patients with diabetes either directly or indirectly and communicate roles to patients

- Add team members from outside of the organization such as CHW, pharmacists, dietitians, dentists
- Assess training needs of care team and implement a training plan with emphasis on stigma reduction, trauma informed care, cultural and language diversity; health literacy; motivational interviewing; and clinical chronic disease topics.
- Consider integration of CHW in the care team

Organized, Evidence-Based Care

- Implement evidence-based guidelines for selected chronic disease
- Identify high-risk populations with the selected chronic condition and ensure they are receiving appropriate care and care management services

Person/Family Engagement:

- Develop/implement or improve process for engaging patients in decision making in plan of care
- Provide self-management support at every visit through goal setting, action planning and follow-up
- Obtain feedback from patient/family about their healthcare experience and use this information for quality improvement
- Review how the organization communicates with patients for culturally appropriate and/or health literacy-level communication
- Integrate Community Health Workers for person/family engagement

Enhanced Access:

- Promote and expand access by assuring established patients have 24/7 access to their care team via phone, email telehealth, and/or in-person visits
- Provide scheduling options that are patient- and family-centered and accessible to all patients
- Integrate usage of Community Health Workers/Peer Support Specialists in the care team (i.e. ensuring appointments are kept)

- Implement telehealth programs that enhance access

Care Coordination:

- Partner with community organizations to support and develop evidence-based interventions such as the Stanford Chronic Disease Self-Management Program, Million Hearts Campaign, Diabetes Prevention Program, or Community Paramedicine.
- Develop/implement or improve follow-up with patients upon discharge from emergency department, urgent care or hospital
- Partner with CBOs for innovative care transitions (i.e. EMS, Community Paramedicine, Community Health Workers)
- Partner with CBOs for innovative diversion strategies (i.e. criminal justice, jails, county, Crisis Triage Center, Mobile Community Intervention Response Team)
- Participate in Health Information Exchange platforms that support sharing across organizations
- Develop document referral, care plan exchange and follow-up processes with key “Medical Home Neighborhood” organizations, which may include specialty care, dental services, pharmacies, EMS, schools, criminal justice system, and CBOs
- Implement referrals to the Pierce County ACH Community HUB
- Become a CCA for the Pierce County ACH Community HUB. Determine target populations of interest.

In addition, by serving as the HUB, Pierce County ACH provides a centralized Care Traffic Control with a platform for Health Information Exchange and implementing an outcomes-based approach to coordination of care, supported by a robust software platform and detailed analytics. Below is a set of tactics specific to implementation of the Community Care HUB.

Care Traffic Control

- Assess regional care coordination efforts and identify and recruit partners and stakeholders for community HUB that includes HET (clinical care coordination, transitions, and diversion) linked with Pathways (Social Determinants of Health)
- Identify and develop technology platform to facilitate cross-system coordination and information sharing, and develop a process for data governance

- Develop community-wide processes and norms for care coordination
- Implement community HUB to facilitate Health Information Exchange with additional data streams

Health Engagement Team

- Pilot HET model for persons and families who need deep, community-based, team-based care coordination for priority populations outlined below
- Identify HET pilot target population. Potentially to focus on opioid, chronic disease, dual diagnosis, and long-term care target populations
- Conduct request for proposal (RFP) process to identify key health systems and community-based partners for HET pilot
- Build technology infrastructure, such as adapting HUB technology platform for HET pilot and connecting to provider EHR systems

Transformation Activities Required for Non-clinical ACH Partners:

CBOs action planning framework uses a systems-change approach to support a transformed health system and changed care delivery by strengthening the link between community and clinical systems and reducing barriers to care. They are required to:

- Identify target population
- Identify how proposed project design aligns with the Pierce County ACH projects (e.g., prevention and management of behavioral health challenges, chronic conditions and/or opioid misuse) and connects with Health Systems
- Implement a process to engage clients and, where appropriate, family members in decision-making
- Reduce barriers to care
- Partner with Health Systems who serve the identified target population
- Develop quality improvement and evaluation processes and metrics
- Develop and implement actions, policies, and initiatives to advance partnerships with health systems and promote health equity

<p>2. Target Populations</p>	<p>Pierce County ACH has used a multi-phase process to identify target populations for this project. With the support of CORE and Pierce County ACH’s DLT Workgroup, council members were asked to identify populations according to need and potential impact. Based on the assessments and data, these set of priority populations with multiple chronic care conditions were identified for Pierce County:</p> <ul style="list-style-type: none"> • Adults with diabetes (particularly Type 2) • Children and adults with obesity • Children and adults with asthma/chronic obstructive pulmonary disease (COPD) • Adults with hypertension and cardiovascular disease <p>Targeted populations are chosen by partnering providers and outlined in Action Plans. Additional populations will be considered in later years as interventions prove successful.</p>
<p>3. Expansion or Scaling of Transformation Strategies and Approaches</p>	<p>The leading approach Pierce County ACH will undertake to advance the communities’ work in chronic disease prevention and control occurs through the deployment of Pierce County ACH’s Strategic Improvement team utilizing the principles of science of improvement, shared learning and building improvement capabilities through in-house Improvement Advisors and capacity-built within the community of partnering providers.</p> <p>Partnering providers will update their Action Plan on an annual basis in consultation with the ACH, thus allowing for sustainability, spread, and ongoing process improvement of chronic disease management and mitigation.</p> <p>Pierce County ACH launched a Community HUB pilot to increase community-clinical linkages and care coordination through use of central software infrastructure and referral system. Future planning includes reaching chronic disease populations specifically in DY3.</p> <p>Pierce County ACH is also finalizing an evaluation and monitoring plan with CORE that will provide ongoing monitoring of key implementation and outcome markers related to this project. Data from this monitoring and evaluation system will support the expansion and scaling of our approaches by helping identify challenges and allowing us to “smart-target” additional efforts or resources at places or populations where implementation or spread is encountering challenges.</p> <p>We expect monitoring and evaluation of work related to this project to begin in Fall 2018.</p>

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Milestone 4: Identification of Partnering Providers. In the Workbook tab D.1, “Additional Partnering Providers,” list additional partnering providers that the ACH has identified as participating in transformation activities, but are not registered in the Financial Executor Portal as of June 30, 2018.

2. Independent Assessor Question: For the three additional providers listed, please indicate project association.

ACH Response:

Here are the projects the organizations will be focused on.

Table A. Partnering Providers

Organization Name	Type of Entity	Project								Shared Domain 1 Provider
		2A	2B	2C	2D	3A	3B	3C	3D	
<i>*Note: These organizations were not registered as of June 30, 2018</i>										
ANSWERS Counseling Consultation & Case management Services	Non-Traditional Provider	X	X			X			X	
Childrens Home Society of Washington	Non-Traditional Provider	X	X							
Northwest Leadership Foundation Leaders in Women's Health	Non-Traditional Provider	X	X			X			X	

Section 2: Standard Reporting Requirements

Item A.3. Key Staff Position Changes: Provide a current organizational chart for the ACH. Use bold italicized font to highlight changes, if any, to key staff positions during the reporting period.

- Independent Assessor Question:** Pierce County ACH indicates that changes to key staffing have occurred during the reporting period, but has not highlighted those changes as requested in item A.3. Please provide information about the changes

ACH Response:

Here is the org chart with the roles that were changed between 1/1/18 and 6/30/18. For the changed roles, new personnel were hired to fill the positions.

See attached organization chart

Item G.3. Table E. Provide additional detail and examples regarding the ACH's DY 1 Incentive expenditures by Use Category.

2. **Independent Assessor Question:** In Table E of Tab G.3 of the workbook, a description for use of funding for Shared Domain 1 Incentives is missing. Please provide detail and examples.

ACH Response:

Table E. Provide additional detail and examples regarding the ACH's DY 1 Incentive expenditures by Use Category. For example, if an ACH's expenditures for Health Systems and Community Capacity Building include funds for Pathways Hub operations, the ACH should indicate that in the table.

Use Category	DY 1 Incentive Expenditures	Expenditure details (narrative)
Administration	\$0	
Community Health Fund	\$0	
Health Systems and Community Capacity Building	\$307,450	Direct payments to Care Coordinating Agencies contracted under Pathways pilot and direct support to providers for training the ACH is sponsoring in the IHI improvement advisor professional development program.
Integration Incentives	\$1,715,209	Payment to Pierce County to be distributed to providers at the discretion of the Pierce County Oversight Board. Funds to be used to assist providers and the County in their behavioral health integration projects.
Project Management	\$0	

Provider Engagement, Participation and Implementation	<p>\$710,000</p>	<p>Incentives to providers for completing certain milestones related to participation and implementation planning. Milestones include: signed Letter of Interest, completion of a regional inventory survey, completion of a current state Clinical or Community-based Organizational Assessment, completion of an HIT/HIE Assessment, finalization of an implementation Action Plan, and signing of a Binding Partnership Agreement for commitment to the full term of the demonstration.</p>
Provider Performance and Quality Incentives	<p>\$0</p>	
Reserve/Contingency Fund	<p>\$0</p>	
Shared Domain 1 Incentives	<p>\$4,915,308</p>	<p>Incentives only to partners that are IGT contributors. (Examples: University of Washington, ASSOCIATION OF WA PUBLIC HOSPITAL DISTRICTS)</p>

Pierce County ACH

Clinical Partner Phase 1 Action Plan



Due Date: June 15, 2018

Please email the completed Phase 1 Action Plan to admin@piercecountyach.org. Contact Tyneka Rene tyneka@piercecountyach.org for assistance and/or to schedule Pierce County ACH's Improvement Advisors to facilitate your team's development of the Phase 1 Action Plan.

Introduction

The Pierce County Accountable Community of Health (Pierce County ACH) is a group of fierce pioneers, committed to health systems change. Our role is to connect health innovation and transformation efforts at the state and local levels. We do this by engaging with community volunteers and partners to develop and support sustainable improvements to the physical and mental health of all Pierce County residents through innovative strategies, collaboration and partnerships.

We seek transformation that not only improves overall outcomes, but also improves access and quality of care for all members of our community. Our goal is to explicitly address the systematic causes of disparities and inequity using the Quadruple Aim that sets goals of better health, better care, lower costs, and improving the work life of health care providers.

We are funded through the Medicaid Transformation Reform Program, a five-year agreement between Washington State and the federal government's Centers for Medicare and Medicaid Services. It will provide up to \$1.5 billion to Washington State for regional projects and health improvement investments through incentive-based payments. Pierce County Accountable Community of Health is one of nine ACHs in the state.

The partner action planning process is divided into two phases— Phase 1 Action Plan and Phase 2 Action Plan. The Phase 1 Action Plan is a high level summary of tactics your organization will use to achieve the goals of the Medicaid Transformation Project. Phase 2 will be a more detailed plan and will be required for the binding letter of agreement which will be completed in the Fall 2018.

Partners who complete the Phase 1 Action Plan will receive Medicaid Transformation [incentive funding](#) from Pierce County ACH. If your organization has not completed the Organization and HIE/HIT assessments, please complete both of these assessments prior to completing this worksheet. Click [here](#) for Organization Assessment and click [here for HIE/HIT assessment](#).

About the Phase 1 Action Plan

The purpose of completing this action plan is to:

- ✓ Develop your high-level plan through December 2019 for systems transformation within any or all of these sectors: Primary care practices (including dental/pediatrics), behavioral health clinics, substance use disorder clinics, pharmacies, emergency departments, and acute care hospitals for a continuum of whole-person care
- ✓ Identify your areas of needed investment to minimize the gaps and achieve the goals of Medicaid Transformation
- ✓ Identify potential metrics that guide Pierce County ACH's metrics list based on the Health Care Authority (HCA) requirements, Pierce County ACH stakeholder input, and partner recommendations
- ✓ Guide Pierce County ACH's overall plan for regional investments, technical assistance, partner development, evaluation and shared learning

The Medicaid Transformation Project is large and complex. The Pierce County ACH seeks to translate Health Care Authority requirements such as the Medicaid Toolkit into a format that is actionable and reduces the burden for our clinical organization partners. The framework for action planning uses a systems change approach that will support a transformed health system long past the transformation efforts.

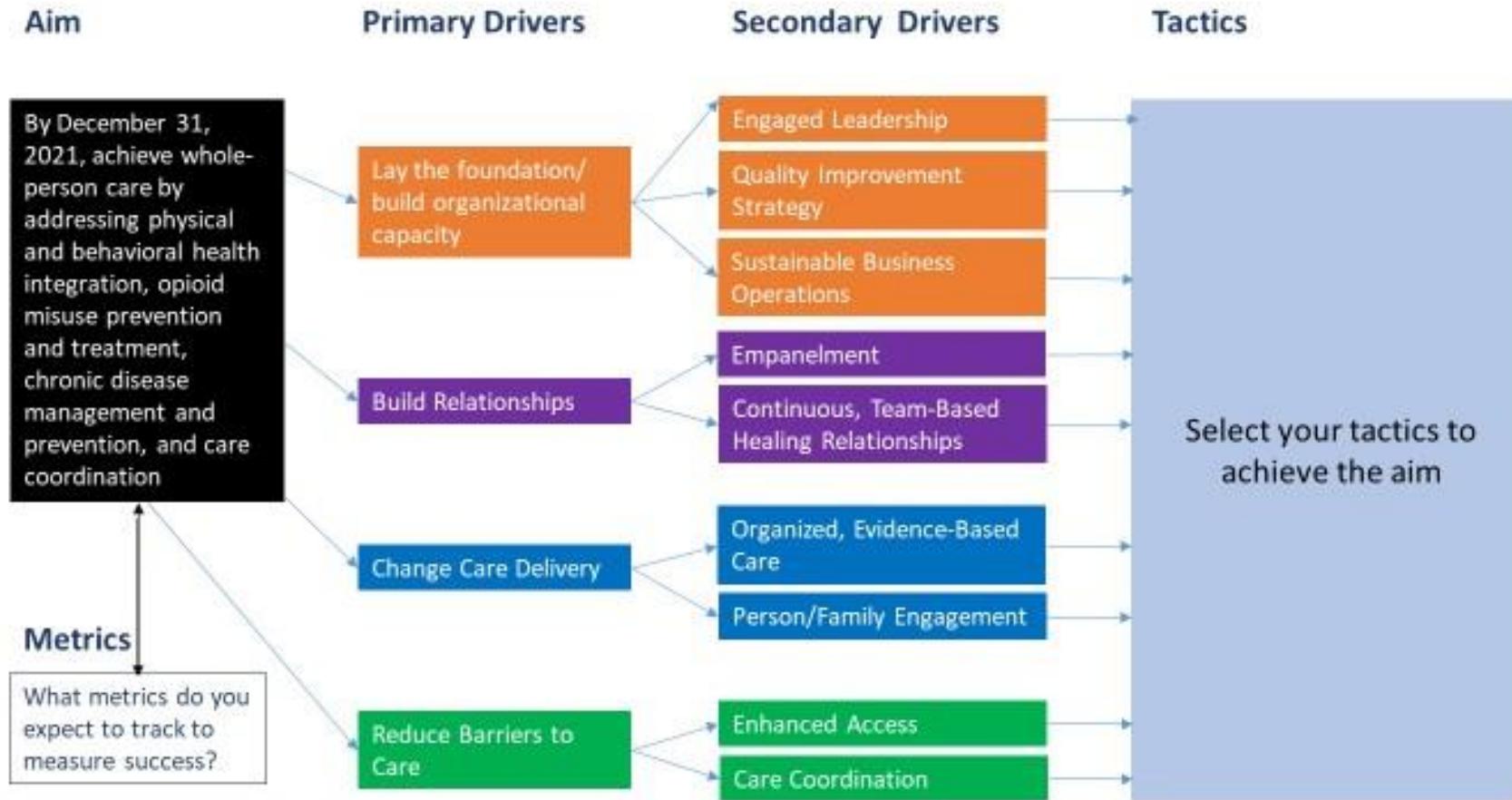
The [four areas of expected system change](#) are:

- ✓ Laying the Foundation for Building Organizational Capacity
- ✓ Building Relationships
- ✓ Changing Care Delivery
- ✓ Reducing Barriers to Care

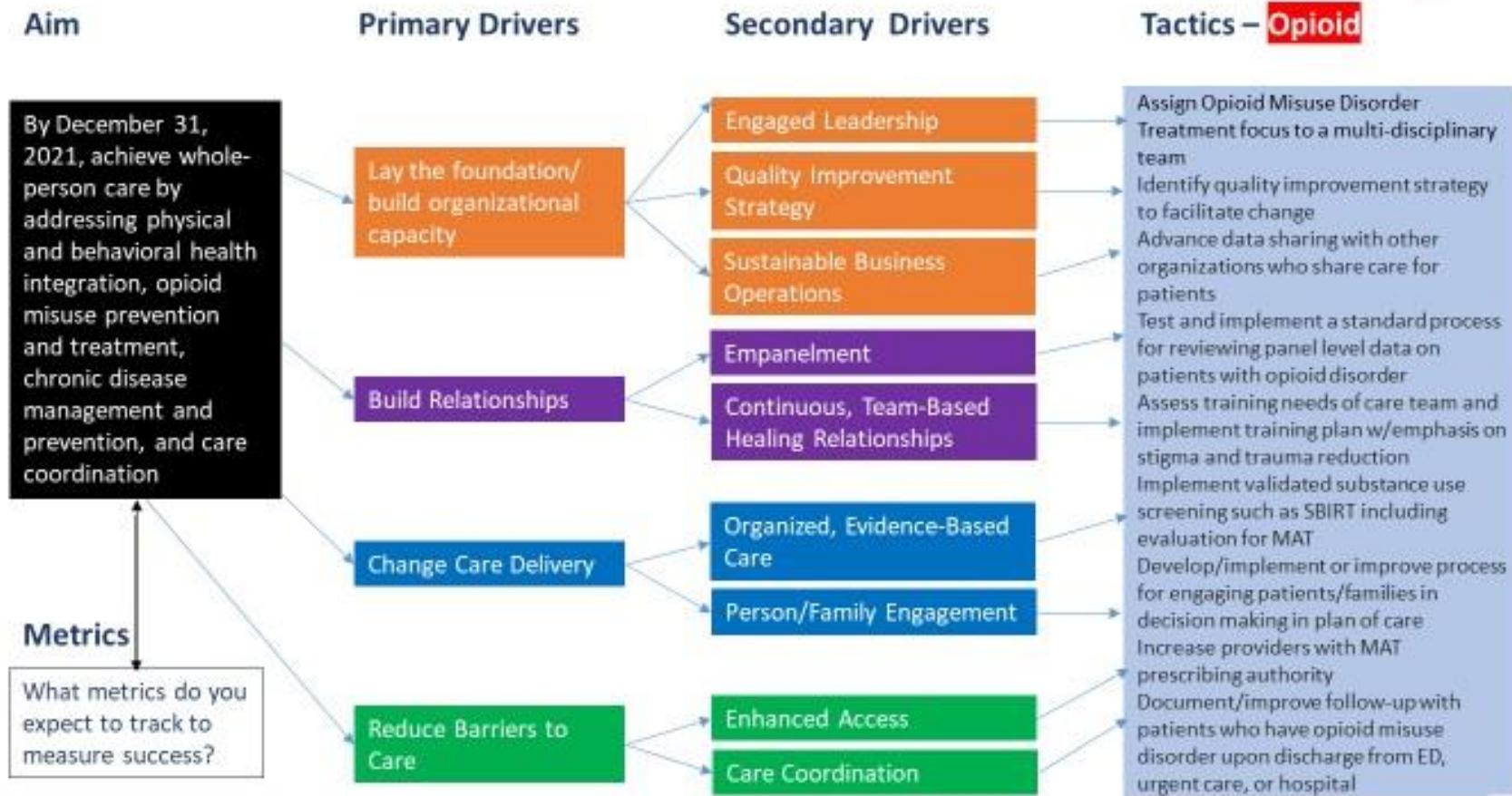
In combination with these four areas of system change, the Pierce County ACH Driver Diagram provides a graphic display of the aim and the primary and secondary drivers that contribute to the achievement of the aim. The Driver Diagram is a tool to help categorize system change components into actionable steps. The primary drivers are the four areas of expected system change and the secondary drivers are components of the primary drivers. Tactics are key changes that your organization will implement to achieve the aim.

The aim and primary and secondary drivers have been developed by Pierce County ACH using our region's [Rules of Engagement](#) as developed and approved by community partners.

Pierce County ACH Medicaid Transformation Driver Diagram



Pierce County ACH Medicaid Transformation Driver Diagram - Example



Tips for Completing the Phase 1 Action Plan Worksheet

- ✓ Schedule a 2-3-hour block of time with your leadership team to complete this Action Plan: Phase 1 worksheet. Pierce County ACH can provide a facilitator to support your planning process. Contact Tyneka Rene Tyneka@piercecountyach.org to schedule a Pierce County ACH facilitator.
- ✓ Linked documents are available for [download here](#).
- ✓ Review the Aim, Primary Drivers, and Secondary Drivers which are defined by Pierce County ACH in the Action Plan: Phase 1 worksheet.
- ✓ Define the population you will be working with to achieve the Aim. Your defined population must include one or more Pierce County ACH's [Rules of Engagement](#) target populations.
- ✓ Determine what tactics your organization will use within each of the Primary Drivers to meet the Aim. Select from the list provided and/or add your own. The tactics are those items you intend to work on through December 2019 and possible beyond.
- ✓ Identify measures that you think demonstrate how you will know if you are successful in meeting the Aim over the next five years. [Refer to the Medicaid Pay-for-Performance Measures and Pay for Reporting document](#).
- ✓ Identify your organization's investment in these activities.
- ✓ Identify what resources you need from external sources such as the Pierce County ACH.
- ✓ Identify what training and technical assistance you need from the Pierce County ACH.

Organizational Information

1. Organization Name: Click here to enter text.
2. Who is the organizational executive sponsor for this Action Plan?
 - Name: Click here to enter text.
 - Title: Click here to enter text.
 - Organization: Click here to enter text.
 - Email Address: Click here to enter text.
 - Phone Number: Click here to enter text.
3. How does the Medicaid Transformation Project work fit with your organization's vision, mission, and/or strategic plan?
 - Click here to enter text.
4. Pierce County ACH is using the [Partnership Accelerator Framework](#) as the continuum of partnership development to achieve the Medicaid Transformation Project goals. How will your organization advance along the continuum in the next 18 months? Please describe actions, policies, and initiatives you plan to implement with which partners. (You may attach additional documents that describe your approach to partnerships.)
 - Click here to enter text.
5. Pierce County ACH is using the [Health Equity Accelerator Framework](#) as the continuum of the integration of health equity across your organization's services to achieve the Medicaid Transformation Project goals. How will your organization advance along the continuum in the next 18 months? Please describe actions, policies, and initiatives you plan to implement. (You may attach additional documents that describe your approach to equity.)
 - Click here to enter text.
6. Please attest to the following:
 - Leadership at my organization has read the embedded supporting materials provided with this Action Plan
 - I understand that this Phase 1 Action Plan will be followed by a deeper Phase 2 Action Plan that will inform a binding agreement between the ACH and partnering organization (Fall 2018)
 - My organization commits to participate in ACH learning events and initiatives, and current governance structures
 - My organization will participate in all monitoring, reporting, and evaluation requirements, including:
 - Semi-annual reporting required by HCA and
 - Monthly and quarterly quality improvement reporting required by Pierce County ACH

Clinical Phase 1 Action Plan Worksheet

Aim: By December 31, 2021, achieve whole-person care by addressing physical and behavioral health integration, opioid misuse prevention and treatment, chronic disease management and prevention, and care coordination

Target Population: Medicaid members with behavioral health (BH) diagnoses, chronic disease, and/or opioid misuse disorder or all. Further describe your target population(s) in the table below.

Medicaid Transformation Target Populations	
<i>Please describe your organization's target population for each of the focus areas in the next 18 months.</i>	
BH/Physical Health Integration	Describe target population criteria: Click here to enter text.
Opioid Misuse Treatment	Describe target population criteria: Click here to enter text.
Chronic Disease Management	Required: Select one or more of the following Chronic Disease target populations: <input type="checkbox"/> Asthma <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Obesity Describe other target population criteria: Click here to enter text.

Instructions: Primary and secondary drivers are set. Tactics are listed for overall system change, and the focus areas of behavioral health/ physical health integration, opioid misuse treatment, and chronic disease management. Tactics with a check mark ✓ are required. Tactics with a check box are listed as possible suggestions and/or there is space to add your own tactics. Please select at least one tactic per secondary driver that your organization commits to implementing in the next 18 months. Do not select tactics that you think your organization already does well.

Note: The focus area of Care Coordination is incorporated as a secondary driver with its own set of tactics.

Primary Driver: Lay the Foundation/ Build Organizational Capacity

Secondary Drivers	System Change Tactics	BH/Physical Integration Tactics	Opioid Misuse Treatment Tactics	Chronic Disease Management Tactics
Engaged Leadership	<ul style="list-style-type: none"> <input type="checkbox"/> Use the IHI Seven Leadership Leverage Points for Organizational-Level Improvement in Health Care to provide visible and sustained leadership to lead overall culture change as well as specific strategies to improve quality and spread and sustain change. <input type="checkbox"/> Ensure providers and staff have dedicated time for improvement activities. <input type="checkbox"/> Other tactics (please list): Click here to enter text. 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Assign behavioral and primary care integration project to a multi-disciplinary team (<i>inclusion of a patient representative recommended</i>) <input type="checkbox"/> Other tactics (please list): Click here to enter text. 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Assign Opioid Misuse Disorder Treatment to a multi-disciplinary team (<i>inclusion of a patient representative recommended</i>) <input type="checkbox"/> Other tactics (please list): Click here to enter text. 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Assign Chronic Disease Management project to a multi-disciplinary team (<i>inclusion of a patient representative recommended</i>) <input type="checkbox"/> Other tactics (please list): Click here to enter text.
Quality Improvement Strategy	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Choose and use a formal model for quality improvement. Suggest Model for Improvement <input type="checkbox"/> Specify model for quality improvement: Click here to enter text. <input type="checkbox"/> Establish and monitor metrics to evaluate improvement efforts and outcome metrics for success <input type="checkbox"/> Include patients, families, providers, and care team members in quality improvement activities. <input type="checkbox"/> Optimize use of health information technology to drive improvement criteria 	<p>Describe your method of improvement to drive systems changes for Behavioral Health/Physical Integration.</p> <p>Click here to enter text.</p>	<p>Describe your method of improvement to drive systems changes for Opioid Misuse Treatment.</p> <p>Click here to enter text.</p>	<p>Describe your method of improvement to drive systems changes for Chronic Disease Management.</p> <p>Click here to enter text.</p>

Primary Driver: Lay the Foundation/ Build Organizational Capacity

Train staff and implement the use of the model for improvement

Other tactics (please list):
[Click here to enter text.](#)

Sustainable business operations	For Behavioral Health providers: Develop a plan to transition to Integrated Managed Care (IMC) payment model	Other tactics (please list): Click here to enter text.	Other tactics (please list): Click here to enter text.	Other tactics (please list): Click here to enter text.
	Develop a plan to transition to Value-based payment (VBP) arrangements	Other tactics (please list): Click here to enter text.	Other tactics (please list): Click here to enter text.	Other tactics (please list): Click here to enter text.
	Population Health Management HIE/HIT – Advance data sharing with other organizations Please describe: Click here to enter text.	<input type="checkbox"/> Other tactics (please list): Click here to enter text.	<input type="checkbox"/> Other tactics (please list): Click here to enter text.	<input type="checkbox"/> Other tactics (please list): Click here to enter text.
	Workforce <input type="checkbox"/> Implement the IHI framework for Improving Joy in Work <input type="checkbox"/> Develop Residency Recruitment and Retention Partnerships <input type="checkbox"/> Develop Partnerships for Graduate Medical Education Programs <input type="checkbox"/> Integrate and/or leverage CHWs/Peer Support Specialists into your workforce	<input type="checkbox"/> Other tactics (please list): Click here to enter text.	<input type="checkbox"/> Other tactics (please list): Click here to enter text.	<input type="checkbox"/> Other tactics (please list): Click here to enter text.

Primary Driver: Build Relationships

Secondary Drivers

System Change Tactics

BH/Physical Integration Tactics

Opioid Misuse Treatment Tactics

Chronic Disease Management Tactics

Empanelment

- Assign all patients to a provider and review and update panel assignments on a regular basis.
- Assess practice supply and demand, and balance patient load accordingly.
- Use panel data and registries to proactively contact, educate, and track patients by disease status, risk status, self-management status, community, cultural, and family need.
- Other tactics (please list):
[Click here to enter text.](#)

- If co-located, Test and implement the integration of behavioral health and physical health care panel management
- If not co-located test and implement a standard process for sharing registries, gaps in care, and patient population outcomes across physical and behavioral health organizations
- Other tactics (please list):
[Click here to enter text.](#)

- Test and implement a standard process for reviewing panel level data on patients with opioid misuse disorder and/or patients who are prescribed opioids.
- Use panel data and registries to proactively contact, educate, and track patients with opioid misuse disorder and/or who are prescribed opioids.
- For non-co-located providers, Test and implement a standard process for integrated treatment plans that are accessible to all providers.
- Develop/implement or improve processes that support continuity of care for all screening, treatment, and follow-up needed by patients who have opioid misuse disorder
- Other tactics (please list):
[Click here to enter text.](#)

- Implement/improve a process for reviewing panel level data on patients with chronic disease and/or who are at risk of chronic disease
- Use panel data and registries to proactively contact, educate, and track patients with chronic disease
- Other tactics (please list):
[Click here to enter text.](#)

Continuous & Team-based Healing Relationships

- Establish and provide organizational support for care delivery teams accountable for the patient population/panel.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members

- Define team roles including those who support patients directly or indirectly and communicate roles to patients.
- Plan and implement a training program on integration and clinical/therapy skills for primary care and behavioral healthcare staff

- Define team roles, including those who support patients with opioid misuse disorder or who are prescribed opioids. Communicate roles to patients.
- Assess training needs of care team and implement a training plan with emphasis on stigma and trauma reduction, trauma

- Define team roles including those who support patients with diabetes directly or indirectly and communicate roles to patients.
- Add team members from outside of the organization such as CHW, pharmacists, dietitians, dentists

Primary Driver: Build Relationships

- Provide clinical and cultural training specific to the care teams' patient panels.
- Optimize use of health information technology to drive improvement criteria
- Train staff and implement the use of the model for improvement
- Other tactics (please list):
[Click here to enter text.](#)

- Assess training needs of care team and implement a training plan with emphasis on stigma reduction, trauma informed care, cultural and language diversity; health literacy; and motivational interviewing
- Integrate CHW/Peer Specialists in the care team
- Other tactics (please list):
[Click here to enter text.](#)

- Informed care, cultural and language diversity; health literacy; motivational interviewing; and opioid misuse disorder treatment and prevention
- Provide training opportunities for MAT for providers and care team members
- Consider integration of CHW/Peer Specialists in the care team
- Other tactics (please list):
[Click here to enter text.](#)

- Assess training needs of care team and implement a training plan with emphasis on stigma reduction, trauma informed care, cultural and language diversity; health literacy; motivational interviewing; and clinical chronic disease topics.
- Consider integration of CHW in the care team
- Other tactics (please list):
[Click here to enter text.](#)

Primary Driver: Change Care Delivery

Secondary Drivers

Organized,
Evidence-based
Care

System Change Tactics

- Implement evidence-based guidelines
- Enable planned interactions with patients by making up-to date information available to all providers and care team at the time of the visit
- Use point-of-care reminders at time of visit based on clinical guidelines
- Identify high-risk populations and ensure they are receiving appropriate care and care management services
- Other tactics (please list):
Click here to enter text.

BH/Physical Integration Tactics

- Identify level of integration using the [SAMSHA-HRSA Center for Integrated Health Solutions Six Levels of Integration](#)
- Current Level: Click here to enter text.
- Goal Level: Click here to enter text.
- Provide [Collaborative Care Model attestation](#)
- Achieve provider-level collaborative care model certification
- Identify the two or more validated screening tools you will adopt for behavioral health conditions and/or substance use disorder
- Develop process for sharing the care plan within and/or across organizations
- Define high-risk populations with behavioral health conditions and/or co-occurring chronic disease and ensure continuity of care/treatment between behavioral and physical healthcare providers
- Other tactics (please list):
Click here to enter text.

Opioid Misuse Treatment Tactics

- [Implement Guidelines on Prescribing Opioids for pain and substance use during Pregnancy](#) (SAMSHA)
- Implement Washington State Medical Directors Group [Interagency Guidelines on Prescribing Opioids for Pain](#)
- For Emergency Department: Implement [Washington Emergency Department Opioid Prescribing Guidelines](#)
- Integrate decision support tools in the Electronic Medical Records (EMR)
- Implement validated substance use screening such as [SBIRT](#) including evaluation for MAT
- Register providers with Prescription Monitoring Program (PMP)
- Integrate PMP with the EMR
- Evaluate appropriateness of co-prescribing naloxone for pain patients
- Other tactics (please list):
Click here to enter text.

Chronic Disease Management Tactics

- Implement evidence-based guidelines for selected chronic disease
- Identify high-risk populations with the selected chronic condition and ensure they are receiving appropriate care and care management services
- Other tactics (please list):
Click here to enter text.

Primary Driver: Change Care Delivery

Person/ Family Engagement

Utilize the Pierce County ACH Community Voices Council for Phase 1 Action Plan feedback.

Develop/implement or improve process for engaging patients/families in decision making in plan of care

Provide self-management support at every visit through goal setting, action planning, and follow-up

Obtain feedback from patients/family about their healthcare experience and use this information for quality improvement

Review how the organization communicates with patients for culturally appropriate and/or health literacy-level communication

Integrate CHWs for Person/Family engagement

Other tactics (please list):
Click here to enter text.

Other tactics (please list):
Click here to enter text.

Other tactics (please list):
Click here to enter text.

Other tactics (please list):
Click here to enter text.

Primary Driver: Reduce Barriers to Care

Secondary Drivers

System Change Tactics

BH/Physical Integration Tactics

Opioid Misuse Treatment Tactics

Chronic Disease Management Tactics

Enhanced Access

- Promote and expand access by ensuring that established patients have 24/7 continuous access to their care team via phone, email, telehealth or in-person visits
- Provide scheduling options that are patient- and family-centered, and accessible to all patients
- Integrate use of CHWs/Peer Supports Specialists in the care team (i.e., ensuring appointments are kept)
- Implement telehealth programs that enhance access
- Other tactics (please list):
[Click here to enter text.](#)

- Other tactics (please list):
[Click here to enter text.](#)

- Increase providers with MAT prescribing authority
- Incentivize providers to use current MAT capacity
- Develop community-clinical linkages to increase access to Naloxone
- Increase access to methadone treatment programs
- Create hospital beds for general community use for opioid utilizers into respite care
- Other tactics (please list):
[Click here to enter text.](#)

- Other tactics (please list):
[Click here to enter text.](#)

Care Coordination

- Develop/implement or improve follow-up with patients upon discharge from emergency department, urgent care, or hospital
- Partner with a Community-based Organization for innovative care transitions (i.e., EMS, Community Paramedicine, CHWs)
- Partner with Community-based Organizations for innovative Diversion

- Other tactics (please list):
[Click here to enter text.](#)

- Other tactics (please list):
[Click here to enter text.](#)

- Partner with community organizations to support and develop evidence-based interventions such as the Stanford Chronic Disease Self-Management Program, Million Hearts Campaign, Diabetes Prevention Program, or Community Paramedicine.
- Other tactics (please list):
[Click here to enter text.](#)

Primary Driver: Reduce Barriers to Care

strategies (i.e., criminal justice, jails, county, Crisis Triage Center, Mobile Community Intervention Response Team

- Participate in HIE platforms that support sharing across organizations
- Develop documented referral, care plan exchange, and follow-up processes with key 'Medical Home Neighborhood' organizations, which may include specialty care, dental services, pharmacies, EMS, schools, criminal justice system, and community-based organizations
- Implement referrals to the Pierce County ACH Community Pathways HUB
- Become a coordinated care agency (CCA) for the Pierce County ACH Community Pathways HUB. Please list target populations of interest:
[Click here to enter text.](#)
- Other tactics (please list):
[Click here to enter text.](#)

Participating Sites

We'd like to know more about the sites from your organization that will be participating in Medicaid Transformation in the next 18 months. Please provide the name, site sponsor, the unduplicated number of Medicaid enrollees served by each site in 2017, and focus areas for each site. (Please attach additional pages to list sites as need.)

Site Name (Name & Title)	Site Location (Address)	Site Sponsor	Medicaid Enrollees Served (number)	Settings/ services provided at this site	Focus Areas
Click here to enter text.	<input type="checkbox"/> Primary Care <input type="checkbox"/> Pediatric Care <input type="checkbox"/> Mental Health <input type="checkbox"/> SUD Treatment <input type="checkbox"/> Dental Care <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Pharmacy	<input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input type="checkbox"/> Chronic Disease Management			
Click here to enter text.	<input type="checkbox"/> Primary Care <input type="checkbox"/> Pediatric Care <input type="checkbox"/> Mental Health <input type="checkbox"/> SUD Treatment <input type="checkbox"/> Dental Care <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Pharmacy	<input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input type="checkbox"/> Chronic Disease Management			
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Click here to enter text.	<input type="checkbox"/> Primary Care <input type="checkbox"/> Pediatric Care <input type="checkbox"/> Mental Health <input type="checkbox"/> SUD Treatment <input type="checkbox"/> Dental Care <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Pharmacy	<input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input type="checkbox"/> Chronic Disease Management			
Click here to enter text.	<input type="checkbox"/> Primary Care <input type="checkbox"/> Pediatric Care <input type="checkbox"/> Mental Health <input type="checkbox"/> SUD Treatment <input type="checkbox"/> Dental Care <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Pharmacy	<input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input type="checkbox"/> Chronic Disease Management			
Click here to enter text.	<input type="checkbox"/> Primary Care <input type="checkbox"/> Pediatric Care <input type="checkbox"/> Mental Health <input type="checkbox"/> SUD Treatment <input type="checkbox"/> Dental Care <input type="checkbox"/> Emergency Dept. <input type="checkbox"/> Pharmacy	<input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input type="checkbox"/> Chronic Disease Management			

Quality Improvement Metrics

How will your organization measure success? Please list **up to three metrics** that your organization would consider using for each of the focus areas below. Refer to the [Medicaid Pay-for-Performance Measures and Pay for Reporting document](#). Metrics may be process or outcomes measures. The Pierce County ACH will use this information to develop a final list of Quality Improvement Metrics for Medicaid Transformation Project. We appreciate your thinking on how to measuring success.

Metric Name	Description	Source	Frequency of Reporting
System Change			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
BH/ Physical Health Integration			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Opioid Misuse Treatment			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Chronic Disease Management			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Metric Name	Description	Source	Frequency of Reporting
Patient Experience			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Staff & Provider Experience			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Medicaid Transformation Resources and Support

What resources and supports will your organization need in the next 6-18 months to achieve the aims describe above?

	Workforce Development, Recruitment, and Retention (Describe)	Population Health Management Health Information Exchange and Technology (Describe)	Building Sustainable Operations (Describe)	Improvement Coaching	Other (Describe)
Technical Assistance Needs	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Training Needs	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Investments Needed (funding, staff, etc.)	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Your Estimated Contributions (In-kind/Direct dollars)	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Please email the completed Phase 1 Action Plan to admin@piercecountyach.org.



Pierce County ACH

Pierce County ACH Community-Based Organization Partner Phase 1 Action Plan

Due Date: June 29, 2018

Please email the completed Phase 1 Action Plan to community-clinicalinkages@piercecountyach.org. Contact Tyneka Rene tyneka@piercecountyach.org for assistance and/or to schedule Pierce County ACH Improvement Advisors to facilitate your team's development of the Phase 1 Action Plan.

Introduction

The Pierce County Accountable Community of Health (Pierce County ACH) is a group of fierce pioneers, committed to health systems change. Our role is to connect health innovation and transformation efforts at the state and local levels. We do this by engaging with community volunteers and partners to develop and support sustainable improvements to the physical and mental health of all Pierce County residents through innovative strategies, collaboration and partnerships.

We seek transformation that not only improves overall outcomes, but also improves access and quality of care for all members of our community. Our goal is to explicitly address the systematic causes of disparities and inequity using the Quadruple Aim that sets goals of better health, better care, lower costs, and improving the work life of health care providers.

We are funded through the Medicaid Transformation Reform Program, a five-year agreement between Washington State and the federal government's Centers for Medicare and Medicaid Services. It will provide up to \$1.5 billion to Washington State for regional projects and health improvement investments through incentive-based payments. Pierce County Accountable Community of Health is one of nine ACHs in the state.

The partner action planning process is divided into two phases—Phase 1 Action Plan and Phase 2 Action Plan. The Phase 1 Action Plan is a high level summary of the innovation/program your organization will use to achieve the goals of the Medicaid Transformation Project. Phase 2 will be a more detailed plan and will be required for the binding letter of agreement which will be completed in the Fall 2018.



Pierce County **ACH**

Partners who complete the Phase 1 Action Plan will receive Medicaid Transformation [incentivefunding](#) from Pierce County ACH. To receive funding, you must:

- 1) Register with the financial executor and
- 2) Complete the Community-Based Organizational (CBO) Assessment.

To register with the financial executor, email to Maggie@piercecountyach.org, your:

- 1) legal name as written on your tax identification
- 2) tax identification number
- 3) the contact name and email address of the person in operations who can work with Maggie to transfer our payment to you into your bank account.

If your organization has not completed the CBO Assessment, please complete it prior to completing this Phase 1 Action Plan. Click [here](#) for CBO Assessment.

If you have not already completed the Health Information Exchange/Health Information Technology (HIE/HIT) Assessment and are interested in completing it, click [hereforHIE/HITAssessment](#). There is no requirement for you to complete the HIE/HIT Assessment.

About the Phase 1 Action Plan

The purpose of completing this action plan is to:

- Develop your organization's high-level plan through December 2019 for systems transformation
- Identify your organization's areas of needed investment to minimize the gaps and achieve the goals of Medicaid Transformation
- Identify potential metrics that guide Pierce County ACH's metrics list based on the Health Care Authority (HCA) requirements, Pierce County ACH stakeholder input, and partner recommendations
- Guide Pierce County ACH's overall plan for regional investments, technical assistance, partner development, evaluation and shared learning

The Medicaid Transformation Project is large and complex. The Pierce County ACH seeks to translate Health Care Authority requirements such as the Medicaid Toolkit into a format that is actionable and reduces the burden for our community based organization partners. The framework for action planning uses a systems-change approach that will support a transformed health system long past the transformation efforts. The areas of expected change that are particularly relevant for community-based organizations are changing care delivery by strengthening the link between



community and clinical systems and reducing barriers to care. The aim, primary and secondary drivers have been developed by Pierce County ACH using our region's [RulesofEngagement](#) as developed and approved by community partners.

Tips for Completing the Phase 1 Action Plan Worksheet

- Complete the Community-Based Organizational Assessment. Click [here](#) for CBO Assessment
- Schedule a 2-3-hour block of time with your leadership team to complete this Action Plan: Phase 1 worksheet. Pierce County ACH can provide a facilitator to support your planning process. Contact Tyneka Rene Tyneka@piercecountyach.org to schedule a Pierce County ACH facilitator.
- Define the population you will be working with to achieve the Aim. Your defined population must include one or more of the following target populations: behavioral illnesses, opioid addiction, or chronic disease. It may include one or more of the other Pierce County ACH's [RulesofEngagement](#) target populations.
- Describe your proposed intervention, program and/or partnership that supports the health and well-being of the population(s) you plan to work with, including the tactics your organization intends to work on through December 2019 and possibly beyond, how you will authentically engage with this population and how your strategy advances health equity.
- Identify the business operations you either have or need to develop to make the proposed intervention, program and/or partnership sustainable.
- Identify measures that you think demonstrate how you will know if you are successful in meeting the Aim over the next five years.
- Identify your organization's investment in these activities.
- Identify what resources you need from external sources such as the Pierce County ACH.
- Identify what training and technical assistance you need from the Pierce County ACH.



Organizational Information

1. Organization Name: Samoan Nurses Org. in WA (SNOW)

2. Who is the organizational executive sponsor for this Action Plan?

Name: Siniva Driggers

Title: President

Organization: SNOW

Email Address: sinivadriggers123@gmail.com

Phone Number: 253-632-9559

3. How does the Medicaid Transformation Project work fit with your organization's vision, mission, and/or strategic plan?

Our vision and mission is healthy Pacific Islanders and all other people in Pierce County. We accomplished this vision with a mission to provide Health Prevention Awareness and Education in the community we serve. We provide these educations through outreach and workshops. We arranged workshops and education in Church group, Senior meal sites and other senior groups and Youth Organizations to teach and give knowledge to help people make wise healthy decisions. We provide other resources to help meet their daily living needs.

4. Pierce County ACH is using the [PartnershipAcceleratorFramework](#) as the continuum of partnership development to achieve the Medicaid Transformation Project goals. How will your organization advance along the continuum in the next 18 months? Please describe actions, policies, and initiatives you plan to implement with which partners. (You may attach additional documents that describe your approach to partnerships.)

We will continue to provide as mention above through education like we have been doing, by referring and connecting people with brokers and other health provider for health insurance and seemed to help them. We help our community with language difficulty and be their voice in doctor's office and in clinics and other places like housing needs. We collaborate with other agency like Mercy Housing and other low income housing for places to apply. We had in the past collaborated with Tacoma Pierce County Health Department with community health



Pierce County **ACH**

worker project doing self management blood pressure project and chronic disease education when they were able to fund for couple months.

- 5. Pierce County ACH is using the [HealthEquityAcceleratorFramework](#) as the continuum of the integration of health equity across your organization's services to achieve the Medicaid Transformation Project goals. How will your organization advance along the continuum in the next 18 months? Please describe actions, policies, and initiatives you plan to implement. (You may attach additional documents that describe your approach to equity.)

We will continue build relationship and trust along with being seeing in the community with them. We found out that people will participate if we are there when we said we will, even if few people showed up. We provide incentives with services that asking for people's private info and promised not to share. We help all people that need services not just our service population. We phone people and make them aware if we need to come to their homes. For example, I got contact info from other family and relatives of clients, then i call them if i could come and fill the survey, they welcome me very well. One of the thing they like, they can see someone that care about them and their needs. Being in person or one to one is one of the action that works very well. We leave our contact info and answer when they call. We know it is time consuming but work best.

Continue group outreach and provide incentives to attract people also a good method that works good too. It help other people to voice their needs and benefit those who are uncomfortable to speak up.

We continue provide interpretation with all issues when people needed, which is a service we have been doing without compensation.

- 6. Please attest to the following:

Leadership at my organization has read the embedded supporting materials provided with this Action Plan

I understand that this Phase 1 Action Plan will be followed by a deeper Phase 2 Action Plan that will inform a binding agreement between Pierce County ACH and partnering organization (Fall 2018).

My organization commits to participate in ACH learning events and initiatives, and current governance structures.

My organization will participate in all monitoring, reporting, and evaluation requirements, including:

- Semi-annual reporting required by HCA and
- Monthly and quarterly quality improvement reporting required by Pierce County ACH.





Community-Based Organization: Phase 1 Action Plan Worksheet

Aim: By December 31, 2021, achieve whole-person care by supporting the health and well-being of people with co-occurring physical and behavioral health diagnoses, opioid misuse prevention and treatment, and chronic disease management and prevention.

Target Population: Medicaid members with behavioral health (BH) diagnoses, chronic disease, and/or opioid misuse disorder or all. Further describe your target population(s) in the table below.

Medicaid Transformation Target Populations	
<i>Please describe your organization's target population for one or more focus areas in the next 18 months.</i>	
Behavioral Health Disorder Prevention and Management (e.g., depression, anxiety, bi-polar disorder, schizophrenia, etc.)	Describe target population criteria: Click here to enter text.
Opioid Misuse Prevention and Management	Describe target population criteria: Click here to enter text.
Chronic Disease Prevention and Management (e.g., asthma, cardiovascular disease, COPD, diabetes, hypertension, obesity)	Describe other target population criteria: Cardiovascular disease, COPD, Diabetes, Hypertension and Obesity: -Provide prevention awareness through education in all these conditions -Provide referral services for those who need treatment -Provide follow up to check with doctors appointments -Follow up reminder for other appointments
Other	Describe other target population criteria: Click here to enter text.



Instructions

Based on the target populations you identified above, please elaborate on the proposed intervention, program and/or partnership that supports the health and well-being of your target population. Be sure to answer all the questions in the corresponding column. For example, if it is an intervention, program or partnership designed to prevent and/or manage chronic disease, answer all the questions in the Chronic disease prevention and management column. If there is a question that is not applicable to your proposal, please enter N/A in that space.

The proposed intervention, program and/or partnership that supports the health and well-being of your target population

	Behavioral Health Disorders Prevention and Management	Opioid Misuse Prevention and Management	Chronic Disease Prevention and Management
What is the aim or goal of your proposal?	Click here to enter text.	Click here to enter text.	The goal is to help people meet their needs through our services and effort by educating them to help them make wise decisions for their health.
Describe the proposed intervention, program and/or partnership	Click here to enter text.	Click here to enter text.	We collaborate with Mercy Housing for housing needs. We collaborate with brokers to refer people find health insurance. We collaborate with TPCHD to help fund existing project and new project like diabetes and obesity awareness. We partner with Carol Milgard for breast cancer awareness.
Describe your partners and the nature of their commitment	Click here to enter text.	Click here to enter text.	As described above my plan of collaboration with several agencies depend on their fund availability.
Identify any evidence base that supports your approach	Click here to enter text.	Click here to enter text.	We have stories to prove what my plan works with the community we serve. Ex: A man complained of poor vision unable to read his Bible. I took him to the optometrist and he was refer to the Opthormology clinic and was taking care



			of by having both eyes operated, and it help him see good again.
Describe how this proposal fits into your current portfolio of work. Is it a new intervention? A way to scale and spread an existing intervention? Is it currently funded by a different source? Does it replace existing programs or services?	Click here to enter text.	Click here to enter text.	It is not a new way for me to do work. I serve these people in senior meal sites that i provide bp clinics and that's where i found them. I know it works because the word of mouth is powerful and that's how they found out of what i do. I have no fund for this work, i do it because i saw the need and people have results.
Other	Click here to enter text.	Click here to enter text.	Click here to enter text.



Tactics you will use to deeply connect with your target population

	Behavioral Health Disorders Prevention and Management	Opioid Misuse Prevention and Management	Chronic Disease Prevention and Management
How you will reach your target population?	Click here to enter text.	Click here to enter text.	Word of mouth as i mentioned earlier and i constantly out in the community serving and part of other cultural organizations where people come and that's my approach that works.
How you will address language barriers?	Click here to enter text.	Click here to enter text.	I provide translation and interpretation for free. I do it all the time with projects I presented to make sure people really understand what i have been telling them.
How you will address cultural differences?	Click here to enter text.	Click here to enter text.	Basically ask people what they prefer to be address or to be call. I can refer them to other appropriate agencies so they can be serve. If they don't mind working with me to help them i will.
How you will promote and expand access for support/services during nontraditional business hours (e.g., 24/7 continuous access via phone, email, tele-health or in-person visits; telehealth)?	Click here to enter text.	Click here to enter text.	I will have a list of other resources and appropriate business i can refer people if they need after hour services. I do not have the capacity for telehealth or nurse on call services.
Identify other organizations you partner with to reach your target population	Click here to enter text.	Click here to enter text.	Asia Pacific Island community center. Local churches and i have connection with Salishan community and housing and community health clinic.
Other	Click here to enter text.	Click here to enter text.	Click here to enter text.

Tactics you will use to reduce barriers to care

	Behavioral Health Disorders Prevention and Management	Opioid Misuse Prevention and Management	Chronic Disease Prevention and Management
Describe how you will partner with health systems to support innovative care transitions (e.g., from hospital stays, jail, long-term care, etc.).	Click here to enter text.	Click here to enter text.	I will connect with the providers to see if they need help doing community follow up visits with their patients.
Describe how you will partner with health systems for innovative diversion strategies (i.e., criminal justice, jails, Crisis Triage Center, etc.).	Click here to enter text.	Click here to enter text.	We use to partner with APCC doing jail outreach to visit and let them know that we are available in the community when they are ready to come out. We're not doing it now because of restrictions of jail system with their laws.
Describe how you will support health systems who are developing 'Medical Home Neighborhood' to develop documented referral, care plan exchange, and follow-up processes with organizations such as specialty care, dental services, pharmacies, EMS, schools, criminal justice system, and community-based organizations.	Click here to enter text.	Click here to enter text.	I do documentation of the work i do. I support documentation by giving results of bp checks to each client that ask to provide results of their bp checks during my clinic so they can show to their doctors. I have no capacity doing electronic documentation but i do with paper communication what i do in the

			community so the provider knows what their patient is doing in the community.
Describe how you will access appropriate care coordination services such as Pierce County ACH Community Pathways HUB	Click here to enter text.	Click here to enter text.	I connect with those care coordination agency and offer my service and help I can provide to bring services to the community and report back results.
Other	Click here to enter text.	Click here to enter text.	Click here to enter text.

Tactics you will use to advance health equity

	Behavioral Health Disorders Prevention and Management	Opioid Misuse Prevention and Management	Chronic Disease Prevention and Management
How will you include the target population, both individuals and families, in decision-making and developing their care?	Click here to enter text.	Click here to enter text.	As mentioned earlier i go to them and ask what they think what works for their situation. Let them tell me what has been working and not working for their situation, then we discuss some solutions that they can try.
How will you regularly get feedback from the target population?	Click here to enter text.	Click here to enter text.	Same as above is to go to them. Call and ask for meeting. Give them my contact info we can connect.
How you will communicate with the target population for culturally appropriate and/or health literacy-level communication?	Click here to enter text.	Click here to enter text.	I'm in the culture that live and know how to manage issues culturally and know the language and appropriate approach when problem arise.
How will you address racism?	Click here to enter text.	Click here to enter text.	Talk about it and respect people like i wanted to be treated.



How will you reduce stigma?	Click here to enter text.	Click here to enter text.	Do what i do best and know how and be mindful of people's feeling.
How will you address trauma and/or adverse childhood experiences (ACEs)?	Click here to enter text.	Click here to enter text.	This is a new phenomenon in my culture. I understand how to deal with now, but it takes time for my population to learn what that has to do with them.
How will you recruit and retain staff who reflect the diversity of your clients	Click here to enter text.	Click here to enter text.	I have to be an example to them. Do treat them with respect and honest
Other	Click here to enter text.	Click here to enter text.	Click here to enter text.



Organizational capacity to successfully implement and sustain the proposed transformation

	Behavioral Health Disorders Prevention and Management	Opioid Misuse Prevention and Management	Chronic Disease Prevention and Management
Describe the various capabilities, resources, workforce, and expertise your organization has to successfully complete the transformation plan you outlined above.	Click here to enter text.	Click here to enter text.	As explained earlier, education is our aim and goal for people to understand what is going on in the health care system and their role in reporting what they feel is good and what needed to change. We build relationship so they trust us with their info.
Describe your ability to be responsive to potential monitoring requirements and to produce outcome data.	Click here to enter text.	Click here to enter text.	Data collection is one of the way to know we reach people like we plan. We have no capability for electronic data collection but we do some paper recording.
What systems do you currently have in place or will put into place for your organization to think long-term as well as to manage its day-to-day operations of transformation efforts?	Click here to enter text.	Click here to enter text.	I don't have a new system but the way i know how to record events and projects i do is mainly paper record.
Describe how you plan to sustain your transformation efforts overtime and outside of the potential waiver dollars.	Click here to enter text.	Click here to enter text.	I plan to be transparent and maintain good and healthy relationships with people that they will put their trust in what i do to help them.



Describe how you will learn about how well your intervention is working. Indicate a need for assistance in developing a quality improvement and evaluation system on the last page of this Action Plan.

	Behavioral Health Disorders Prevention and Management	Opioid Misuse Prevention and Management	Chronic Disease Prevention and Management
What formal model for quality improvement will you use? For example, <i>Model for Improvement</i>	Click here to enter text.	Click here to enter text.	When i hear and see good results from what people say about my work, i know i change someone’s thinking. So my model is to be present and be seen by the community and offer what i know will make a change in people’s lives.
Describe how will you establish and monitor metrics to evaluate improvement efforts	Click here to enter text.	Click here to enter text.	I will need some help in this if not any of those things i already mentioned doesn’t apply to this.
Describe how will you establish and monitor metrics to evaluate your outcomes	Click here to enter text.	Click here to enter text.	Same thing as i mentioned above.
Describe how will you obtain feedback from patients/family about their experience and how you will use this information for quality improvement	Click here to enter text.	Click here to enter text.	I have lots of stories related to outcome of what people experienced from the help they got.
Describe how will you include other organizations that work with your clients in quality improvement activities	Click here to enter text.	Click here to enter text.	I will share my experience and offer my expertise to help other organization that ask for my help in doing their project.
Describe how will you assure that staff have the skills and time to participate in quality improvement activities	Click here to enter text.	Click here to enter text.	I am the one who give instructions and teach them with skills they need. We do meet on the phone due to staff different schedules.





Participating Sites

We'd like to know more about the sites from your organization that will be participating in Medicaid Transformation in the next 18 months. Please provide the name, site sponsor, the unduplicated number of Medicaid enrollees, if known, served by each site in 2017, and focus areas for each site. (Please add rows or attach additional pages to as needed.)

Site Name (Name & Title)	Site Location (Address)	Site Sponsor	Medicaid Enrollees Served (number)	Settings/Services Provided at This Site	Focus Areas
Apcc Samoan Seniors of Tacoma- meal site	4851 South Tacoma Way Tacoma, WA 98409	Samoan Nurses Organization in WA SNOW	Click here to enter text.	<input type="checkbox"/> Social Service <input type="checkbox"/> Housing <input type="checkbox"/> Public Health <input type="checkbox"/> Educational <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Institution <input checked="" type="checkbox"/> Community <input type="checkbox"/> EMS/Fire & Rescue <input type="checkbox"/> Center <input type="checkbox"/> Other (describe: <input type="checkbox"/> Click here to enter text.	<input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input checked="" type="checkbox"/> Chronic Disease Management
Good Samaritan Church Samoan Seniors meal site	Good Samaritan Church 8421 S G Street Tacoma, WA 98444	Pastor T. Asaeli & Pastor M. Pomele	Click here to enter text.	<input type="checkbox"/> Social Service <input type="checkbox"/> Housing <input type="checkbox"/> Public Health <input type="checkbox"/> Educational <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Institution <input checked="" type="checkbox"/> Community <input type="checkbox"/> EMS/Fire & Rescue <input type="checkbox"/> Center <input type="checkbox"/> Other (describe: <input type="checkbox"/> Click here to enter text.	<input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input checked="" type="checkbox"/> Chronic Disease Management
Mercy Housing	1709 S G Street Tacoma, WA 98405	Mercy Housing	Click here to enter text.	<input checked="" type="checkbox"/> Social Service <input checked="" type="checkbox"/> Housing <input type="checkbox"/> Public Health <input type="checkbox"/> Educational <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Institution <input type="checkbox"/> Community <input type="checkbox"/> EMS/Fire & Rescue <input type="checkbox"/> Center <input type="checkbox"/> Other (describe: <input type="checkbox"/> Click here to enter text.	<input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input checked="" type="checkbox"/> Chronic Disease Management
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	<input type="checkbox"/> Social Service <input type="checkbox"/> Housing <input type="checkbox"/> Public Health <input type="checkbox"/> Educational <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Institution	<input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment



				<input type="checkbox"/> Community <input type="checkbox"/> Center <input type="checkbox"/> Other (describe): Click here to enter text.	<input type="checkbox"/> EMS/Fire & Rescue <input type="checkbox"/> Chronic Disease Management
Click here to enter text.	<input type="checkbox"/> Social Service <input type="checkbox"/> Public Health <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Community <input type="checkbox"/> Center <input type="checkbox"/> Other (describe): Click here to enter text.	<input type="checkbox"/> Housing <input type="checkbox"/> Educational <input type="checkbox"/> Institution <input type="checkbox"/> EMS/Fire & Rescue <input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input type="checkbox"/> Chronic Disease Management			
Click here to enter text.	<input type="checkbox"/> Social Service <input type="checkbox"/> Public Health <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Community <input type="checkbox"/> Center <input type="checkbox"/> Other (describe): Click here to enter text.	<input type="checkbox"/> Housing <input type="checkbox"/> Educational <input type="checkbox"/> Institution <input type="checkbox"/> EMS/Fire & Rescue <input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input type="checkbox"/> Chronic Disease Management			
Click here to enter text.	<input type="checkbox"/> Social Service <input type="checkbox"/> Public Health <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Community <input type="checkbox"/> Center <input type="checkbox"/> Other (describe): Click here to enter text.	<input type="checkbox"/> Housing <input type="checkbox"/> Educational <input type="checkbox"/> Institution <input type="checkbox"/> EMS/Fire & Rescue <input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input type="checkbox"/> Chronic Disease Management			
Click here to enter text.	<input type="checkbox"/> Social Service <input type="checkbox"/> Public Health <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Community <input type="checkbox"/> Center <input type="checkbox"/> Other (describe): Click here to enter text.	<input type="checkbox"/> Housing <input type="checkbox"/> Educational <input type="checkbox"/> Institution <input type="checkbox"/> EMS/Fire & Rescue <input type="checkbox"/> BH/ Physical Health Integration <input type="checkbox"/> Opioid Misuse Treatment <input type="checkbox"/> Chronic Disease Management			





Quality Improvement Metrics

How will your organization measure success? Please list **up to three metrics** that your organization would **consider** using for each of the focus areas below. Refer to the [Medicaid Pay-for-Performance Measures and Pay for Reporting document](#) to better understand the metrics for which Pierce County ACH will be held accountable by the HCA. Metrics may be process or outcomes measures. Pierce County ACH will use this information to develop a final list of Quality Improvement Metrics for Medicaid Transformation Project. We appreciate your thinking on how to measure success.

Metric Name	Description	Source	Frequency of Reporting
System Change			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
BH/ Physical Health Integration			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Opioid Misuse Treatment			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Chronic Disease Management			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.



2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Individual and Family Experience			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Staff Experience			
1. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
2. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
3. Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

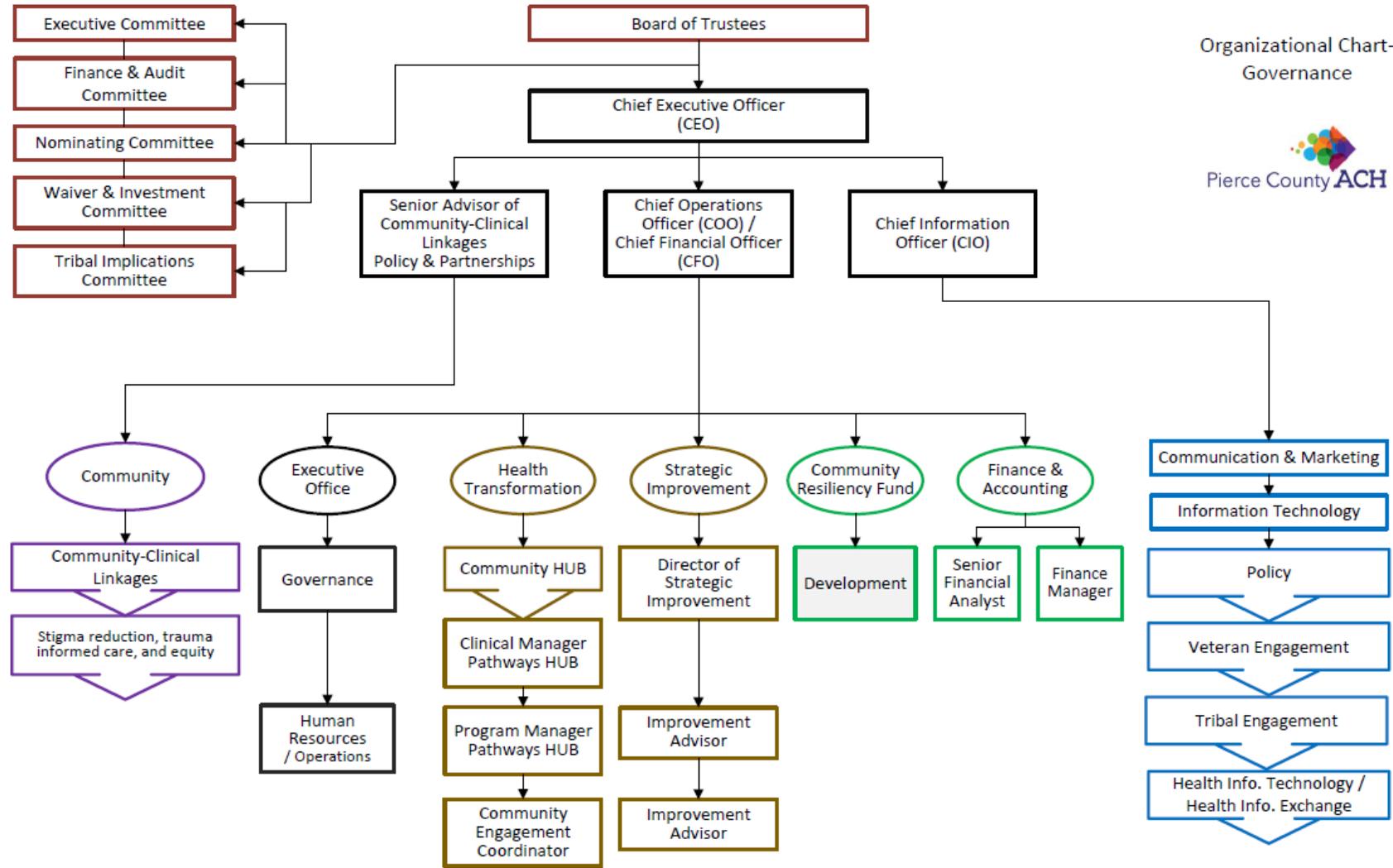
Medicaid Transformation Resources and Support

What resources and supports will your organization need in the next 6-18 months to achieve the aims describe above?

	Workforce Development, Recruitment, and Retention (Describe)	Building Sustainable Operations (Describe)	Population Health Management Health Information Exchange and Technology (Describe)	Quality Improvement and Evaluation Systems	Other (Describe)
Technical Assistance Needs	We need help to recruit workers	We don't have a building. We go to where programs already there	We need to connect to data process	We need help in this	We need fund for mileage
Training Needs	We need workers to help	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Investments Needed (funding, staff, etc.)	We don't have money to be invested	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Your Estimated Contributions (In-kind/Direct dollars)	I don't have fund to contribute but i have a lot of time	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Please email the completed Phase 1 Action Plan to community-clinicalinkages@piercecounyach.org



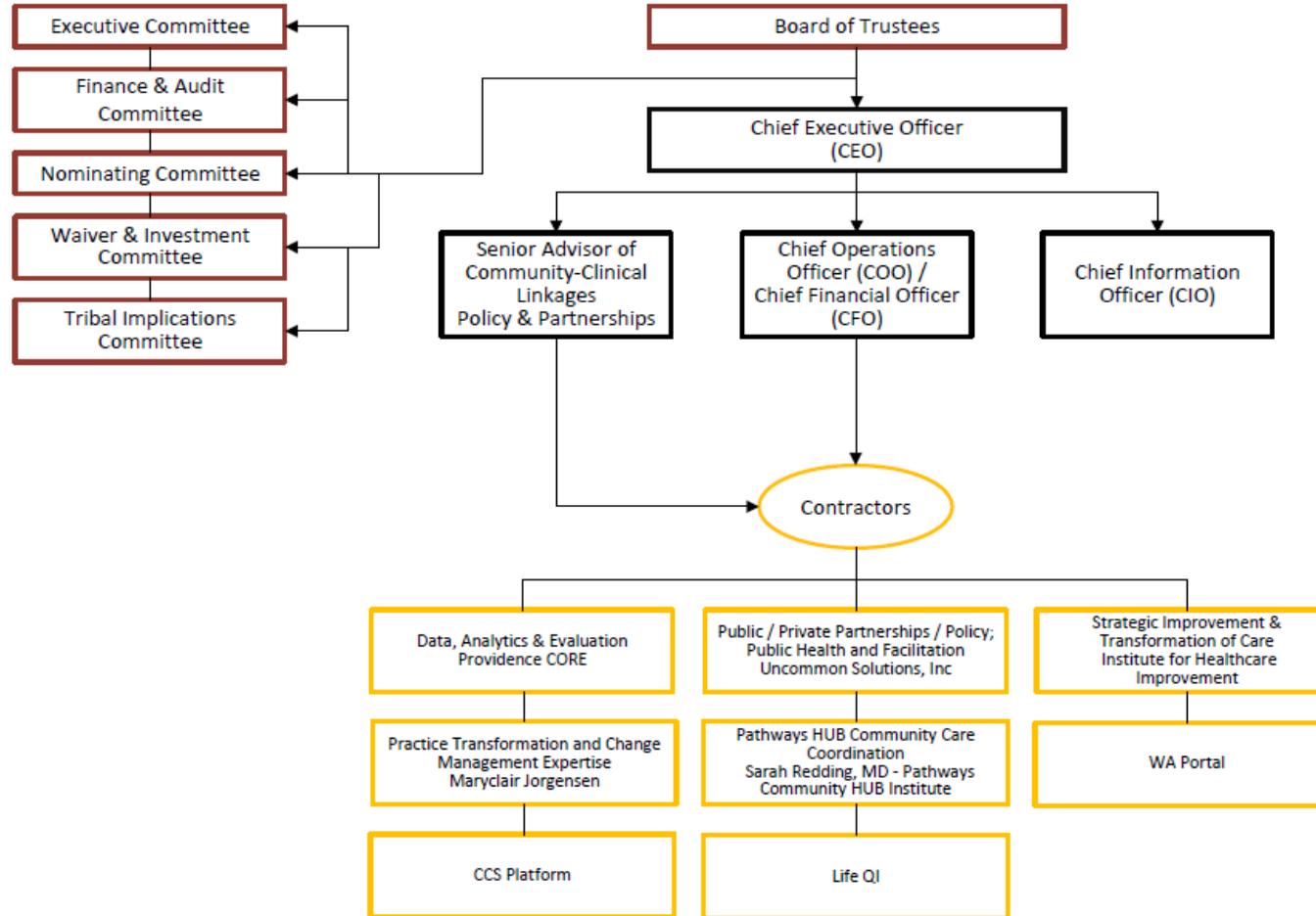


Organizational Chart-Governance



LEGEND

- Black = Executive
- Brown = Strategy & Operations
- Grey box indicates position currently vacant. Plan to fill by 2018
- Orange = Consultant
- Purple = Community Relationships
- Blue = Technology
- Green = Finance
- Dark Red = Committees
- Arrow Boxes (any color) = Function



Organization Name	Letter of Intent	Assessments			Action Plans		
		HIT/HIE	Clinical	CBO	CAP Phase 1	CBO Phase 1	CAP Phase 2
1 Asian Counseling Treatment Services/ ACTS	1	1	1		1		
2 Catherine Place				1			
3 Catholic Community Services of Western Washington	1		1		1	1	
4 Center for Dialogue and Resolution	1			1		1	
5 Centerforce	1			1			
6 Central Pierce Fire & Rescue	1	1				1	
7 CHI Franciscan Health System	1	1	1		1		
8 Children's Home Society of WA	1						
9 City of Tacoma	1			1			
10 City of Tacoma Fire Department	1	1				1	
11 Community Health Care	1	1	1		1		
12 Comprehensive Life Resources	1	1	1		1		
13 Consejo Counseling and Referral Service	1	1	1	1	1	1	
14 Answers Counseling Consultation & Case Mgmt service	1			1		1	
15 East Pierce Fire and Rescue	1	1			1		1
16 Emergency Food Network	1			1			
17 First 5 FUNDamentals	1			1		1	
18 Graham Fire & Rescue	1			1		1	
19 Greater Lakes Mental Healthcare	1	1	1		1		
20 HopeSparks	1	1	1	1	1		
21 Kaiser Permanente of Washington	1	1	1		1		
22 Korean Women's Association (KWA)	1	1		1		1	
23 Leaders in Women's Health	1						
24 Lutheran Community Services NW	1						
25 Metropolitan Development Council	1	1	1	1	1		
26 Multicare Behavioral Health	1	1	1				
27 MultiCare Health System	1						
28 Northwest Integrated Health	1	1			1		
29 Northwest Physicians Network	1	1	1		1		
30 Olalla Recovery Centers		1			1		
31 Orting Valley Fire & Rescue	1			1			
32 Pediatrics Northwest P.S.	1	1	1		1		
33 Perinatal Collaborative of Pierce County	1					1	
34 Pierce County AIDS foundation	1			1		1	
35 Pierce County Office of the Executive	1						
36 Pierce County Human Services	1	1		1		1	
37 Pioneer Human Services	1	1	1		1	1	
38 Planned Parenthood of the Great Northwest and the Hawaiian Islands	1	1	1		1		
39 Prosperity Counseling & Treatment Services	1	1	1		1		
40 Pt. Defiance Aids Project/Tacoma Needle Exchange	1			1		1	
41 Sea Mar Community Health Centers	1	1	1				
42 Somoan Nurses Org in WA	1			1		1	
43 Sound Outreach	1			1			
44 Step By Step				1		1	
45 Tacoma Pierce County Affordable Housing Consortium				1			
46 Tacoma-Pierce County Health Department - Treatment Services Program	1		1		1		
47 Tacoma-Pierce County Health Dept	1	1		1		1	
48 United Way of Pierce County	1			1			
49 West Pierce Fire & Rescue	1			1			
50 Tacoma Housing Authority				1		1	
51 New Connections				1			
52 Safe Streets				1		1	
Total Submissions	45	24	19	30	18	20	

Key	
	Overdue
	Not applicable
1	submitted
bold	eligible CBO and Clinical