

## SECTION I: ACH-LEVEL

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### Regional Health Needs Inventory

*Under the Demonstration, ACHs will use data to support project selection and design. As part of this data-driven planning effort, ACHs conduct an assessment to identify regional health needs, disparities in care, and significant gaps in care, health, and social outcomes. Data used in the regional health needs analysis may include data sources provided by the state and other public sources, as well as regional and local-level data sources, and existing reports or other assessments (e.g. community, hospital). It is expected that the regional health needs inventory will be conducted in collaboration with regional stakeholders, partners, and providers who have knowledge of local data and conditions.*

Describe how the ACH has used data to inform its decision-making, from identifying the region's greatest health needs, to project selection and implementation planning. This section should serve as a summary description of how data were used. Additional data relevant to specific projects should be referenced in each project description and justification in Section II of the Project Plan Template.

Address the following:

- Describe how the ACH has used data to inform its project selection and planning.
- Describe the data sources the ACH has acquired or gathered to inform its decision-making, noting where data were provided by partnering providers (Managed Care Organizations (MCOs), providers, Community-Based Organizations (CBOs), etc.).
- Provide a high-level summary of the region's health needs relevant to Demonstration project planning. Highlight key sub-regions or sub-population groups if/as appropriate. For each identified topic, cite the data sources and the processes/methods used:
  - Medicaid beneficiary population profile, including number of beneficiaries, geographic, demographic and socioeconomic characteristics, and prevalence of adverse social determinants of health
  - Medicaid beneficiary population health status, including prevalence of chronic conditions, vital statistics, and other measures of health
  - Existing health care providers serving the Medicaid population (e.g., hospitals, Federally Qualified Health Centers, primary care providers, mental health and substance use disorder treatment providers) available across the care continuum in the community, and how these health care providers are currently serving the Medicaid population
  - Existing community-based resources available to the Medicaid beneficiary population (e.g., supportive housing, homeless services, legal services, financial assistance, education, nutritional assistance, transportation, translation services, community safety,

- and job training or other employment services), and how those community-based organizations are currently serving the Medicaid population
  - Medicaid beneficiary population’s level of access or connection to care, and their greatest barriers to accessing needed health care and supportive services
- Outline any identified capacity or access gaps between the Medicaid population’s identified health care and health care access needs, and the services (or service capacity) currently available from identified providers and CBOs.

## ACH Response

### *Describe how the ACH has used data to inform its project selection and planning*

Since its inception in 2015, the [Performance Measurement and Data Committee](#) (PMD, formerly the Performance Measurement Work Group), a committee of the King County Accountable Community of Health (KCACH), has worked to support the evolving data and information needs of the KCACH and advance data integration overall in the context of health and social services transformation (Appendix 1). KCACH leveraged the work of the PMD to ensure a data-driven approach to project selection and planning.

To date, the PMD has used three approaches to use data to inform KCACH project selection and planning. First, the PMD engaged in a multi-ACH advocacy approach to identify and communicate to the state the cross-cutting data needs for project selection and planning. In response, the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) have produced multiple data products over the past few months to assist in identifying regional needs and gaps. Second, the PMD developed an online, interactive, dynamically updated Regional Health Needs Inventory ([RHNI](#)) that includes health, social, and demographic information on [Medicaid](#) clients and the [overall](#) population of King County; [care/client volume data](#) by service type, provider, and diagnostic categories; [information](#) about the pay-for-performance (P4P) measures; and a [KCACH performance gap analysis](#). Lastly, the PMD assigned data support staff to each project Design Team to meet targeted data needs during the project selection and planning process. An example of a customized data slide deck prepared for a project Design Team is attached (Appendix 2).

The RHNI has been used to identify Medicaid and overall population health needs and disparities across the region, especially regarding the statewide outcome measures. This tool allowed the Governing Board and the Demonstration Project Committee (DPC) to evaluate which strategies from the Medicaid Transformation Project toolkit would be most likely to drive toward improved outcomes and reduced disparities. The [King County Performance Gap Analysis](#) has been used to support project selection by visualizing the magnitude of improvement required to hit initial improvement targets for given projects and P4P measures. Specifically, this tool has been used in project Design Teams and DPC meetings to compare the “number needed to treat” across projects and measures. This tool has been helpful in improving KCACH stakeholder understanding of what is expected, what may be within reach, and how certain improvement targets will be shared across multiple project areas (e.g., emergency department utilization).

***Describe the data sources the ACH has acquired or gathered to inform its decision-making, noting where data were provided by partnering providers (Managed Care Organizations (MCOs), providers, Community Based Organizations (CBOs), etc.).***

The PMD has relied upon administrative data (e.g., Medicaid claims), vital statistics, population-based surveys, and program data to guide initial thinking around project selection and planning. Data sources have included: official population estimates (Office of Financial Management), demographic and social determinants of health data (US Bureau of Labor Statistics, American Community Survey, Office of Superintendent of Public Instruction, DSHS Community Risk Profiles), Behavioral Risk Factor Surveillance System, birth records, death records, Pregnancy Risk Assessment Monitoring System, Title X trends, all-payer hospitalization data (Comprehensive Hospital Abstract Reporting System), Medicaid eligibility and claims data (First Steps Database, Community Checkup), jail health data, emergency medical services data, and dental service utilization data from the Arcora Foundation (formerly the Washington Dental Service Foundation). These data sources have either been provided by the state (RHNI “Starter Kit,” ESHB 1519/5372 measures from DSHS Research and Data Analysis, Healthier Washington Dashboard, ad hoc data products) or derived from locally available data.

Managed care organizations have been part of the PMD since its inception. Under the Medicaid Transformation Project (MTP), they have provided valuable input about data resources and project planning, including identifying [alignment](#) between their 1% premium withhold value-based payment measures and the MTP’s P4P measures. To date, specific data products have not been requested of managed care organizations, consistent with their collective wishes for claims data-related requests to be centralized at the HCA. Both existing and newly shared provider data have been used occasionally for project planning, including jail, jail health services, and Harborview Medical Center emergency department data generated for the Familiar Faces Initiative (i.e., high jail utilizers with behavioral health conditions).

***Provide a high-level summary of the region’s health needs relevant to Demonstration project planning:***

***Who are Medicaid members? A demographic and socioeconomic comparative analysis of King County’s Medicaid population***

As of February 2017, total Medicaid enrollment in King County was 430,977 (HCA enrollment totals, HCA correspondence). Of these, 425,470 (98.7%) had coverage offering full medical benefits. Excluding partial duals (who will not be included in P4P measures), enrollment drops to 412,836 (95.8% of total enrollment). To assess geographic distribution of Medicaid enrollee residence, the PMD generated a series of zip code-level maps to support project selection and planning (Appendix 3), which also included zip code-level maps of emergency department visits (broad definition) and avoidable emergency department visits. Half of the King County Medicaid population resides in 17 zip codes that comprise south Seattle neighborhoods (Georgetown, Beacon Hill, Rainier Valley), Southwestern cities (Auburn, Covington, Des Moines, Federal Way, Kent, Renton, and SeaTac/Tukwila), and the North End (Shoreline, Aurora corridor).

Given that Medicaid eligibility aligns tightly with income and other characteristics (e.g., disability status), there are large and expected demographic and socioeconomic characteristic differences

between Medicaid and non-Medicaid individual residents of King County. Using American Community Survey data (2015 Public Use Microdata Sample), the PMD conducted a demographic and socioeconomic analysis of the Medicaid and non-Medicaid populations in King County, with selected findings shown in Table 1. Compared to King County residents without Medicaid coverage (excluding those with Medicare coverage), Medicaid clients are more likely to be a child (under 18 years), elder (65 years and older), female, person of color, English language learner, live in a linguistically isolated household, foreign-born, lower-income, receive food assistance benefits (Supplemental Nutrition Assistance Program), rent a home as opposed to own, experience a high housing cost burden, unemployed or not in the labor force, have low educational attainment, have given birth to a child in the past year, have a child present in the household, and report a disability or difficulty (self-care, hearing, vision, independent living, ambulatory, cognitive).

**Table 1. King County Demographic and Socioeconomic Characteristics by Medicaid Status, 2015**

	<b>Medicaid</b>	<b>Non-Medicaid</b>
<b>Age group</b>		
Under 18 years <sup>a</sup>	40.0%	19.5%
18–34 years	21.3%	30.3%
35–49 years	14.8%	26.9%
50–64 years	13.5%	22.4%
65 years and older	10.4%	0.8%
<b>Sex</b>		
Female <sup>a</sup>	53.6%	48.6%
<b>Race/ethnicity</b>		
American Indian/Alaska Native alone or in combination <sup>a</sup>	4.2%	1.6%
Asian	15.0%	17.6%
Black <sup>a</sup>	16.3%	4.4%
Latino <sup>a</sup>	18.2%	8.7%
Multiple race <sup>a</sup>	9.3%	5.8%
Native Hawaiian/Pacific Islander alone or in combination	0.3%	0.4%
White	48.2%	67.7%
<b>Language</b>		
English language learner <sup>a</sup>	14.5%	9.0%
Lives in a linguistically isolated household <sup>a</sup>	12.5%	4.2%
<b>Citizenship status</b>		
Born in United States	77.3%	77.7%
Naturalized <sup>a</sup>	12.1%	9.7%
Noncitizen	10.6%	12.6
<b>Income as a percentage of federal poverty level (FPL)</b>		

< 138% of FPL <sup>a</sup>	44.9%	7.3%
138%–399% of FPL <sup>a</sup>	41.7%	28.0%
400% of FPL and greater	13.4%	64.7%
<b>Received food assistance (SNAP) in past year<sup>a</sup></b>	47.9%	5.8%
<b>Tenancy</b>		
Owns home with mortgage	29.2%	53.6%
Owns home free and clear	9.4%	10.8%
Rents home for cost <sup>a</sup>	60.3%	34.8%
Rents home for no cost	1.2%	0.8%
<b>Housing cost burden</b>		
Housing costs 30% or more of income <sup>a</sup>	57.5%	24.2%
Housing costs 50% or more of income <sup>a</sup>	31.2%	7.5%
<b>Employment status</b>		
Employed	35.4%	80.5%
Unemployed <sup>a</sup>	8.5%	2.8%
Not in labor force <sup>a</sup>	56.1%	16.7%
<b>Educational attainment</b>		
Less than high school <sup>a</sup>	43.6%	20.9%
High school diploma or equivalent <sup>a</sup>	17.7%	11.6%
Some college	19.3%	22.5%
Bachelor degree	9.0%	26.7%
Graduate/professional degree	10.4%	18.3%
<b>Mobility</b>		
Moved in past year	21.8%	20.1%
<b>Fertility</b>		
Gave birth to a child in the past year <sup>a</sup>	8.1%	4.4%
Child present in household <sup>a</sup>	66.6%	50.0%
<b>Disability/difficulty</b>		
Self-care difficulty <sup>a</sup>	6.3%	0.4%
Hearing difficulty <sup>a</sup>	4.3%	0.9%
Vision difficulty <sup>a</sup>	4.4%	0.9%
Independent living difficulty <sup>a</sup>	14.0%	1.0%
Ambulatory difficulty <sup>a</sup>	12.2%	1.4%
Cognitive difficulty <sup>a</sup>	13.5%	1.7%

Notes: FPL, federal poverty level; SNAP, Supplemental Nutrition Assistance Program. Data from US Census Bureau, American Community Survey, Public Use Microdata Sample, 2015. To make the comparison between Medicaid and non-Medicaid populations as similar as possible with respect to age, individuals with Medicare

coverage not on Medicaid are excluded from the non-Medicaid group.

<sup>a</sup> Characteristic statistically significantly over-represented among Medicaid clients, compared to King County residents without Medicaid coverage ( $p < .05$ ).

***Comparative analysis of health status, risk factors, and access to care among King County Medicaid members***

Since the KCACH was established in 2015, its work has been guided by an equity and social justice framework whereby it recognizes that where a person lives, works, learns, and plays strongly shapes their health and social well-being. With this in mind, the PMD used data to explore service utilization as well as health and social disparities by race/ethnicity, language, place, and income throughout the project selection and planning process. This section of the RHNI assesses health and health care disparities in King County, both within the Medicaid population (e.g., race/ethnicity, place), as well as by comparing the Medicaid population with the overall and commercially insured populations.

The PMD used state agency-provided summary data to identify substantial disparities by age, sex, race/ethnicity, Medicaid coverage group, and behavioral health needs status, defined as when a subgroup is 1.5 times or more likely to be represented in a “negative” outcome group (e.g., a “negative” outcome for the “percentage arrested” P4P measure is being arrested). A summary of this analysis is presented in Table 2. Across the range of measures presented here, one can see that Medicaid clients with a “negative” outcome are consistently more likely to be American Indian/Alaska Native, Black, and have mental health and/or substance use disorder treatment needs.

**Table 2. Disparities Analysis of P4P and Related Measures Among Medicaid Adults Ages 18–64, 2017**

Metric	This subgroup . . .	. . . is over-represented in the negative outcome group by . . .
Percentage arrested	Male	1.5 times
	American Indian/Alaska Native	2.6 times
	Black	1.6 times
	Serious mental illness	1.8 times
	SUD treatment need	5.4 times
	Co-occurring MH/SUD	4.9 times
Breast cancer screening	American Indian/Alaska Native	1.6 times
Diabetes—blood sugar testing	Age 18–24 years	1.9 times
	Age 25–34 years	2.0 times
	American Indian/Alaska Native	1.9 times
	SUD treatment need	1.9 times
	Co-occurring MH/SUD	1.8 times
3 or more ED visits per year	American Indian/Alaska Native	2.3 times
	Black	1.6 times
	Disabled	2.2 times
	Any mental health need	2.2 times
	Serious mental illness	2.7 times

	SUD treatment need	4.5 times
	Co-occurring MH/SUD	5.6 times
Percentage employed	Disabled	5.8 times
	Any mental health need	1.5 times
	Serious mental illness	1.7 times
	SUD treatment need	1.8 times
	Co-occurring MH/SUD	2.1 times
Follow-up after ED visit for alcohol or drug dependence within 7 days	Age 18–24 years	1.9 times
	American Indian/Alaska Native	1.8 times
	Black	1.5 times
Follow-up after ED visit for alcohol or drug dependence within 30 days	Age 18–24 years	1.9 times
	American Indian/Alaska Native	1.8 times
	Black	1.5 times
Follow-up after hospitalization for mental illness within 7 days	Latino	1.5 times
Percentage homeless (narrow)	Male	1.5 times
	American Indian/Alaska Native	2.6 times
	Black	1.7 times
	Any mental health need	1.5 times
	Serious mental illness	1.9 times
	SUD treatment need	4.3 times
	Co-occurring MH/SUD	4.2 times
Plan all-cause 30-day readmission	Co-occurring MH/SUD	1.5 times

*Notes:* ED, emergency department; MH, mental health; P4P, pay for performance; SUD, substance use disorder. Data from Measure Decomposition Data, Released July 7, 2017, WA State Department of Social & Health Services, Research & Data Analysis Division. Data represents adults (age 18–64, with the exception of breast cancer screening—age 50–64) with full-benefit Medicaid coverage, with exclusion of persons with third-party coverage from most metrics. Most metrics require 11 of 12 months with Medicaid coverage to qualify for measurement and 11 of 12 months with residence in the region to qualify for ACH attribution. Employment, arrest, and homelessness measures are less restrictive, requiring 7 of 12 months of Medicaid enrollment and residence in the region.

Within King County, the neighborhood where a Medicaid client calls home is also unfortunately a strong predictor of health care utilization and health outcomes. Using zip code-level data extracted from the state’s [Healthier Washington Dashboard](#), the PMD ranked King County’s zip codes according to their median performance on 18 health care utilization and outcome measures among Medicaid clients (Appendix 2, slide 8). Place-based disparities among King County’s Medicaid clients are substantial and in many cases overwhelm the magnitude of race, ethnicity, and language-based disparities. For example, avoidable emergency department visits among children (ages 1–17) range from a low of 10% to a high of 29% (Table 3).

**Table 3. Highest and Lowest Zip Code-Level Performance by Measure, King County, 2015–2016**

Measure	Worst performing zip code	Best performing zip code
Asthma diagnosis	6%	1%

Asthma med management	19%	46%
Adult PCP access (20+)	63%	84%
Adult PCP access (20–44)	61%	83%
Adult PCP access (45–64)	67%	90%
Adult PCP access (65+)	76%	100%
Child PCP access	75%	100%
Well-child visits (3–6)	44%	74%
Diabetes diagnosis	7%	2%
Diabetes eye exam	17%	49%
Diabetes HbA1c test	63%	100%
Diabetes kidney test	71%	100%
Depression diagnosis	24%	6%
ED visits (broad) (0–17)	52 per 1,000 mm	10 per 1,000 mm
ED visits (broad) (18+)	194 per 1,000 mm	21 per 1,000 mm
Avoidable ED visits (1–17)	29%	10%
Avoidable ED visits (18+)	17%	8%
Plan all-cause readmission	41%	10%

Notes: ED, emergency department; MM, member months; PCP, primary care provider. Data from Healthier Washington Dashboard, Medicaid claims data, October 2015 to September 2016.

Given these substantial place-based disparities and the clustering of the Medicaid client population noted in Appendix 3, the areas with the greatest opportunity for shifting the KCACH region’s performance on MTP P4P metrics can be identified. For example, the PMD identified that 15 King County zip codes account for half of all ED visits among Medicaid clients (Appendix 2, slide 12) and additionally, 14 of these zip codes account for half of all avoidable ED visits among Medicaid clients (Appendix 2, slide 13).

The PMD has also assessed health disparities by comparing Medicaid clients to the King County commercially insured population. Using locally available data from the Behavioral Risk Factor Surveillance System, Table 4 shows selected differences in health status comparing the Medicaid and commercially insured adult populations in King County. The median age of Medicaid and commercially insured individuals was 44 and 48 years, respectively. Compared to commercially insured residents of King County, Medicaid clients are more likely to report chronic respiratory disease, arthritis, frequent mental distress, serious psychological distress, obesity, low physical activity, and current use of cigarettes, electronic cigarettes, and marijuana.

**Table 4. Adult Health Status of King County Medicaid and Commercially Insured Adults (Ages 18 and Older), 2014–2015**

	Medicaid	Commercial
<b>Chronic disease prevalence</b>		
Asthma	12.6%	7.5%
Diabetes	7.8%	4.2%
Hypertension	24.9%	18.4%
High cholesterol	47.6%	33.8%

Heart attack	3.9%	2.1%
Coronary heart disease	2.1%	1.3%
Stroke	1.0%	0.8%
Chronic respiratory disease <sup>a</sup>	9.3%	1.8%
Arthritis <sup>a</sup>	20.7%	13.8%
Frequent mental distress (14 or more days per month) <sup>a</sup>	23.4%	7.8%
Serious psychological distress <sup>a</sup>	13.1%	2.3%
<b>Health and social risk factor prevalence</b>		
Obesity (body mass index 30 or more) <sup>a</sup>	29.4%	20.8%
Not meeting physical activity recommendation	78.4%	74.7%
Current cigarette smoking <sup>a</sup>	25.9%	10.2%
Electronic cigarette use (past 30 days) <sup>a</sup>	11.7%	3.4%
Binge drinking	19.6%	23.7%
Current marijuana use (past 30 days) <sup>a</sup>	35.7%	23.7%

Notes: Data from Behavioral Risk Factor Surveillance System, 2014–2015.

<sup>a</sup>Statistically significant difference comparing Medicaid to Commercial ( $p < 0.05$ ).

Leading causes of hospitalization among adults show a different picture (Table 5), where hospitalizations for mental illness account for 11% of all hospitalizations among Medicaid adults, but for only 4% among commercially insured adults. This finding supports the greater burden of *self-reported* mental illness among Medicaid adults drawn from the Behavioral Risk Factor Surveillance System (Table 4).

**Table 5. Leading Causes of Hospitalization Among King County Medicaid and Commercially Insured Adults (Ages 18 and Older), 2016**

Rank	Medicaid (Count of hospitalizations)	Commercial (Count of hospitalizations)
1	Pregnancy/childbirth-related (38,896)	Pregnancy/childbirth-related (38,935)
2	Mental illness (17,687)	Heart disease (20,761)
3	Septicemia (14,279)	Osteoarthritis (14,952)
4	Heart disease (11,515)	Septicemia (11,966)
5	Unintentional injuries (6,212)	Cancer and benign tumors (11,952)
6	Urinary system disease (4,857)	Unintentional injuries (9,809)
7	Cancer and benign tumors (4,840)	Stroke (7,680)
8	Skin infections (4,010)	Mental illness (7,242)
9	Respiratory failure (3,853)	Lower gastrointestinal disorders (6,849)
10	Diabetes with complications (3,804)	Urinary system disease (6,185)

Notes: Data from Comprehensive Hospital Abstract Reporting System (hospital discharge data), 2016. Insurance coverage type drawn from all three “payer” fields in Comprehensive Hospital Abstract Reporting System data set; this payer information may be different than what is submitted with health insurance claims. Provisional count of unintentional injuries based on proposed ICD-10-CM External Cause Matrix for Reporting Injury Morbidity, available at

[http://c.ymcdn.com/sites/www.safestates.org/resource/resmgr/isw9/ISW9\\_FINAL\\_Report.pdf](http://c.ymcdn.com/sites/www.safestates.org/resource/resmgr/isw9/ISW9_FINAL_Report.pdf).

Examining the leading causes of death among the King County Medicaid population compared with the overall population shows striking disparities in both the ranks (Table 6) and percentage of total deaths attributed to each leading cause (data not shown). For example, 18.6% of deaths among Medicaid clients are due to unintentional injuries, whereas for the overall population this figure is 5.3%. Suicide and homicide account for 5.6% and 2.9% of deaths among Medicaid clients, respectively, whereas for only 2.1% and 0.4% of total deaths in the overall population. Chronic liver disease accounts for 7.6% of deaths among Medicaid clients and only 1.7% of deaths in the overall population, a difference likely due in some part to differential prevalence of alcohol use disorders.

**Table 6. Leading Causes of Death Among King County Medicaid Clients Versus the Overall Population**

Rank	Medicaid, 2015 (Count of deaths)	Overall population, 2011–2015 average (Average count of deaths per year)
1	Cancer (255)	Cancer (2,941)
2	Unintentional injury (208)	Heart disease (2,534)
3	Heart disease (169)	Alzheimer’s disease (832)
4	Chronic liver disease and cirrhosis (85)	Unintentional injury (654)
5	Suicide (62)	Stroke (605)
6	Homicide (32)	Chronic lower respiratory disease (571)
7	Chronic lower respiratory disease (29)	Diabetes (370)
8	Diabetes (28)	Suicide (255)
9	Viral hepatitis (15)	Chronic liver disease and cirrhosis (210)
10	Septicemia (13)	Influenza and pneumonia (183)

Notes: Data from RHNI “Starter Kit” (Medicaid), death certificate data, Washington State Department of Health (overall).

Despite the importance of identifying disparities by place, race, ethnicity, language, income, and health insurance coverage type, broad demographic categories such as the racial/ethnic groups shown in Table 1 often hide a deeper, more meaningful understanding of demographic differences across populations. For example, within the overall King County population, one typically sees above-average health outcomes among Asian residents, whereas this consistent pattern is not seen within Medicaid clients (data not shown). See Table 7 for an example of the ethnic composition of King County residents who identified as “Asian” on the American Community Survey, comparing Medicaid with non-Medicaid individuals. After Chinese ancestry (the most common ancestry for both Medicaid and non-Medicaid Asian residents), one can see that King County Asian residents with Medicaid coverage are most likely to identify as Vietnamese as compared to Asian residents with non-Medicaid coverage, who are most likely to identify as Asian Indian.

**Table 7. Comparing Reported Ancestry Between Asian Medicaid and Non-Medicaid King County Residents**

Ancestry, first reported	Medicaid	Non-Medicaid
Asian Indian	7%	18%
Cambodian	5%	1%
Chinese	19%	25%

Filipino	9%	12%
Japanese	4%	6%
Korean	6%	9%
Laotian	5%	1%
Taiwanese	1%	2%
Vietnamese	17%	9%

Notes: Data from US Census Bureau, American Community Survey, Public Use Microdata Sample, 2015. To make the comparison between Medicaid and non-Medicaid populations as similar as possible with respect to age, individuals with Medicare coverage not on Medicaid are excluded from the non-Medicaid group.

In the context of identifying health and social disparities, there should be a consideration for both absolute and relative disparities. With absolute disparities in mind, one may identify participating providers that already serve the largest numbers of Medicaid clients with the greatest room for improvement on P4P measures. Relative disparities, on the other hand, often imply a deeper sense of injustice or inequity to be addressed. For example, the PMD met with the Urban Indian Health Institute to begin a discussion on how best to describe and disseminate information about the persistent and widespread American Indian/Alaska Native health disparities in the Medicaid population (Table 2).

The persistent place, race, and income disparities routinely seen in King County reveal a troubling reality of social determinants of health. People and communities of color are more likely to be experiencing multiple complex barriers to health that significantly impact their ability to both access health and social services and to act on the advice of their providers. These disparities will be important to continue to measure at the population level as the KCACH considers how the MTP can address social inequities in the King County region. At the provider/client level, such disparities indicate the need to improve cultural competence and cultural relevance of providers and the services they offer. This impacts how KCACH will consider implementation of the specific projects and how KCACH selects partnering providers.

With the social determinants of health in mind, it is also critical to understand the societal context in which the MTP will be implemented. Local trends are likely to influence health and human services transformation efforts, and local opportunities for advancing health equity. For example, the interrelated forces of gentrification (Appendix 4, slide 6) and Puget Sound’s soaring real estate market (Appendix 4, slide 11) continually push lower-income families farther from urban cores and as a result, often further from needed health and social services. As lower-income individuals and families are pushed farther from employment, educational, and health and human service resources, the impacts of core social factors, such as housing and transportation access, in shaping health and well-being become evident.

***Access to and utilization of health care providers and services***

To assess how the current health care delivery system is meeting the needs of the King County Medicaid population, the PMD has looked at both availability (supply of providers and services) and gaps (i.e., unmet need for services). To understand availability of health care providers and services, the PMD assessed both the number of health care delivery providers by type serving the King County

Medicaid population, as well as the volume of unique clients served and claims paid in order to identify high-volume providers by service type (e.g., inpatient vs. outpatient).

Using information provided by the HCA on *active* providers serving Medicaid clients (drawn from provider registry information in the ProviderOne), the PMD identified 16 emergency departments, 19 hospitals, 83 outpatient facilities, 447 dental providers, and 4,961 non-institutional providers (i.e., individual providers who bill for professional services) physically located within King County.

The PMD developed an interactive [website](#) to display the volume of health care service utilization by claims and unique members, by ACH region, service type, and primary diagnosis. This information contains fee-for-service claims and managed care encounters for both physical and behavioral health services, and has been used primarily to identify highest-volume providers for given service types; in other words, the organizations and providers that have robust, existing therapeutic relationships with the Medicaid population. For example, looking at claims among King County Medicaid beneficiaries in 2016, Federally Qualified Health Centers were responsible for 35% of all dental claims, Harborview Medical Center was responsible for 19% of all outpatient facility claims, three hospitals (Swedish Medical Center, Valley Medical Center, Harborview Medical Center) were responsible for 42% of all hospitalizations, and four emergency departments (Valley Medical Center, Highline Medical Center, Harborview Medical Center, Swedish Medical Center) were responsible for 45% of all emergency department visits.

When assessing the underlying health care needs for these services, data show that of the almost 5 million claims paid for providing outpatient and professional services to King County Medicaid clients in 2016, 41% of these claims were for services primarily related to a behavioral health concern. Of the more than 2 million outpatient and professional claims paid for services primarily related to a behavioral health concern, six organizations were responsible for 60%—Sound Mental Health, Therapeutic Health Services, Evergreen Treatment Services, Navos Mental Health Solutions, Community Psychiatric Clinic, and Valley Cities Counseling and Consultation. These six organizations were paid for 1.2 million such claims in 2016 for providing services to over 36,000 unique individuals, which equates to an average of 34 claims per person per year. In contrast, for the highest-volume billing provider of professional claims in 2016 (UW Physicians), 98% of claims were not related to behavioral health concerns, and their clients averaged 2.3 claims per person per year.

In an effort to better understand underlying health care needs by service and provider type, the PMD has asked the state to provide similar care volume data using more detailed Clinical Classification Software diagnostic categories developed by the [Healthcare Cost and Utilization Project](#). KCACH has used information about highest-volume providers (e.g., Appendix 5) for provider engagement, such as efforts to assess the health information technology capacity of providers through the KCACH's recent provider engagement [survey](#).

### ***Access to and utilization of social service providers and services***

Although there is robust, available information on utilization of health care delivery services (see above), the same is not historically true for social or community-based services, both at the population and point-of-care level. Rather than collecting new and more data, the PMD is initiating and strengthening cross-sector relationships that will result in greater access to cross-sector

information. For instance, the PMD is developing a data-sharing agreement with the [Crisis Clinic](#) (i.e., King County 2-1-1) through which comprehensive data on social service providers and call-level data on social service referrals by demographic characteristics (including insurance coverage, ethnicity, zip code of residence) can be gathered.

From an availability perspective, the types of social services available to the Medicaid population are described in detail on the Washington Information Network 211's [website](#). A King County location filter reveals 6,207 services available to King County residents, including services for basic needs (e.g., food, housing, transportation), consumer services (e.g., tax services), criminal justice and legal services (e.g., ex-offender re-entry programs), education (e.g., educational support programs), health care (e.g., medical expense assistance), income (e.g., temporary financial assistance), individual and family life (e.g., spiritual enrichment), mental health and substance use disorder services (e.g., transitional mental health services), and target population services (e.g., immigration services). The database also includes services that are included in the description of health care services above (e.g., hospitals), and the PMD aims to tease these apart with future analysis of King County 2-1-1 data.

King County government also has some limited existing services that provide intensive and comprehensive services within a supportive Housing First Permanent Supportive Housing (PSH) framework. For example, the Substance Abuse and Mental Health Services Administration-funded Housing Opportunities and Meaningful Engagement program can serve 60 long-term shelter stayers at any one time. The Forensic Intensive Supportive Housing and Forensic Assertive Community Treatment programs provide 110 housing units and supports to chronically homeless adults with repeated incarcerations. King County's two Program of Assertive Community Treatment teams provide PSH and intensive services to 180 individuals being discharged from long psychiatric hospital stays.

While All Home, the Seattle/King County Continuum of Care, manages 1,404 units of PSH for people experiencing chronic homelessness, fewer than 200 of these units have intensive behavioral supports. These programs are nearly all in Seattle and are at full capacity. The proposed Small Housing Authority Reform Proposal program will work with a portion of the 1,404 PSH units to expand the number of units with service intensity sufficient for the population of focus. In doing so, the program will begin to develop capacity to address the considerable remaining gaps in provision of Housing First PSH coupled with intensive, comprehensive services for the population of focus.

### ***Service gaps and barriers to accessing needed care and services***

To understand service gaps, the PMD reviewed both self-reported and claims-based measures of access to care and use of preventive care (Table 8). Compared to commercially insured adult residents of King County, Medicaid adults were significantly less likely to have had a dental visit in the past year, meet mammography recommendations, receive a flu shot in the past year, and were more likely to have had unmet medical needs due to cost in the past year. Claims-based measures of access to care and use of preventive services align well with these self-reported barriers, including lower levels of screening for cancer (breast, cervical, colon), lower levels of access to primary care across the lifespan, and a higher rate of potentially avoidable emergency department visits. In contrast, compared to commercially insured individuals, Medicaid beneficiaries were more likely to have received a mental health service in the past year if they had an identified need, though it was not

possible to compare whether the acuity of mental health needs differed across these two populations, as suggested earlier in Table 5.

**Table 8. Access to Care and Use of Preventive Care: Medicaid and Commercially Insured Individuals**

	Medicaid	Commercial
<b>Self-reported measures, adults (2014–2015)<sup>a</sup></b>		
Dental visit in past year <sup>c</sup>	46.1%	78.2%
Has a usual primary care provider	73.3%	76.7%
Unmet medical need due to cost in past year <sup>c</sup>	17.0%	8.0%
Meets cervical cancer screening recommendations (Pap)	77.1%	85.2%
Meets mammography recommendations <sup>c</sup>	59.8%	80.4%
Received flu shot in past year <sup>c</sup>	34.4%	44.3%
<b>Claims-based measures (2015)<sup>b</sup></b>		
Access to primary care		
Age 1–2 years	88%	98%
Age 2–6 years	68%	90%
Age 7–11 years	83%	91%
Age 12–19 years	83%	91%
Age 20–44 years	69%	92%
Age 45–64 years	74%	96%
Age 65 years and older	86%	98%
Well-child visits (age 3–6 years)		
Adolescent primary care visits	40%	46%
Potentially avoidable ED visits	17%	10%
Among those with identified mental health service need, percentage who received one or more services in a given year		
Adults (age 18–64 years)	51%	30%
Children (age 6–17 years)	65%	33%
Disease screening		
Breast cancer	30%	77%
Cervical cancer	54%	79%
Chlamydia	55%	42%
Colon cancer	44%	67%

Notes: Abbreviation: ED, emergency department. Data from <sup>a</sup>Behavioral Risk Factor Surveillance System (BRFSS), 2014–2015, <sup>b</sup>WA Health Alliance Community Checkup, 2016.

<sup>c</sup> Statistically significant difference ( $p < 0.05$ ); differences were only tested for BRFSS data.

A 2014 Substance Use Disorder Services Gap Analysis conducted by Dale Jarvis & Associates revealed a significant gap in those who are underserved (Table 9). In King County, three-quarters (76%) of adults in need of substance use disorder services did not receive care.

**Table 9. Substance Use Disorder Gap Analysis for King County Regional Service Area, 2014**

Safety net population	
Medicaid	396,300
Uninsured <200%	74,200
Total	470,500
Substance use disorder service need	
Medicaid	53,300
Uninsured <200%	5,800
Total	61,000
Number of persons receiving substance use disorder services	
Outpatient	8,880
Residential/inpatient	2,170
Opiate substitution therapy	3,410
Total	14,460
% of need served	24%
Substance use disorder service gap	
Unservd gap	46,640
Unservd gap %	76%

Note: Data from Dale Jarvis & Associates, March 2014.

A 2014 Community-Based Mental Health Services Gap Analysis conducted by Dale Jarvis & Associates revealed a significant gap in those who are underserved (Table 10). In King County, 65% of those needing ambulatory mental health service did not receive care.

**Table 10. Community-Based Mental Health Services Gap Analysis for King County Regional Service Area, 2014**

Safety net population	
Medicaid	396,300
Uninsured <200%	74,200
Total	470,500
Mental health service need	
Medicaid	129,500
Uninsured <200%	19,200
Total	148,700
Number of persons receiving ambulatory mental health services	
Medicaid	50,300
Uninsured <200%	6,300
Total	56,600
% of need served	38%

Substance use disorder service gap	
Medicaid	79,200
Uninsured <200%	12,900
Total	92,100
Gap %	62%

Note: Data from Dale Jarvis & Associates, March 2014.

At the community level, another window into access to care barriers is the [Seattle/King County Clinic](#) that has been held annually at Seattle Center since 2014. Compared to the overall King County population, clients of the Seattle/King County Clinic in 2015 were almost four times as likely to be Native Hawaiian/Pacific Islander, and about half as likely to be White (Appendix 6, slide 11). These clinics have also offered insights into the reasons why individuals seek this free medical care despite living in a region that has implemented Medicaid expansion and has a state health insurance marketplace. The top three reasons clients report are: (1) lack of health insurance, (2) having health insurance but being unable to afford medical procedures, and (3) dissatisfaction with the timeliness of health care.

***Outline any identified capacity or access gaps between the Medicaid population’s identified health care and health care access needs, and the services (or service capacity) currently available from identified providers and CBOs***

When considering unmet health and social needs of the King County Medicaid population, critical gaps include access-to-care barriers (e.g., transportation, workforce capacity, and financial burden), fragmentation of health and social services, and the quality of health care and social services (e.g., use of evidence-based practices, cultural relevance of services).

Access-to-care barriers may present at the individual level as difficulty in finding a provider, getting to a provider, and/or paying for a service. For example, 26% of King County Medicaid adults who delayed getting medical care in the past year did so because of lack of transportation options, compared to 8% of commercially insured adults ( $p = 0.003$ , BRFSS, 2014–2015). From a financial burden perspective, lower-income individuals and families often balance a variety of health and social needs, and thus health care service-associated costs can become quite burdensome even with Medicaid coverage. In 2014, about one in five King County Medicaid adults (19%) reported having health care bills that they were paying off over time (BRFSS, 2014). Additionally, 17% of Medicaid adults reported not seeking care in the past year because of cost, compared to 8% of commercially insured adults ( $p = 0.003$ , BRFSS, 2014–2015).

Access-to-care barriers also exist from the workforce capacity perspective. The Federally Qualified Health Centers engaged in planning MTPs all report long-standing challenges with referring primary care patients to specialty providers. With low Medicaid reimbursement rates for oral health care providers, the percentage of dentists accepting Medicaid clients also continues to be a challenge in Washington state, which is likely part of the story behind the [low dental service utilization rates](#) among Medicaid clients. Additionally, behavioral health care provider shortages continue to pose access-to-care barriers in King County. The King County’s Mental Illness and Drug Dependency sales tax has funded a local workforce survey of 29 behavioral health agencies, which found that most agencies report difficulty hiring and retaining the staff they need to meet demand for services.

Specifically, 79% of agencies reported having at least one open job position (total of 168 open positions), and over 80% of agencies reported that they had lost employees due to high caseloads, or wanting better pay or benefits. Agencies reported these workforce recruitment and retention challenges were even more severe for bilingual and bicultural staff.

When looking at subsets of the Medicaid population struggling to meet clinical quality metrics (e.g., chronic disease screening, chronic disease management) and avoid social crises (e.g., unemployment, arrest, homelessness) there is an over-representation of individuals with behavioral health needs, and in particular, an over-representation of individuals with co-occurring mental health and substance use disorder treatment needs (Table 2). Among the 92,463 King County Medicaid beneficiaries with a mental health diagnosis or substance use disorder treatment need, two of three (67%) have one or more chronic physical disease (Behavioral Health and Chronic Conditions data product; HCA Analytics, Interoperability, and Measurement team; September 2017). These findings point to the critical need for integration of physical, behavioral, and social services to support Medicaid beneficiaries (and all individuals) to be provided with the right service at the right time, regardless of their point of entry.

“Gap to goal” P4P measures for the MTP allows KCACH to understand the greatest opportunities for improvement for health care metrics, though not for social service utilization and quality measures. The [King County Performance Gap Analysis](#) identifies such gaps (e.g., difference between current performance and national 90th percentile benchmarks among managed Medicaid plans), shown in Table 11. The gap analysis shows that for those “gap to goal” measures far below the national benchmark, the performance for King County commercially insured individuals is typically much closer to, or even surpasses, the national Medicaid plan benchmark, giving one a sense of what may be achievable in this community.

**Table 11. King County ACH Gap Analysis of MTP P4P “Gap to Goal” Measures**

Measure	King County Medicaid rate	90th percentile national benchmark for Medicaid plans	King County commercially insured rate
Adolescent access to PCP (age 12–19 years)	90%	94.9%	91%
Antidepressant med management, acute	51%	62.6%	71%
Antidepressant med management, chronic	32%	48.5%	57%
Asthma med management	25%	44.1%	66%
Child access to PCP (age 2–6 years)	86%	92.9%	90%
Child access to PCP (age 7–11 years)	91%	95.9%	91%
Child access to PCP (age 12–23 months)	94%	98.2%	98%
Chlamydia screening in women	55%	68.6%	42%
Diabetes care: blood sugar test	85%	91.9%	91%
Diabetes care: eye exam	29%	67.9%	78%
Diabetes care: kidney screening	86%	87.7%	88%

Well-child visits (age 3–6 years)	65%	83.8%	76%
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Notes: Data from [King County Performance Gap Analysis](#) (King County Medicaid rates, 90th percentile benchmarks), WA Health Alliance [Community Checkup](#) (King County commercial rates).

Another approach to understanding the quality of health and social services provided to Medicaid clients is to consider cultural representativeness of providers and cultural relevance of services. For example, how likely is it for a Medicaid beneficiary in King County to see themselves represented in their care providers? Or how likely is it for individuals to receive services in a preferred language? For example, in 2015, 40% of King County Medicaid beneficiaries identified as White ([Medicaid enrollee health profile](#), PMD), whereas in 2012, 79% of primary care physicians working in King County identified as White ([WA State Primary Care Provider Survey](#), 2011–2012, Center for Health Workforce Studies). Similarly, 16% of King County Medicaid beneficiaries identified as Latino, whereas 2.1% of primary care nurse practitioners identified as Latino. This is only the tip of the iceberg, however, and more current and actionable information is needed to identify key areas of opportunity for improving cultural relevance of health and social services provided to Medicaid beneficiaries.

### ACH Theory of Action and Alignment Strategy

*ACHs are encouraged to think broadly about improving health and transforming care delivery beyond the Medicaid program and population. Advancing a community-wide vision and approach will be critical in ensuring the sustainability of health system transformation.*

*The term “health equity,” as used in this Project Plan Template, means reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.<sup>1</sup>*

Describe the ACH Theory of Action and Alignment Strategy. In the narrative response, address the following:

- Describe the ACH’s vision for health system transformation in its region; include a vision statement and a discussion of how the vision addresses community needs, and the priorities of the whole population.
- Define the ACH’s strategies to support regional health and health care needs and priorities.
- Indicate projects the ACH will implement (a minimum of four).

Project Plan Portfolio	
<b>Domain 2: Care Delivery Redesign</b>	
<input checked="" type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input checked="" type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
<b>Domain 3: Prevention and Health Promotion</b>	
<input checked="" type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services

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

- Describe the process the ACH followed to consider and select projects as part of a portfolio approach.
  - What were the criteria for selecting projects?
  - Describe how the ACH applied its whole-population vision for health system transformation to inform its project selection and planning.
  - Which interventions, resources, and infrastructure will be shared throughout the project portfolio, and how will they be shared?
- Describe how, through these projects, the ACH plans to improve region-wide health outcomes.
- Describe how, through these projects, the ACH plans to improve the region-wide quality, efficiency, and effectiveness of care processes.
- Describe how, through these projects, the ACH plans to advance health equity in its community.
- Describe how, through these projects, the ACH plans to demonstrate a role and business model as an integral, sustainable part of the regional health system.
- Discuss how the ACH addressed any gaps and/or areas of improvement, identified in its Phase II Certification, related to aligning ACH projects to existing resources and initiatives within the region.
- Submit logic model(s), driver diagrams, tables, and/or theory of action illustrations. The attachments should visually communicate the region-wide strategy and the relationships, linkages, and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes (*submit as ACH Theory of Action and Alignment Strategy—Attachment A*).

## ACH Response

### *Describe the ACH's vision for health system transformation in its region; include a vision statement and a discussion of how the vision addresses community needs, and the priorities of the whole population.*

The vision of King County Accountable Community of Health (KCACH) is that “by 2020, the people of King County will experience significant gains in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities.”

This vision addresses the needs and priorities not just of Medicaid beneficiaries but of the whole county. Collective county-wide action is needed to break down today's siloes within health care and between health and social services. Given the stark disparities in well-being that exist by race/ethnicity and income within the King County region, KCACH is deliberately applying an equity lens to what it does and how it does it. Understanding and acting on the wisdom and resources within communities is also vital to developing a system truly capable of providing whole-person, client-centered care.

KCACH's vision recognizes two critical points of care: **prevention**, to keep people and communities healthy, and **recovery**, to support the health of people and communities struggling with substance use disorder, mental illness, and chronic disease. Achieving this vision will result in a better health care delivery system for the entire population of King County, not just Medicaid beneficiaries.

Based upon the review of data (summarized in the Regional Health Needs Inventory section) and the early work of the Interim Leadership Council of the KCACH in 2016 to develop a Regional Health Improvement Plan (RHIP), the following are the key priority areas of the whole population:

- Physical and behavioral health integration
- Care coordination (including transitional care)
- Chronic disease prevention
- Maternal and child health
- Social determinants of health
- Health equity

An additional high priority that has emerged since the RHIP is addressing opioid use, both at local and national levels. (Note: the RHIP was informed by a review of over 50 existing community needs assessments, analysis of extensive community engagement findings, and input from the KCACH RHIP workgroup and the Interim Leadership Council.)

### *Define the ACH's strategies to support regional health and health care needs and priorities.*

To advance this vision, KCACH is working on strategies to “build healthier communities through a collaborative regional approach focusing on social determinants of health, clinical-community linkages, and whole person care.” KCACH will do the following in order to support regional health and health care needs and priorities:

- Serve as the long-term structure for continued, authentic community and consumer engagement.
- Elevate and integrate social determinants of health and equity as critical components of an effective and efficient care delivery system.
- Build a stronger bridge between medical, behavioral health, and community providers.
- Make strategic investments in prevention and recovery.
- Work to align Medicaid Transformation Projects (MTP) with related efforts and investment flows to maximize county-wide impact and achieve results.

The MTP funds will strengthen the region’s immediate and long-term ability to collaborate and align the efforts of providers, payers, local government, consumers, tribes, and community-based organizations.

*Indicate projects the ACH will implement (a minimum of four).*

Project Plan Portfolio	
<b>Domain 2: Care Delivery Redesign</b>	
<input checked="" type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input checked="" type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
<b>Domain 3: Prevention and Health Promotion</b>	
<input checked="" type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input checked="" type="checkbox"/>	3D: Chronic Disease Prevention and Control

KCACH plans to implement four projects with additional requirements for all four: the projects must meaningfully address (1) social determinants of health, (2) community-based care coordination needs, (3) prevention, and (4) equity. The King County region is large and complex and needs to be focused and strategic in its approach to transformation to create the greatest opportunity for success. In selecting four projects with cross-cutting underlying requirements, KCACH will make deeper and more targeted investments while addressing social determinants of health, community-based care coordination needs, prevention, and equity improvements in a way that will improve population outcomes, accelerate health system transformation, and speed the transition to value-based payment in the region.

*Describe the process the ACH followed to consider and select projects as part of a portfolio approach.*

The KCACH Governing Board used a multilayered and iterative decision-making process from April to October 2017 to choose projects. The final Governing Board decision on October 12, 2017, was based on recommendations made by the Demonstration Project Committee (DPC). The DPC includes leaders from community organizations and delivery systems with subject matter expertise and hands-on experience in the region. The DPC was created by the Governing Board in April 2017 and tasked with designing the overall MTP project strategy and recommending a portfolio of projects for review and approval by the Governing Board.

KCACH developed project concepts in all eight potential project areas using project Design Teams with cross-sector representation, including community health and behavioral health care centers, managed care plans, hospitals, community partners, consumer perspectives, and community-based organizations. The DPC provided Design Teams with specific guidance and criteria to guide project development, such as addressing inequities, obtaining input from affected people, demonstrating sufficient reach to move county-wide Medicaid metrics, and balancing evidence-based and innovative strategies. The Design Teams worked over five months (May through October 2017) to develop projects with the greatest potential to address the region's priority health needs, meet performance targets, and contribute to system transformation. Design Teams used the Regional Health Needs Inventory data to design the scope of projects. After a preliminary review of project proposals by the DPC in July 2017, a first round of public comment was solicited in August 2017. Final project plan templates were submitted to the DPC in September 2017.

The DPC, with support from Health Management Associates, met for two hours bi-weekly in August and weekly from mid-September through mid-October to discuss projects and the overall portfolio strategy. The DPC evaluated each project, its fit for King County, and the guidance provided from the Governing Board for project selection. Thoughtful discussions took place throughout the process, with all DPC members actively engaged and considering multiple perspectives.

#### ***What were the criteria for selecting projects?***

The Governing Board directed the DPC to use the following criteria in developing the project portfolio recommendation:

- Use the Regional Health Needs Inventory.
- Maintain the Governing Board's commitment to equity and addressing health disparities.
- Consider the outcome metrics and the region's ability to maximize Delivery System Reform Incentive Program funds.
- Contribute to long-term, sustainable system transformation.
- Ensure the portfolio improves the lives of the people of King County.

The DPC members used these criteria and brought the lens of their respective sectors to a decision-making process characterized by a remarkable commitment to a collective approach that placed the needs of the region at the center, rather than the individual interests of any one sector. DPC members came out of the process feeling a stronger sense of commitment to each other and to the work of KCACH. The charter for the DPC stipulates that a simple majority is all that is needed for a decision; members strove for consensus and the final recommendation to the Governing Board was almost unanimous.

#### ***Describe how the ACH applied its whole-population vision for health system transformation to inform its project selection and planning.***

Both the DPC and the Governing Board kept KCACH's vision for health system transformation firmly in mind throughout the project planning process and while deciding on the project portfolio. The Governing Board believes the focused efforts of KCACH's project portfolio is the best approach for:

- Providing client-centered, whole person, integrated care.
- Promoting equity and reducing health disparities.
- Ensuring community-rooted, culturally responsive, and linguistically appropriate care.
- Addressing important population health needs in the region, including prevention and recovery.
- Supporting the transition to value-based payment and long-term sustainability.

KCACH and its partnering providers and stakeholders recognize that developing a more robust system of care coordination is fundamental to the success of system transformation. That said, after much deliberation with local partners and stakeholders as well as national consultants and the developers of the Pathways Community Hub model, KCACH did not select 2B: Community-Based Care Coordination as a project. The Pathways Community Hub model does not fit with the KCACH regional needs. Rather, KCACH has elected to take a cross-cutting approach to building a robust system of community-based care coordination that leverages existing efforts and provides a stronger bridge between clinics and community resources.

***Which interventions, resources, and infrastructure will be shared throughout the project portfolio, and how will they be shared?***

Community-based care coordination is a foundational component that will be shared across each of the projects. Community-based care coordination is a critical cross-cutting strategy for reducing fragmentation and inefficiency in the health system. After conducting an environmental scan of community-based care coordination, KCACH will develop strategies to support and make investments to improve it across all projects. This includes investments in health information technology that supports care coordination between and among clinical and community-based providers (e.g., shared care plans); development of the community health worker and peer support specialist workforce; and development of value-based payment models to support the long-term sustainability of community-based care coordination. These cross-cutting investments will benefit all projects.

Additional resources and infrastructure to support all projects include the provision of data technical assistance and support; the KCACH Equity Impact Assessment Tool (Equity Tool) and support for its use; and the various KCACH committees and workgroups that include the Clinical Committee, Consumer/Community Voice Committee, Tribal Engagement, and the Performance Measurement and Data Committee.

***Describe how, through these projects, the ACH plans to improve region-wide health outcomes.***

The selection of projects for the KCACH project portfolio was a strategic decision of how to provide the region with the best chance of improving a “narrow” set of indicators (i.e., limiting the number of unique indicators that would only pertain to an individual project). For instance, all four projects aim to reduce outpatient emergency department visits and inpatient hospitalization. Thus, KCACH will be engaging in multiple activities that will collectively help to improve this outcome region-wide. With the exception of a few unique indicators for chronic disease (e.g., statin therapy) and transitional care (e.g., percentage of homeless), there is considerable overlap of pay-for-performance (P4P) measures required between those projects and the bi-directional care project. While the Opioid Project, a required project, has the most number of unique P4P measures, KCACH will collaborate with and leverage additional efforts going on in

the region to address the opioid crisis, increasing the chances of improving outcomes for individuals struggling with opioid use disorder. The selection of these four projects most closely aligns with the quality metrics in the Medicaid managed care organizations (MCO) contracts. For example, successful implementation of the Chronic Disease Project should result in improved diabetes outcomes through the provision of comprehensive diabetes care.

For each of the projects, KCACH is working to engage providers that collectively serve significant portions of the Medicaid population. Using data on the number of Medicaid claims by provider, KCACH is able to identify providers whose engagement is critical to achieving region-wide performance metrics. In addition, the work on identifying key partners includes smaller providers and social service organizations that provide critical services to disparity populations who KCACH also wants to reach.

*Describe how, through these projects, the ACH plans to improve the region-wide quality, efficiency, and effectiveness of care processes.*

Key activities to improve the region-wide quality, efficiency, and effectiveness of care processes include:

- **Plan for monitoring and continuous improvement.** To both monitor day-to-day/real-time performance and support partnering providers to achieve continuous improvement, KCACH will likely use a web-based, dynamically updated project monitoring tool (e.g., Tableau) to facilitate both internal and external conversations around project performance. As KCACH develops its project implementation plan in 2018, predictive analytics will be used to determine process and outcome metric milestones over a more frequently monitored timeline than that required by the state and Centers for Medicare & Medicaid Services. These predictive analytics will be used to check the course of any given project and activity and determine the progress of the project. By quantifying such project milestone gaps, KCACH staff and participating providers can use a continuous quality improvement framework to make needed adjustments to project implementation and/or ongoing operations.
- **Support for providers in practice transformation.** KCACH will link providers to technical assistance providers such as Qualis Health, the University of Washington Advancing Integrated Mental Health Solutions (UW AIMS) Center, and the Arcora Foundation. KCACH will also educate and work with providers to take advantage of the resources available through the Healthier Washington Practice Transformation Support Hub. Access to these resources to support practice transformation will ensure implementation of high-quality, evidence-based models of care that have been proven to improve overall health and well-being.
- **Building capacity in performance measurement systems and workforce.** As described below, KCACH will also support cross-cutting infrastructure in health information technology and health information exchange and workforce. Specifically, working with providers to adapt a common platform for shared care plans to support coordination across and within the projects. Access to shared care plans and additional technologies and workforce infrastructure to support coordination of care will create efficiencies in the system by reducing duplication and streamlining access to needed interventions.

*Describe how, through these projects, the ACH plans to advance health equity in its community.*

KCACH is working to ensure improved health outcomes by addressing root causes and creating an environment that enables all people to achieve their highest level of health. The biggest predictor of health involves an individual's ethnicity, income level, and neighborhood (Healthy People 2020). In identifying the roles that racism and discrimination play in the health of communities, the Design Teams and other stakeholders have considered the ways in which institutions and organizations perpetuate bias and historical trauma. To this end, KCACH is striving to ensure the diverse communities served by KCACH are represented in its Governing Board, subcommittees (e.g., Demonstration Project Committee; Community/Consumer Voice Committee [CCV]), and project Design Teams. Moreover, project plan development included a diverse range of participants and used the Equity Tool to prevent unintended consequences for vulnerable populations and to promote movement toward health equity.

The Equity Tool included examining disparities in outcomes by race/ethnicity, gender, geographic location, and income level. Significant disparities exist in the King County region as it relates to certain health conditions, behavioral health, and access to treatment. During the planning phase, Design Teams will receive more in-depth training on the use of the Equity Tool and will use it, in partnership with members of the CCV, to continue to apply an equity lens to this work. All projects will be assessed by their ability to address systemic and other barriers to accessing services and resources including race/ethnicity, gender, geographical location, and income level. Investments will be targeted toward regions and populations that represent the greatest disparities.

Some of the largest Medicaid providers in King County include providers who specialize in best practices in the care of minority and foreign-born populations including SeaMar, Asian Counseling and Referral Service, Therapeutic Health Services, HealthPoint, International Community Health Services, Refugee Women's Alliance, and Lutheran Community Services Northwest. These agencies have culturally diverse staff and have established best practices within these populations. KCACH will draw on the expertise of these and other key partners in the planning and implementation phases to ensure Medicaid beneficiaries have access to culturally and linguistically appropriate services and resources.

***Describe how, through these projects, the ACH plans to demonstrate a role and business model as an integral, sustainable part of the regional health system.***

KCACH will build upon existing infrastructure and local investments to leverage the impact of the MTP to meet the Triple Aim of access, outcomes, and costs. Reinvestment strategies will be focused on strategies that can be sustained based on their ability to demonstrate value by influencing system metrics and reducing overall spending. KCACH has used sustainability as a project criterion from its earliest stages to ensure projects are designed to lead to durable improvements in care delivery systems and to align these with the interests of potential long-term funders, such as the MCOs. For example, KCACH will work in partnership with all five Medicaid MCOs and the King County Behavioral Health Organization to support the transition to fully integrated managed care (FIMC) and ensure the bi-directional care strategy aligns with the goals and outcomes in the FIMC contract. In addition, KCACH will work with MCOs in the design of each of the projects to ensure that the activities implemented could be structured within a value-based payment arrangement, when appropriate, to test models that integrate traditional health care delivery activities with activities that support overall health and well-being (i.e., care coordination, social determinants). Domain 1 strategies that underlie all four projects also will support sustainable changes to the regional health system.

A planned KCACH Social Equity and Wellness Fund, with its focus on the social determinants of health, would be an ongoing mechanism for improvements in health and well-being for the entire region long after the MTP ends. Once established, this fund can be expanded through shared saving arrangements with other entities/funders (e.g., philanthropy, government, health plans) that would result in additional resources to contribute to continued investment in prevention activities and social determinants. The KCACH would be in a position to continue to convene multisector leadership through the Governing Board to identify regional priorities and determine who to align investments with to fill gaps. KCACH would continue to assist with design, implementation, and monitoring of transformation efforts.

***Discuss how the ACH addressed any gaps and/or areas of improvement, identified in its Phase II Certification, related to aligning ACH projects to existing resources and initiatives within the region.***

Phase II Certification requested no additional focus areas for project plans, but cited a lack of clarity and specificity in some areas. Since that time, KCACH has undertaken substantial work throughout its project selection process to build a project portfolio that takes into account regional needs, strengths, and challenges, and leverages funds available through the MTP to make foundational investments that will pay off long after the MTP ends.

KCACH serves as a neutral convener and facilitates meaningful collaboration among clinical and community-based providers, payers, and systems. KCACH plays a unique role in its ability to bring community and consumer voices to the table for meaningful engagement. KCACH will serve these functions through the life of the MTP while building capacity for this work through its partnering providers.

Concrete plans have been developed to ensure regional assets are identified, catalogued, and considered in project implementation plans during the planning phase. One example of this is the environmental scan KCACH plans to conduct in early 2018 to determine the amount and array of community-based care coordination throughout the region.

***Submit logic model(s), driver diagrams, tables, and/or theory of action illustrations.***

See ACH Theory of Action and Alignment Strategy—Attachment A.

## **Governance**

Describe the ACH's governance structure. In the narrative response, address the following:

- Describe how the ACH's governance provides oversight for the following five required domains:
  - **Financial**, including decisions about the allocation methodology, the roles and responsibilities of each partnering providers, and budget development
  - **Clinical**, including appropriate expertise and strategies for monitoring clinical outcomes and care delivery redesign and incorporating clinical leadership, including large, small, urban, and rural providers
  - **Community**, including an emphasis on health equity and a process to engage the community and consumers
  - **Data**, including the processes and resources to support data-driven decision-making and formative evaluation

- **Program management and strategy development**, including organizational capacity and administrative support for regional coordination and communication
- If applicable, provide a summary of any significant changes or developments related to the governance structure (e.g., composition, committee structures, decision-making approach) and decision-making processes since Phase II Certification, including a rationale for changes.
- Discuss how the ACH addressed areas of improvement identified in its Phase II Certification related to its governance structure and decision-making processes.
- Describe the process for ensuring oversight of partnering provider participation and performance, including how the ACH will address low-performing partnering providers or partnering providers who cease to participate with the ACH.
- Submit a visual/chart of the governance structure (*submit as Governance—Attachment A*).

## ACH Response

### *Describe the ACH's governance structure:*

### *Describe how the ACH's governance provides oversight for the five required domains (financial, clinical, community, data, program management, and strategy development).*

Ultimate responsibility for King County Accountable Community of Health (KCACH) governance lies within its 26-member Governing Board, including broad sector representation and expertise across the five required domains. The Governing Board and Executive Committee also have a robust and clear committee structure/decision-making process to ensure effective oversight (see Governance—Attachment A, Figures 1 - 3).

### *Financial—including decisions about the allocation methodology, the roles and responsibilities of each partnering provider, and budget development*

The KCACH Governing Board assumes full fiduciary responsibility, including approval of the organization's annual budget and Delivery System Reform Incentive Program (DSRIP) fund allocations consistent with its mission.

It has charged the Finance Committee with overseeing internal functions: reviewing and recommending KCACH's annual budget, overseeing internal control processes, and ensuring adequate protection of KCACH's assets. It is also responsible for external DSRIP fund allocations: overseeing funds flow to partners and investment priorities, and monitoring contract requirements with state, provider, and community partners.

Thuy Hua-Ly, former chief financial officer of Washington state's Health Care Authority, serves as chief financial officer for KCACH and is responsible for the day-to-day financial management of the organization (e.g., budgeting, financial forecasts, contract oversight, financial reporting). Ms. Hua-Ly and the Finance Committee will establish and review contracts with partners to set clear responsibilities, milestones, metrics, and mechanisms for addressing low-performance. As a

subsidiary of the Seattle Foundation, KCACH is also subject to the Seattle Foundation’s auditing and internal control processes.

***Clinical—including appropriate expertise and strategies for monitoring clinical outcomes and care delivery redesign and incorporating clinical leadership, including large, small, urban, and rural providers***

The KCACH Governing Board will establish a Clinical Committee to engage a broad spectrum of providers. At present, Dr. Kristin Conn, a KCACH Governing Board member and practicing family practitioner at Kaiser Permanente, is leading a Provider Engagement Workgroup (a precursor to the Committee) to build awareness and engage provider partners.

Through June 2018, the focus will be to sign contracts with “go first” provider/community partners, ensure provider perspectives are incorporated into project planning, and host provider trainings on the KCACH Equity Impact Assessment Tool (Equity Tool). Mid-2018 and beyond, KCACH will shift to a Clinical Committee that supports provider/community partners with implementing practice transformations (e.g., providing technical assistance and Domain 1 investments). The Clinical Committee will include clinical expertise specific to the four selected projects and will work with the Finance and Performance Measurement and Data Committees to monitor outcomes.

Finally, KCACH is recruiting for a clinical innovations manager to support health care, behavioral health, social service, and other providers (e.g., rural, urban, large, small). The clinical innovations manager will ensure partnering providers have the resources and support necessary to successfully transform practice including providing/brokering technical assistance and trainings, promoting best practices, monitoring overall performance, and serving as lead staff to the Clinical Committee. The expected hire date is November 30, 2017.

***Community—including an emphasis on health equity and a process to engage the community and consumers***

The KCACH Governing Board takes its responsibility for community/consumer engagement and health equity very seriously. As shown in Attachment A, Figure 3, community engagement is a core responsibility of every KCACH Governing Board committee and workgroup; it is not delegated to the Community/Consumer Voice Committee (CCV) alone.

The CCV is comprised of 23 community leaders including the Healthy King County Coalition, Hopelink, Living Well Kent, Mercy Housing Northwest, NAACP, Regional Equity Network, Seattle Children’s, SEIU 1199NW, Somali Health Board, Washington Community Action Network, YWCA Works, and others.

The following is a list of what the CCV is empowered to do:

- Work with communities to solicit guidance on equity and social justice issues to inform KCACH decisions.

- Actively recruit and support community members/consumers serving on KCACH’s committees.
- Gather data and information on the experience of Medicaid clients.
- Develop, monitor, and implement a community engagement plan and budget.
- Build capacity for community-based organizations and consumers to participate.
- Monitor results and ensure accountability and transparency about the KCACH’s work.

From a governance perspective, KCACH supports consumers to serve on various decision-making bodies: three seats on the Governing Board, three seats on the Demonstration Project Committee, five seats on project Design Teams, and soon, consumer seats on Project Implementation Teams. It will also develop workstreams with community-based organizations serving special populations (i.e., immigrants, homeless, communities of color) to incorporate their experiences and needs into an ongoing feedback loop related to Medicaid Transformation Projects (MTPs).

Finally, KCACH is recruiting for a community and tribal engagement manager to support capacity building and infrastructure for ongoing community and consumer voice in driving system transformation. They will ensure that community partners, consumers, and tribal organizations have the resources and supports necessary to participate in all aspects of design, implementation, and ongoing oversight and monitoring of the MTP. KCACH has prioritized the goal of establishing a long-term sustainable infrastructure that will ensure system transformation is driven by those most impacted by the system. The community and tribal engagement manager will serve as lead staff to the CCV. The expected hire date is December 30, 2017.

***Data—including the processes and resources to support data-driven decision-making and formative evaluation***

KCACH’s Performance Measurement and Data Committee (PMD) includes representatives from county/city governments, MCOs, hospital systems, and community providers, and is now re-forming its membership to represent consumers, health care providers, social service providers, and population health–focused organizations. The PMD is co-led by Dr. Marguerite Ro, Chief of the Assessment, Policy Development, and Evaluation unit at Public Health – Seattle & King County, and Ms. Amina Suchoski, the managed care organization representative to the KCACH Governing Board and Vice President of Marketing and Business Development at United Healthcare. The following list shows what the PMD is empowered to do:

- Produce and support data-driven planning, implementation, and monitoring of the projects.
- Facilitate partnerships with stakeholders to support data sharing, linkage, and dissemination.
- Liaise with the HCA Analytics, Interoperability, and Measurement (AIM) team and other ACHs to support multi-ACH/state data systems and infrastructure.
- Develop recommendations/guidance on data investments that support projects (i.e., Domain 1).

KCACH is also leveraging the vast expertise and infrastructure of King County (Public Health – Seattle & King County and the Department of Community and Human Services) through a backbone services

contract. This includes county staff resources and data systems critical to data-driven decision-making and formative evaluation.

***Program Management and Strategy Development—including organizational capacity and administrative support for regional coordination and communication***

KCACH has expanded its internal staffing capacity significantly in recent months with the hiring of an executive director, chief financial officer, director of programs, project manager, and executive assistant. It is also in the process of recruiting a clinical innovations manager and a community and tribal engagement manager. Together, this team is responsible for overall program management and strategy development. As KCACH moves into the planning and implementation phase of the MTP, the executive director, in partnership with her leadership team and the Executive Committee of the KCACH, will further evaluate the ongoing staffing needs of the organization for the duration of the project. Additional staff will be hired in 2018 to support ongoing project design and implementation, monitoring, and quality improvement activities.

KCACH also has significant organizational capacity via contracts with organizations with deep expertise in DSRIP, data/analytics, community engagement, and project management:

- **Backbone services contract** with Public Health – Seattle & King County to provide project planning, Design Team support, data systems/analytics, performance monitoring, Regional Health Needs Inventory, and certification support.
- **DSRIP consultant contract** with Health Management Associates to provide MTP project planning and financial modeling expertise.
- **Community engagement contract** with Healthy King County Coalition to convene the CCV and engage Medicaid consumers and under-resourced communities.
- **Governance/facilitation contract** with Hulet Consulting to support governance, structural, and decision-making practices.
- **Operating agreement with the Seattle Foundation** to serve as fiscal sponsor (e.g., payroll, human resource services).

KCACH is also evaluating its communications needs relative to messaging, branding, and information flow, particularly as it relates to its clinical engagement strategy, and is currently interviewing firms to support short-term communication needs while evaluating the longer-term plans to include potentially hiring a communications staff member and/or contracting with a communications firm.

***If applicable, provide a summary of any significant changes or developments related to the governance structure (e.g., composition, committee structures, decision-making approach) and decision-making processes since Phase II Certification, including a rationale for changes.***

The KCACH's governance decision-making structure was well established by Phase II Certification; no significant changes were necessary. That said, KCACH has recently done the following:

- **Hired four additional staff.** Chief financial officer, director of programs, project manager, and executive assistant. Job postings for two additional positions are in process: clinical innovations manager and community and tribal engagement manager.
- **Increased Committee responsibilities.** The Governing Board increasingly relies on the expertise and recommendations of its committees (e.g., the Demonstration Project Committee was charged with developing KCACH’s project portfolio and is now facilitating coordination between projects).
- **Laid the foundation for a Clinical Committee** with a Provider Engagement Workgroup that is planning for ongoing provider connections and partnerships.

*Discuss how the ACH addressed areas of improvement identified in its Phase II Certification related to its governance structure and decision-making processes.*

Phase II Certification cited a lack of clarity on KCACH’s lean staffing model, roles, and accountability between KCACH and Public Health – Seattle & King County (PHSKC), and processes for broad sector representation and communication. To address these, KCACH has done the following:

- Hired additional staff (detailed above, see Attachment A, Figure 4).
- Signed a contract with PHSKC for backbone staffing support through the transition to the new KCACH and defining clear roles and responsibilities (see Attachment A, Figure 5).
- Shifted responsibilities from PHSKC to KCACH for program management, strategy development, financial planning/budgeting, and administrative support as KCACH has hired and grown the organization.
- Has processes under way with Governing Board members, the CCV, and the newly formed Provider Engagement Workgroup to strengthen community/provider representation and communication.

*Describe the process for ensuring oversight of partnering provider participation and performance, including how the ACH will address low-performing partnering providers or partnering providers who cease to participate with the ACH.*

Formal contracts with partnering provider organizations will serve as the basis for addressing low-performing partners or those who cease to participate. While these contracts have not yet been developed, they will include very specific terms and contingency plans for how to address these issues should they arise.

The executive director and chief financial officer, in partnership with the KCACH Governing Board’s Finance Committee, will oversee the development of these contracts and evaluate performance per contract terms. KCACH will hire staff to support monitoring and continuous quality improvement with all partnering providers and will work with the PMD and through a services contract with King County for data and analytics support to develop processes and provider feedback mechanisms to ensure timely course correction when needed. KCACH, through its clinical innovations manager, will work with partnering providers to ensure they have the resources and support necessary to successfully implement projects and meet reporting requirements and outcomes. In addition, KCACH staff will coordinate with the Clinical Committee to monitor clinical outcomes.

*Submit a visual/chart of the governance structure.*

See Governance—Attachment A.

## **Community and Stakeholder Engagement and Input**

Describe the ACH’s community and stakeholder engagement and input. In the narrative response, address the following:

- Describe and provide evidence of how the ACH solicited robust public input into project selection and planning (e.g., attachments of meeting minutes or meeting summaries where input was solicited) (*submit as Community and Stakeholder Engagement and Input—Attachment A*). In the narrative, address:
  - Through what means and how frequently were these opportunities for input made available? (e.g., ACH website posting, ACH listserv, surveys, newspaper, etc.)
  - How did the ACH ensure a broad reach and ample response time in its solicitation?
  - How did the ACH ensure transparency to show how public input was considered?
  - How did the ACH address concerns and questions from community stakeholders?
- Provide examples of at least three key elements of the Project Plan that were shaped by community input.
- Describe the processes the ACH will use to continue engaging the public throughout the Demonstration period.
- Describe the processes the ACH used, and will continue to use, to engage local county government(s) throughout the Demonstration period.
- Discuss how the ACH addressed areas of improvement, as identified in its Phase II Certification, related to meaningful community engagement, partnering provider engagement, or transparency and communications.

### **ACH Response**

*Describe the ACH’s community and stakeholder engagement and input:*

*Describe and provide evidence of how the ACH solicited robust public input into project selection and planning*

In spring 2017, King County Accountable Community of Health (KCACH) began soliciting robust public input by holding at least one Community Learning Session for each potential project in the Health Care Authority (HCA) toolkit. Notices of sessions were posted on the KCACH website and disseminated via the KCACH electronic mailing list, which includes over 1,000 individual provider, community member, and stakeholder names. A total of 10 Community Learning Sessions across the eight project areas were held, averaging 40 attendees each from multiple sectors; these were open to the public and encouraged attendees to provide input into project planning.

Following the Community Learning Sessions, community-driven Design Teams were formed—one for each potential project domain—and five community members joined Design Teams and participated in shaping the project plans. Once drafted, proposed projects were posted on the KCACH website

from August 21 to September 8, 2017, for public comment. These dates were announced in advance to KCACH partners and stakeholders via the KCACH electronic mailing list, Governing Board meetings, the Community/Consumer Voice Committee (CCV), and Design Teams. Across the eight projects, 200 responses were received (see Community and Stakeholder Engagement and Input—Attachment A for summaries of public comment). Design Teams received complete survey results to review and use to inform revision of project plans.

Additionally, the CCV conducted a survey of Medicaid beneficiaries to inform KCACH's work. The survey was disseminated three times in August and September 2017—with a group of Iraqi seniors hosted by the Center for MultiCultural Health (CMCH), at a CMCH meeting with the Congolese community, and at a Living Well Kent consumer meeting—for a total of 60 responses. Local ethnic health boards have indicated an interest in participating in future surveys, which will be rolled out through Healthy King County Coalition member organizations this winter.

Once the draft portfolio was complete, a second public comment period was held from October 17 to 24, 2017. This draft portfolio included revised plans for the four projects selected by the Governing Board. Twenty-four responses were received, and complete survey results were used to further refine projects and address the concerns of community stakeholders (Attachment A).

In addition to the public comment process, KCACH Governing Board and committee members took responsibility for engaging stakeholders from their sectors, including other hospital systems, provider associations, or community organizations, and brought those perspectives forward through input on revised drafts of the project plans or discussion about the overall project portfolio at various committee meetings. KCACH also addressed concerns and questions from the community through ongoing dialogue with those participating on Design Teams, presentations to a range of partners and stakeholders, and one-on-one meetings.

***Provide examples of at least three key elements of the Project Plan that were shaped by community input.***

Public comments received across projects emphasized the importance of information technology and data sharing as essential needs, with an emphasis on interoperability and minimizing the burden on providers. This consensus shaped the development of the foundational role of the Systems for Population Health Management portion of the Domain 1: Health and Community System Capacity Building proposal.

The Opioid Crisis Design Team sought a Medicaid client with lived experience to help shape Project 3A: Addressing the Opioid Use Public Health Crisis. Design Team lead staff reached out to Voices of Community Activists and Leaders (VOCAL-WA), a grassroots organization that “builds power among low- and no- income people directly affected by the war on drugs, homelessness, mass incarceration, and the HIV/AIDS epidemic to create healthy and just communities for all.” A VOCAL-WA volunteer with lived opioid use disorder experience served on the Opioid Crisis Design Team and helped shape the medication-assisted treatment expansion plan (Attachment A).

A number of public comments during both phases of public comment highlighted Law Enforcement Assisted Diversion (LEAD) as an essential partner in successful opioid efforts (Attachment A). This

feedback led to revisions to the Opioid Project that included enhanced collaboration with LEAD efforts at the Seattle Police Department and the King County Sheriff's Office to ensure alignment of activities and further support for diversion of individuals with opioid use disorder from jail.

Finally, KCACH received multiple comments throughout the public comment periods indicating the need to ensure that the KCACH project portfolio addressed issues of equity and to strengthen the connections to social determinants of health (Attachment A). As a result, the KCACH Governing Board directed the Demonstration Project Committee to ensure that the project portfolio as a whole, and each individual project, addressed social determinants of health and strengthened connections to community-based care coordination.

***Describe the processes the ACH will use to continue engaging the public throughout the Demonstration period.***

During the Year 2 planning phase in design, Design Teams will partner with the CCV to engage communities and consumers experiencing the greatest health disparities into the planning and implementation of the overall portfolio. KCACH will provide capacity-building resources and supports to ensure enhanced community organization and consumer participation. In alignment with public comment feedback, efforts will focus on culturally and linguistically appropriate outreach to engage across projects and regarding Domain 1 investments. Design Teams will receive more in-depth training on the use of the KCACH Equity Impact Assessment Tool and will continue to apply an equity lens to projects with CCV collaboration. All strategies across projects will be assessed for their ability to address systemic and other barriers to accessing services and resources, including barriers related to race/ethnicity, gender, geographical location, and income level. Investments will be targeted toward regions and populations that experience the greatest disparities.

KCACH Governing Board and other committee meetings will continue to be open to the public, with materials circulated in advance via electronic mailing list and designated public comment time on the agenda. The CCV will continue to hold evening meetings at least once per quarter to expand participation and expand outreach to ethnic health boards and other community-based organizations and consumers who may have other obligations during daytime hours. KCACH will provide ongoing resources to support attendance and participation at these meetings.

KCACH will continue to leverage existing community expertise through its contract with the Healthy King County Coalition to facilitate the CCV as well as continue dedicated outreach to Medicaid recipients through existing organizations and groups such as the *Promotora* network, Familiar Faces advisory group, and VOCAL-WA.

KCACH will maintain a dynamic, user-friendly website where members of the public can turn to find out all things ACH-related. Meeting schedules, materials, and summaries will be posted to the website in a timely manner. KCACH will also post information about implementation of the overall project portfolio and semiannual and annual reports as a means to inform the public and keep stakeholders engaged. KCACH will have a dedicated email address that can be accessed via the website for members of the public to ask questions or submit comments and feedback on the Medicaid Transformation Project.

Committees and workgroups will proactively facilitate community and consumer engagement, and all Governing Board members are required to solicit input from their sectors and communicate the work of KCACH to the broader public. The CCV and Design Teams will continue to reach out to community members with lived experience and their family members to ensure that projects meet the needs of communities. The CCV has invited diverse stakeholders to serve on KCACH committees and workgroups and will establish policies to support this participation, including stipends, transportation reimbursement, and food at meetings. These provisions will support the continued involvement and expanded participation of consumers on the Governing Board, Demonstration Project Committee, and Design Teams. Staff will continue to meet with community and consumer groups to share updates and gather feedback.

Ultimate success will be defined by KCACH's ability to engage Medicaid beneficiaries, community members, and the organizations that serve them in a dialogue that helps transform the delivery system into one that focuses on prevention, improves equity, and embraces long-term recovery. The ultimate aim is to co-create solutions, establish ongoing processes, and build long-term connections that address the priorities of people covered by Medicaid and the community at-large.

***Describe the processes the ACH used, and will continue to use, to engage local county government(s) throughout the Demonstration period.***

As a single-county ACH, the KCACH Governing Board has three designated government seats: one for King County, one for the City of Seattle, and one for the suburban areas. In addition, two government agency directors hold the local public health and long-term care services/supports seats. Within King County government, regular reports and outreach are made to the King County Council, the King County Executive, the Board of Health, and the Human Resources Division of King County, which shares an interest in pay-for-performance and health reform. For the City of Seattle, the sector representative provides updates to the Mayor's office, city councilmembers, and other impacted department leaders. The representative also works closely with the Governing Board member in the long-term care services and support seat, who is representing the Area Agency on Aging, located within the City of Seattle's Human Services Department Aging and Disability division.

KCACH has also engaged with King County government, and specifically the King County Behavioral Health Organization, to plan for the transition to fully integrated managed care (FIMC). The executive director of KCACH is a member of the King County FIMC Leadership Group along with King County Behavioral Health Organization (BHO) leaders, the CEOs of all five Medicaid MCOs, and Health Care Authority leadership. The FIMC Leadership Group will provide regular updates to the KCACH Governing Board. KCACH implementation of Project 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation will be aligned with the vision of the FIMC Leadership Group, and KCACH will make investments that help support provider transition to integrated care as well as Domain 1 investments, including assisting providers to transition to value-based payment (VBP) arrangements that support integration.

***Discuss how the ACH addressed areas of improvement, as identified in its Phase II Certification, related to meaningful community engagement, partnering provider engagement, or transparency and communications.***

Phase II Certification cited the need for additional focus on strategies or processes to address the barriers and challenges for engagement with providers beyond KCACH's Governing Board and committees. This topic is described in the Governance section, where the Clinical domain provides details on the formation of a Provider Engagement Workgroup that has begun work to build awareness across a broad array of providers and to actively engage and support partners implementing the Medicaid Transformation Project. Results are leading to the formation of a Clinical Committee in 2018, supported by a clinical innovations manager position that is currently being recruited.

## Tribal Engagement and Collaboration

Describe the ACH's current tribal and Indian Health Care Provider (IHCP) engagement and collaboration efforts. In the narrative response, address the following:

- How are tribal and IHCP priorities being identified, either through the ACH or through tribal/IHCP partners?
- Have those priorities informed project selection and planning?
  - If applicable, provide examples of at least three key elements of the Project Plan that were informed by tribal input.
  - If tribes/IHCPs are not involved in ACH project selection and design, describe how the ACH is considering the needs of American Indians/Alaska Natives in the ACH region.
- If possible, provide as attachments statements of support for the ACH from Indian Health Service, tribally operated, or urban Indian health program (ITUs) in the ACH region. (*Submit as Tribal Engagement and Collaboration—Attachment A.*)
- Discuss how the ACH addressed areas of improvement identified in its Phase II Certification related to tribal engagement and collaboration.

### ACH Response

*Describe the ACH's current tribal and Indian Health Care Provider (IHCP) engagement and collaboration efforts.*

King County Accountable Community of Health (KCACH) has been engaging with and collaborating with tribes and Indian Health Care Providers (IHCPs) in a variety of ways:

1. **KCACH Governing Board:** Esther Lucero, co-chair of the KCACH Governing Board, is CEO of the Seattle Indian Health Board (SIHB), the largest provider of community health care and services to the urban American Indian/Alaska Native (AI/AN) population in the King County region. The Health and Human Services director for the Cowlitz Indian Tribe, Steve Kutz, is also a member of the KCACH Governing Board. Since the KCACH Governing Board assumed responsibility in May 2017 (replacing the former Interim Leadership Council), AI/AN perspectives have been an integral part of Governing Board conversation on topics such as culturally appropriate and responsive care, models for physical and behavioral health integration, and the limitations of evidence-based practices for cultures that have chosen not to assimilate. In addition, the Governing Board has designated itself as the committee responsible for assessing AI/AN impacts per its Tribal Collaboration and Communication Policy, which it will monitor through a feedback loop operationalized through the KCACH Equity Impact Assessment Tool (or Equity Tool—see also the Community and Stakeholder Engagement and Input section).
2. **Project Design Team input:** As elaborated in the ACH Theory of Action and Alignment Strategy section, KCACH formed Design Teams to support the eight project areas. Design Teams worked between May and October 2017 to develop projects with the greatest potential to address the region's priority health needs. Design Teams used the Regional Health Needs Inventory data, which included available data on the AI/AN population, to design the scope of projects. They solicited Design Team participation from tribes and IHCPs. For example, for Project 2A: Bi-Directional Integration, the Design Team made repeated efforts to engage the Muckleshoot

Indian Tribe, and solicited input from tribes on the draft project template, but never received a response. However, Project 3D: Chronic Disease Prevention and Control, benefited from the expertise of Matt EchoHawk-Hayashi, with Headwater Consulting and the SIHB, who served as co-chair of the Design Team and contributed to the design of the asthma/community health workers component of the project.

3. **Access to AI/AN data:** The KCACH Performance Measurement and Data Committee (PMD) met with the Urban Indian Health Institute (UIHI) to begin a discussion around how best to describe and disseminate information about the persistent and widespread AI/AN health disparities in the Medicaid population. UIHI, a division of the SIHB, studies the health and well-being of urban AI/AN communities nationwide and provides information to support program planning, research, reports, grant writing, and advocacy. The UIHI is one of 12 tribal epidemiology centers funded by the Indian Health Service.
4. **Provider survey:** As described in the Domain 1 Strategies section, KCACH conducted its own provider survey to assess interest in project participation. While no tribal clinics have responded yet, the SIHB has indicated interest in Project 3D: Chronic Disease, and KCACH staff are conducting additional outreach to encourage providers who serve AI/AN clients to respond.

*How are tribal and IHCP priorities being identified, either through the ACH or through tribal/IHCP partners?*

The PMD included all available demographic data on the AI/AN population as part of KCACH's [Regional Health Needs Inventory](#). These data were used to identify target populations and define the scope of project plans that were posted for public comment, reviewed by the Demonstration Project Committee (DPC), and approved by the Governing Board.

These data, shared by Design Teams through the Equity Tool, informed project design and show that the AI/AN population has long experienced lower health status when compared to other groups in the King County region. AI/AN people continue to die at higher rates across many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases. AI/ANs are disproportionately more likely to be arrested, and disproportionately suffer from substance abuse, alcohol abuse, and mental health issues.

As part of the process set out by the Equity Tool, the Community/Consumer Voice Committee will work closely with Design Teams and under the direction of the Governing Board to (a) contact affected communities to learn about community and social determinants contexts, priorities and concerns of affected communities, and alignment of the proposed project with those priorities and concerns; (b) assess potential negative impacts as a result of implementation of any of the projects and identify equitable alternatives; and (c) establish a communication loop for accountability and a mechanism for addressing unintended consequences. This process will be a built-in component of project design and will include meetings and outreach with tribes and IHCP partners through Community Learning Sessions and focus groups, which will also be made available to other affected communities.

Looking ahead, KCACH will engage clinical providers already serving AI/AN Medicaid clients. All Federally Qualified Health Centers, which serve a majority of Medicaid clients in King County, will participate in the planning and implementation of bi-directional integration, chronic disease, and other projects. Additionally, it will be essential for KCACH to continue to engage primary health and social service providers already serving AI/AN Medicaid clients in King County, such as the SIHB and tribal clinics. Their participation will help further inform tribal and IHCP priorities.

Finally, KCACH is recruiting for a community and tribal engagement manager to support the ongoing capacity building and infrastructure for ongoing community and consumer voice, including tribal partners, in driving system transformation. The community and tribal engagement manager will ensure that community partners, consumers, and tribal organizations have the resources and supports necessary to participate in all aspects of design, implementation, and ongoing oversight and monitoring of the Medicaid Transformation Project (MTP). KCACH has prioritized establishing a long-term sustainable infrastructure that will ensure that system transformation is driven by those most impacted by the system. The community and tribal engagement manager will serve as lead staff to the Community/Consumer Voice Committee and as a liaison to tribal organizations. The expected hire date is December 30, 2017.

***Have those priorities informed project selection and planning?***

AI/AN and tribal priorities have helped inform project selection as part of a target population review that identified persistently lagging metrics of the AI/AN Medicaid population in King County. The persistent place, race, and income disparities routinely seen in King County tell a deep story about the social determinants of health. In particular, people and communities of color, including those with AI/AN heritage, are more likely to experience multiple complex barriers to health that significantly impact their ability both to access health and social services and to act on the guidance of their providers. With this in mind, these disparities were considered by Design Teams and the DPC when putting forth recommendations for project selection, including how the MTP could be leveraged to address social inequities in the King County community.

KCACH will utilize the new community and tribal engagement manager to continue to engage all tribes within the King County region to participate in the planning and implementation of the MTP and to continue to support alignment of the projects with tribal priorities.

***If applicable, provide examples of at least three key elements of the Project Plan that were informed by tribal input.***

Dan Cable from the Muckleshoot Indian Tribe served on the King County Heroin and Prescription Opiate Addiction Task Force, the precursor to the Opioid Crisis Design Team for Project 3A: Addressing the Opioid Use Public Health Crisis. Both the Muckleshoot Tribe and the SIHB have been actively involved in medication-assisted treatment expansion for people experiencing opioid use disorder, and they are advocates for more resources for those who have difficulty accessing traditional health and behavioral health resources, seeking to remove barriers for individuals in need of treatment. For example, they have helped to inform the design of the Buprenorphine Pathways Clinic at the Needle Exchange in downtown Seattle—a project designed to provide low-barrier access

to medication-assisted treatment. Specific perspectives of tribal partners on reducing barriers were incorporated into KCACH's Project 3A: Addressing the Opioid Use Public Health Crisis project plan.

At the August 10, 2017, KCACH Governing Board meeting, members discussed the challenge of using evidence-based models for projects affecting tribal communities. The KCACH Governing Board's tribal members expressed how traditional and culturally appropriate practices have been used by tribes and IHCPs with good results, but these practices have not necessarily been studied, and would not be considered evidence-based. Tribal members described that for tribes that have resisted the urge to assimilate, culture is an important tool and key resource that builds resilience in a community. The Governing Board agreed that as KCACH moves into project planning and implementation, cultural considerations need to be taken into account as they evaluate innovative and promising practices in addition to evidence-based ones. This perspective was adopted as a core value of KCACH, and direct guidance was provided to the DPC to ensure a portfolio that balances the use of evidence-based as well as other promising practices.

On September 21, 2017, Design Team staff met with SIHB staff to discuss Project 3D: Chronic Disease Prevention and Control. The SIHB affirmed the pivotal role of community health workers in health teams and as key links to expanding access to underserved AI/AN communities. These elements were incorporated into the Project 3D plan.

***If tribes/IHCPs are not involved in ACH project selection and design, describe how the ACH is considering the needs of American Indians/Alaska Natives in the ACH region.***

Tribes and IHCPs have already been involved in KCACH project selection and design. Given the persistence of disparities affecting this population and the potential impacts of these projects on the AI/AN community, KCACH now seeks additional and deeper participation as it moves into the project design and implementation phases, as described above. KCACH will be recruiting for a community and tribal engagement manager to support capacity building and infrastructure for ongoing community and consumer voice in driving system transformation including tribes. The community and tribal engagement manager will ensure that community partners, consumers, and tribal organizations have the resources necessary to participate in all aspects of design, implementation, and ongoing oversight and monitoring of the MTP, and will liaise with the state Health Care Authority Tribal liaison and work to strengthen and/or establish ongoing participation of all tribes in the King County region.

***If possible, provide as attachments statements of support for the ACH from Indian Health Service, tribally operated, or urban Indian health program (ITUs) in the ACH region.***

Statements of support were submitted by the SIHB and Cowlitz Indian Tribe Health and Human Services as part of the Phase II Certification process and are included as Tribal Engagement and Collaboration—Attachment A.

***Discuss how the ACH addressed areas of improvement identified in its Phase II Certification related to tribal engagement and collaboration.***

As part of Phase II Certification, KCACH was encouraged to continue outreach to the Muckleshoot and Snoqualmie Tribes, which it did through the provider survey described at the top of this section. KCACH will continue such outreach as part of project planning and implementation.

## Funds Allocation

### Funds Flow Oversight

Describe the ACH's process for funds flow oversight. In the narrative response, address the following:

- Describe how the ACH will manage and oversee the funds flow process for DSRIP funds (Project Incentive funds, Managed Care Integration Incentive funds, and VBP Incentive funds), including how decisions will be made about the distribution of funds earned by the ACH.
- Discuss the roles and responsibilities of, and relationships between, the ACH governance body and partnering providers in managing the funds flow process.
- Describe the ACH process for ensuring stewardship and transparency of DSRIP funds (project design funds, project incentive funds, managed care integration incentive funds, and VBP incentive funds) over the course of the Demonstration.
- If applicable, provide a summary of any significant changes since Phase II Certification in state or federal funding or in-kind support provided to the ACH and how the funding aligns with the Demonstration activities.
- If applicable, provide a summary of any significant changes to the ACH's tracking mechanism to account for various funding streams since Phase II Certification.

## ACH Response

### *Describe the ACH's process for funds flow oversight.*

KCACH has established its organizational structure to provide collaborative decision-making and robust accountability for the expenditure of Delivery System Reform Incentive Payment program (DSRIP) funds. The composition of the Governing Board and the Finance Committee represent a broad cross-section of stakeholders, including providers, managed care organizations, community-based organizations, public health, and local government. In addition, KCACH intends to establish a Budget and Funds Flow Workgroup composed of health care finance subject matter experts (e.g., chief financial officers, finance directors) to advise funds flow decisions with appropriate expertise in the intricacies of financial accountability as well as value-based payment models. The KCACH executive director, Susan McLaughlin, and chief financial officer, Thuy Hua-Ly, are the fiduciary liaisons between KCACH and its Governing Board and committees.

### *Describe how the ACH will manage and oversee the funds flow process for DSRIP funds, including how decisions will be made about the distribution of funds earned by the ACH.*

The charters of the Governing Board, Finance Committee, and Budget and Funds Flow Workgroup define the hierarchy of funds flow decision-making. The Budget and Funds Flow Workgroup will grapple with the technical aspects of funds allocation, including projection of KCACH revenues based on the still-evolving availability of DSRIP funds, prospective methodology for funds distribution, timing of distributions, and compilation and analysis of performance data as it relates to funds flow, and will contribute to the communication and training plan with participating partners. The recommendations

of the Budget and Funds Flow Workgroup will be reviewed and approved or amended by the Finance Committee, in consultation with the appropriate KCACH subcommittees, for recommendation to the Governing Board, which will have ultimate authority for funds flow decisions.

The budgets for KCACH administrative operations, Domain 1 investments, project expenditures, and distributions to partnering organizations will be prospectively approved and regularly monitored. The chief financial officer will prepare and submit, for approval by the Finance Committee and Governing Board, monthly financial statements including budget-to-actual variances. The executive director and chief financial officer will have limited authority to approve deviations from budget (e.g., functional reallocations between use categories), but material deviations—those exceeding dollar thresholds or involving substantive changes to allocation methodology—will require Finance Committee and/or Governing Board approval. Prior to submitting distribution direction to the financial executor, all distributions will be reviewed and approved by the Finance Committee, and reported and approved by the Governing Board.

The Finance Committee and Governing Board have adopted a set of funds flow principles to guide allocation (see Appendix 7—Funds Flow Oversight). These principles provide the framework for funds flow decisions, specifically providing for:

- A collaborative process
- A transparent approach
- Adaptability and responsiveness to variability
- Distribution decisions made in a thoughtful, objective manner
- Consideration of consumers and community
- Addressing health disparities and social determinants of health
- Accountability of KCACH and its partnering organizations

***Discuss the roles and responsibilities of, and relationships between, the ACH governance body and partnering providers in managing the funds flow process.***

The chief financial officer will be responsible for executing memorandums of understanding (MOUs) with the partnering organizations, as well as monitoring the compliance with, performance under, and distribution of funds in accordance with the terms of the MOU. KCACH is established as a limited liability corporation under the fiscal sponsorship of the Seattle Foundation and is utilizing the foundation's accounting systems, procedures, and personnel for financial reporting. KCACH's financial statements, therefore, will be audited by the Seattle Foundation's auditor, Clark Nuber, P.S.

The KCACH funds flow guiding principles explicitly state that accountability for success of the Medicaid Transformation Project is shared by KCACH and its partnering organizations. KCACH, as the "holder of the purse strings," is the convener and catalyst for the transformation activity. In early 2018, KCACH will execute MOUs with its partnering organizations that will stipulate the specific roles and responsibilities of each party. As mentioned above, the Finance Committee and Governing Board membership includes representatives from organizations that may receive DSRIP funds. All members are expected to adhere to the KCACH conflict of interest policy (see Appendix 8—Funds Flow Oversight).

***Describe the ACH process for ensuring stewardship and transparency of DSRIP funds over the course of the Demonstration.***

The funds flow guiding principles explicitly state that “the approach to defining and administering the funds flow will be transparent to all stakeholders, while maintaining confidentiality and propriety of information where required.” Governing Board meetings, where final funds flow decisions will be made, are open to the public. Meeting minutes and materials, including financial statements, will be made available to the public in a manner yet to be finalized—either online or on demand. When appropriate, key decisions may be published for public comment in advance. As mentioned earlier, as the KCACH fiscal sponsor, the Seattle Foundation will include KCACH accounting and financial statements in its annual financial audits.

***If applicable, provide a summary of any significant changes since Phase II Certification in state or federal funding or in-kind support provided to the ACH and how the funding aligns with the Demonstration activities.***

During the Design Phase, Public Health – Seattle & King County (PHSKC) played a major role in establishing the KCACH. PHSKC, along with the King County Department of Community and Human Services, have provided meeting space and materials in addition to staff support above and beyond the staffing funded by either the State Innovation Models (SIM) grant or the KCACH service contract with PHSKC covering the April 2017 to December 2017 time frame. Since Phase II Certification, KCACH has hired four new staff (a chief financial officer, a director of programs, a project manager, and an executive assistant) in addition to the executive director hired in July 2017. Following the appointment of the executive director, KCACH began transitioning core organizational functions from King County government staff to KCACH staff and the Seattle Foundation. Shared service functions such as financial systems/processes, human resources, information technology, and project management are now being provided by the Seattle Foundation, the fiscal sponsor for KCACH, as well as by KCACH staff. KCACH has secured space, purchased equipment, and assumed most operations of the ACH, further establishing KCACH as an independent and autonomous organization. KCACH anticipates adding an additional five or more full-time staff in Demonstration Year 2 and to be fully staffed by no later than Demonstration Year 3.

There are no other significant changes to in-kind support or additional state or federal funds since Phase II Certification.

***If applicable, provide a summary of any significant changes to the ACH’s tracking mechanism to account for various funding streams since Phase II Certification.***

Since Phase II Certification submission, PHSKC has completed the transition of fiscal oversight to KCACH. KCACH continues to utilize the Seattle Foundation’s financial management systems for tracking, monitoring, and reporting its financials. The recently hired KCACH chief financial officer will be reviewing the accounting policies and procedures, but considering the Seattle Foundation’s long-standing financial management history, no significant modifications are anticipated. KCACH will provide additional policies and processes as needed to comply with federal rules and regulations. As new funding streams, both DSRIP and non-DSRIP, come online, the KCACH general ledger will be updated accordingly to track project revenues and expenditures. For example, as SIM grant funds

were transferred from PHSKC to KCACH in August, a new account was established in the KCACH general ledger to record SIM transactions separate from the DSRIP budget.

Moving forward, the KCACH chief financial officer will provide a monthly financial report to both the Finance Committee and the Governing Board for review and approval.

### **Project Design Funds**

Describe, in narrative form, how Project Design funds have been used thus far and the projected use for remaining funds through the rest of the Demonstration.

#### **ACH Response**

*Describe, in narrative form, how Project Design funds have been used thus far and the projected use for remaining funds through the rest of the Demonstration.*

KCACH is the largest ACH in the state, with 24% Medicaid attribution and a large number of potential partnering organizations. The effort to coordinate and administer the Medicaid Transformation Project (MTP) in King County is commensurate with the size of the population covered and the complexity of the delivery system in the region. Each ACH received \$6 million in Design Funds regardless of size, complexity, or cost of doing business in a metropolitan area. KCACH intends to assess a percentage of the DSRIP incentive fund to supplement the administrative costs that are beyond the \$6M Design Funds.

The largest expenditure of Design Funds to date has been for KCACH's service contract with Public Health – Seattle & King County (PHSKC). PHSKC has provided staffing for KCACH activities since the inception of KCACH and through its transition to a separate legal entity, while KCACH was establishing its own administrative infrastructure. Through Demonstration Year 1 (calendar year 2017), approximately \$1.3M (22% of total) will be reimbursed to PHSKC for deferred and current payables. Under the contract, the following specific activities will be performed by PHSKC:

- Consumer/community engagement (10%)
- Project planning (35%)
- Project technology/data analysis (40%)
- KCACH administrative infrastructure and operations (15%)

The current contract term expires on December 31, 2017, at which point administrative activities will be assumed by KCACH.

The balance of the \$4.7M (\$6.0M less \$1.3M of the PHSKC services contract) in Design Funds was budgeted for KCACH operations, including:

- KCACH salary and benefits (54%)
- Seattle Foundation sponsor fee and lease of office space (7%)
- DSRIP consultants (4%)
- New lease of office space (6%)

- Insurance, communication, legal expenses (4%)
- B&O tax (2%)
- Technology and supplies (1%)
- Travel, other expenses (1%)

Beginning in early 2018, the Design Funds will be supplemented by an allocation of expected project incentive funds (12%), per the Governing Board–approved funds flow (see Funds Flow Distribution section), to ensure adequate funding of KCACH project management and administration costs.

### Funds Flow Distribution

Describe the ACH’s anticipated funds flow distribution. In the narrative response, address the following:

- Describe how Project Incentive funds are anticipated to be used throughout the Demonstration. Provide a narrative description of how funds are anticipated to be distributed across use categories and by organization type. (*Refer to the Funds Distribution tabs of the ACH Project Plan Supplemental Data Workbook for use categories and organization types to inform the narrative response*).

### ACH Response

*Describe the ACH’s anticipated funds flow distribution:*

*Describe how Project Incentive funds are anticipated to be used throughout the Demonstration. Provide a narrative description of how funds are anticipated to be distributed across use categories and by organization type.*

The funds flow distribution plan was made in a thoughtful, objective manner, consistent with the goals of the Medicaid Transformation Project (MTP). Using the Governing Board–approved funds flow guiding principles, along with incentive revenue estimation tools provided by the Health Care Authority (HCA), the Finance Committee defined use categories, allocations by use category, and distribution by organization types. KCACH approached the funds flow distribution methodology with consideration of the recent HCA reduction to Demonstration Year 1 revenue and the uncertainty about funds availability for subsequent years. The KCACH Finance Committee evaluated and assigned use categories to ensure a model that is adaptable and responsive to variability in the amount of accessible funds. Variability may be due to lack of nonfederal funds to qualify for match, actual ACH performance, or unforeseen changes in project execution.

The overall goal of Delivery System Reform Incentive Payment (DSRIP) is to catalyze the transition from a fee-for-service system to a value-based payment (VBP) system. DSRIP funds represent a piece of the investment in transitioning to a VBP system, and it is anticipated that these funds will not cover the full costs of project implementation for all KCACH partners. Partners that choose to participate in a project will therefore be expected to carry some of the financial responsibility for funding practice transformation, realizing that the path to a Healthier Washington will include resources beyond DSRIP incentives.

To develop a meaningful funds flow distribution plan, the Finance Committee must understand the projects selected and the participation level of providers for each project. In consideration of the upcoming planning year, the allocation of Demonstration Year 1 funds has been prioritized for investments in Domain 1 activities and to engage KCACH partners and providers to ensure they are positioned to respond to transformation activities. The intent is that a share of the Provider Engagement, Participation, and Implementation category will be distributed to engage partners in activities that address health disparities and social determinants of health, complementary to activities in the MTP portfolio. Investments will be made to build out the infrastructure of KCACH, and KCACH will establish a reserve fund to protect against financial exposure from unforeseen circumstances. Unused reserve funds will be distributed at the end of the MTP according to criteria to be developed and approved by the Finance Committee and Governing Board.

Looking beyond Demonstration Year 1, the Governing Board and Demonstration Project Committee requested that Design Teams provide cost estimates for 2018, the first year of projects. These estimates were based on salary ranges, training costs, staffing needs, and costs to operate similar models. Project plans are still in development, and many of the details of current state and project implementation specifics are not yet known. Therefore, it is anticipated that these estimates will be subject to change as factors evolve. It is in consideration of this that, across all five years, the bulk of funds have been allocated for investment in project-focused activities, with payment to partners transitioning to performance-based payments in later years to incentivize achievement of milestones and metrics.

KCACH will also seek to leverage resources outside of DSRIP funds, such as health transformation programs and initiatives; other public sources, including federal (e.g., Centers for Medicare & Medicaid Services, Agency for Healthcare Research and Policy, Health Resources and Service Administration) and state (e.g., State Innovation Models); and private foundations to further the vision of KCACH and provide increased opportunity for system transformation beyond what can be accomplished over the course of the MTP.

To achieve a high-performing health care delivery system, the allocation plan contemplates a strong bi-directional partnership between clinical and community-based providers. The methodology for allocating funds to partnering organizations is yet to be fully established, due in part to uncertainty about total available funds and lack of data upon which to base allocations. However, the methodology will ensure that priority investments are adequately funded and that allocations are objective and equitable.

The KCACH Finance Committee recommended, and the Governing Board approved, eight use categories for the distribution of incentive funds. The following list describes what is provided in the use category distribution plan:

- Infrastructure to support KCACH strategy; policy; fiscal and programmatic management; partnership and advocacy with the state; project oversight, management, and support; data analysis; communication; and consumer and community engagement.
- Investments in regional, project-specific, and partner-specific activities integral to the planning and execution of the MTP.

- Incentive-based, metric-driven payments for reporting progress toward meeting project milestones (pay for reporting—P4R) and for meeting project goals (pay for performance—P4P) toward KCACH achieving its vision of high-quality care, better health outcomes, and lower costs.
- Domain 1 investments to achieve financial stability through transition to VBP.
- Domain 1 population health management via project technology support and data analysis.
- Domain 1 workforce needs to recruit and hire professionals necessary to achieve project goals.
- Social equity and wellness fund, which is the activation of nontraditional Medicaid community-based organizations in addressing social determinants of health to transform the health care delivery system.
- Contingency/reserve fund for unanticipated events or costs to safeguard resources for projects and overall KCACH administration.

The Finance Committee applied a conservative approach to the allocations by use categories based on the following agreed-upon assumptions:

- 27% reduction in available funds across all five years.
- Valuation based on number of attributed Medicaid clients as determined by HCA.
- Selection of four projects.
- Project plan score of 100%.
- Average P4R achievement value of 90% across all four years.
- Average P4P achievement value of 70% across all three years.

**Table 12. Allocation of Project Funds by Use Category**

Use Category	DY1 (2017)	5-Year Total
Project management (3%) and administration (12%)	15%	15%
Provider engagement, participation, and implementation	55%	33%
Provider performance and quality incentive payments	0%	30%
Financial stability through VBP (Domain 1)	0%	2%
Population health management (Domain 1)	20%	7%
Workforce (Domain 1)	5%	4%
Social equity and wellness fund	0%	6%
Reserve fund	5%	3%

Notes: DY1 = Demonstration Year 1. VBP = value-based payment.

In unison with the Governing Board, the Finance Committee contemplated the following principles for allocations to organization types:

- KCACH:
  - Overall direct administration, resources to build capacity in support of program strategies, analytics, contracting, partner monitoring and reporting, and rapid cycle improvement.
  - Overall project management support to ensure accountability and successful implementation.
- Tribes/Indian Health Service, tribal or urban Indian health programs:
  - Funds to ensure engagement in project implementation, to support workforce needs to drive KCACH performance, and to participate effectively in design, implementation, and monitoring of projects through a tribal lens.
- Providers traditionally reimbursed by Medicaid:
  - Funds to focus on implementation and integration with non-Medicaid partners, and also to acknowledge the financial disruption from the transition to VBP contracting.
- Providers not traditionally reimbursed by Medicaid:
  - Funds to support engagement with KCACH, participate in KCACH-required planning year activities, and support implementation—recognizing the opportunity to make significant contributions to KCACH performance.
- Other:
  - Domain 1 investments to fund KCACH resources to advance VBP capabilities among partners, including population health management and workforce.
  - KCACH management of the reserve fund for future distribution by the end of the MTP.

**Table 13. Allocation of Project Funds by Organization Type**

Organization Type	DY1 (2017)
ACH	15%
Medicaid providers	36%
Non-Medicaid providers	36%
Tribes/ITU	6%
Other <sup>a</sup>	7%
Total	100%

*Notes:* DY1 = Demonstration Year 1. ITU = Indian Health Service, tribally operated, or urban Indian health program.

<sup>a</sup> See Other category described above.

Going forward, KCACH will be guided by the principles of collaboration and accountability in allocating project funds to partnering organizations. Allocation decisions will contemplate the value of the project, the target population, and the partner organization’s level of resource and commitment, readiness and expertise, financial resources, and success in achieving milestones and outcome goals.

- Using the **Funds Distribution tabs** of the **ACH Project Plan Supplemental Data Workbook**:

- **Funds Distribution—1:** Provide the projected percent funding of the Project Incentive funds by use category over the course of the demonstration (DY 1 through DY 5 combined). “Project Management and Administration,” “Provider Engagement, Participation and Implementation,” “Provider Performance and Quality Incentive Payments,” and “Health Systems and Community Capacity Building” are use categories that are fixed in the workbook. ACHs may enter additional use categories. For each use category (fixed and additional), ACHs must provide a definition and the projected percentage of Project Incentive funds over the course of the demonstration.
- **Funds Distribution—2:** Provide the projected percent funding of the Project Incentive funds by/for organization type for DY 1. “ACH Organization/Sub-contractors” and four “Partnering Provider Organizations” types are fixed in the workbook. ACHs must define “Other” organizations if the organization type is used. For each organization type, ACHs must provide a projected percentage of Project Incentive funds for DY 1.
- Attest to whether all counties in the corresponding Regional Service Areas have submitted a binding letter of intent (LOI) to integrate physical and behavioral health managed care.

YES	NO
X	

- Attest to whether the ACH region has implemented fully integrated managed care.

YES	NO
	X

- If the ACH attests to having implemented fully integrated managed care, provide date of implementation.

DATE (month, year)	

- If the ACH attests to not having implemented fully integrated managed care, provide date of projected implementation.

DATE (month, year)	January, 2019

- If applicable (*regions that have submitted LOI and implementation is expected*), please describe how the ACH is working within the community to identify how Integrated Managed Care Incentive funds will be used or invested. Identify the process for determining how Integration Managed Care Incentives will be allocated and invested, including details for how behavioral health providers and county government(s) are participating in the discussion. Additionally, using the guidance provided below, describe anticipated use of funds.

*(The Managed Care Integration Incentives are intended to assist providers and the region with the process of transitioning to integrated managed care. This could include using funds to assist with the uptake of new billing systems or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with managed care business processes. County governments are one example of a potential partnering provider that could receive earned integration incentives, but integration incentives are dispersed by the financial executor, according to an allocation approach defined by the ACHs. Include use categories defined by the ACH for planned funds distribution).*

## ACH Response

*Describe how the ACH is working within the community to identify how Integrated Managed Care Incentive funds will be used or invested. Identify the process for determining how Integration Managed Care Incentives will be allocated and invested, including details for how behavioral health providers and county government(s) are participating in the discussion. Describe anticipated use of funds.*

In addition to the allocation by use categories (described in the Funds Flow Distribution section) and the distribution of project incentive funds, King County has opted to become a mid-adopter of fully integrated managed care (FIMC). The County submitted the required letter of intent on September 15, 2017, making KCACH eligible for additional incentive funds to aid the transition to FIMC. KCACH intends to work collaboratively with the **FIMC Leadership Group**—a group that includes **King County Behavioral Health Organization leadership, Medicaid managed care organization leadership, Health Care Authority leadership**, and KCACH leadership, as well as the Bi-directional Care Design Team—to determine the best utilization of FIMC incentive funding. The FIMC incentive funding will be used to help provider organizations, for both behavioral health and primary care providers, make a successful transition to FIMC, including the transition to VBP arrangements. Drawing on lessons learned from FIMC early adopter regions, KCACH and the FIMC Leadership Group propose that the first installment of FIMC incentive funding be used in the following ways:

- **Establishing partnerships**—KCACH to lead efforts to connect and foster relationships between behavioral health care providers, primary care providers, and managed care organizations.
- **Technical assistance**—ACH to lead efforts to help behavioral health care providers identify their level of readiness to transition to integrated managed care. Technical assistance will include learning and knowledge-sharing opportunities to move toward VBP.
- **Information technology infrastructure capacity building**—Provide assistance to providers to develop or enhance their capacity to transition to integrated managed care. Funds will be used to build or reinforce operations; select, switch, or modify electronic health records; and enhance billing systems, claims processing, and so forth.
- **Workforce capacity building**—KCACH to lead efforts to build workforce capacity, especially among behavioral health care providers, and to include new types of workforces such as care coordination and peer support.
- **Training**—Provide training on specific topics to include issues and gaps identified in readiness assessments. This may include best practices in integration of behavioral health services, financial models, and integrating billing system into workflows.

KCACH will work with partnering providers and managed care organizations during the planning phase to determine specific providers and associated dollar amounts for these investments. Incentive funds for Demonstration Year 3 (2019 implementation) will be used to assist in further establishing clinical integration and in transitioning providers to outcome-based contracting.

KCACH has not yet defined allocation of VBP incentive funds. The Finance Committee will address this issue in early 2018, in conformity with the funds flow guiding principles.

## **Required Health Systems and Community Capacity (Domain 1) Focus Areas for all ACHs**

*The Medicaid Transformation Project Demonstration requires all ACHs to focus on three areas that address the core health system capacities that will be developed or enhanced to transform the delivery system: financial sustainability through value-based payment (VBP), workforce, and systems for population health management.*

*The focus areas in Domain 1 require system-wide planning and capacity development to support payment and service-delivery transformation activities. ACHs, in collaboration with HCA and statewide partners and organizations will need to work to use existing infrastructure, and develop sustainable solutions. While regional project implementation will require some level of targeted efforts, ACHs should focus on collective approaches to develop and reinforce statewide strategies and capacity. As a foundation for all efforts within Domains 2 and 3, this collective effort will enhance efficiency, lead to coordinated solutions, and promote sustainability. To the maximum extent possible, ACHs should seek to collaborate with state government and statewide entities, and support partnerships between ACHs, providers, and payers on common topics for all Domain 1 strategies in order to promote efficiencies and reduce costs.*

### **Domain 1 Strategies**

- Describe how capacity building in these three Domain 1 focus areas will support all selected projects.
- Describe the investments or infrastructure the ACH has identified as necessary to carry out its projects in Domain 2 and 3.

### **Value-based Payment Strategies**

*ACHs should use the statewide and regional results from the 2017 MCO and Provider VBP Surveys, and other engagement with partnering providers, to respond to the questions within this section.*

Describe the ACH's approach to implementing and supporting VBP strategies in all projects. In the narrative response, address the following:

- Describe how the ACH supported and/or promoted the distribution of the 2017 Provider VBP Survey.
- Describe the current state of VBP among the ACH's providers.
  - Has the ACH obtained additional information beyond what the survey included? If so, were these findings consistent or inconsistent with the survey results?
- How do providers expect their participation in VBP to change in the next 12 months?
- For your partnering providers, what are the current barriers and enablers to VBP adoption that are

- driving change?
- Describe the regional strategies that will support attainment of, and readiness to, achieve statewide VBP targets, including plans for the ACH to partner with MCOs and provider associations.
- What will be the ACH's role in supporting providers in the transition to VBP arrangements? What are the preliminary considerations and strategies regarding alignment of VBP strategies in all projects?

### **Workforce Strategies**

*Workforce strategies provide a foundation for creating sustainable community-based and statewide delivery system transformation. ACHs should consider opportunities to invest their resources to ensure sustainable workforce capacity assessment and development by leveraging collaborative activities with Washington's statewide health workforce resources.*

Describe the ACH's preliminary considerations and approach to adapting workforce strategies across all selected projects. In the narrative response, address the following:

- Describe how the ACH will identify the workforce necessary to support payment and service delivery transformation activities, and assess current workforce capabilities, capacity, and gaps.
- Describe how the ACH is considering and prioritizing the advancement of statewide and regional innovations and approaches in workforce capacity development. How will the ACH use existing workforce initiatives and resources, including strategies to support team-based care, cultural competency, and health literacy (i.e., Workforce Training & Education Coordinating Board's Health Workforce Council, Department of Health's Office of Rural Health, Health Sentinel Network, Practice Transformation Support Hub, etc.)?

### **Population Health Management Systems**

*The term population health management systems refers to health information technology (HIT) and health information exchange (HIE) technologies that are used at the point-of-care, and to support service delivery. Examples of HIT tools include, but are not limited to, electronic health records (EHRs), OneHealthPort (OHP) Clinical Data Repository (CDR), registries, analytics, decision support, and reporting tools that support clinical decision-making and care management.*

*The overarching goal of population health management systems is to expand interoperable HIT and HIE infrastructure and tools so that relevant data (including clinical and claims data) can be captured, analyzed, and shared to support VBP models and care delivery redesign.*

Describe the ACH's preliminary considerations and approach for expanding, using, supporting and maintaining population health management systems across all selected projects. In the narrative response, address the following:

- Describe how the ACH will work with partnering providers to identify population health management systems that are necessary to support payment and service delivery transformation activities, and to assess current population health management systems capabilities, capacity, and gaps.
- Describe how the ACH will work with partnering providers, managed care organizations and other ACH stakeholders to expand, use, support, and maintain population health management systems across all projects.

## ACH Response

### **Domain 1 Strategies:**

#### ***Describe how capacity-building in three Domain 1 focus areas will support all selected projects.***

Capacity building in Domain 1 focus areas is critical to the success, long-term impact, and sustainability of each of KCACH's selected projects. Clear issues have emerged as part of early project-level needs and gaps assessments. For example, KCACH early **workforce** assessments across selected projects indicate a need to better integrate community health workers and peer support specialists into person-centered health teams and as a strategy to further community-based care coordination.

Improving **population health management systems** through interoperable data systems and improvements in data sharing are needed to support collaboration among medical care, behavioral health care, and social service systems for every project.

Finally, support for providers to engage successfully in **value-based payment (VBP)** planning efforts to meet the Healthier Washington goals is needed to ensure a successful transition to new payment methodologies and long-term sustainability. Capacity building will focus on addressing barriers and promoting enablers that were identified in the Managed Care Organization (MCO) and Provider VBP Surveys.

KCACH will continue to work in partnership with providers and MCOs during the planning phase to identify key cross-cutting infrastructure needs and shared activities across project plans that will support the success of the entire portfolio. KCACH has identified Domain 1 investments as a key use category for distribution of project incentive funding, and significant upfront investments in population health management systems and workforce will be made during Demonstration Years 1 and 2 to support implementation.

#### ***Describe the investments or infrastructure the ACH has identified as necessary to carry out its projects in Domain 2 and 3.***

KCACH will provide the administrative and project infrastructure to support Domain 1 improvements that will benefit Domains 2 and 3, such as facilitation and support for multistakeholder committees that will guide and/or provide critical input into the Domain 1 strategies. These committees include the Performance Measurement and Data Committee, the Clinical Committee, the Workforce Workgroup, the Community/Consumer Voice Committee (CCV), and KCACH representation in the state's Medicaid Value-based Purchasing Action Team. In addition, a percentage of KCACH earnings are being set aside for Domain 1 (see the Funds Flow Distribution section).

Domain 1 infrastructure investments that have been identified to date include information technology investments that support mechanisms for shared care planning and sharing of information across clinical and community-based providers to support care coordination; training and technical assistance in multiple evidence-based interventions described throughout the KCACH project portfolio to support the workforce; investment in new types of workforce positions including care coordinators, community health workers, and peer support specialists; and technical assistance and capacity

building to support providers to transition to value-based payment (VBP). Specific investments and infrastructure needs will be further detailed during the planning phase through support of the KCACH committees described above.

***Value-Based Payment Strategies:***

***Describe the ACH's approach to implementing and supporting VBP strategies in all projects.***

KCACH will support providers and partners at the regional level through education, technical assistance, and by convenings around VBP topics. Further details are provided below.

***Describe how the ACH supported and/or promoted the distribution of the 2017 Provider VBP Survey.***

KCACH distributed the 2017 Provider VBP Survey multiple times during the survey period via direct email to King County Medicaid providers, including behavioral health care providers. KCACH also promoted the VBP survey at Governing Board, Demonstration Project Committee, and Design Team meetings. Health system representatives on the Governing Board and Demonstration Project Committee also promoted the VBP survey through announcements and reminders at their provider organization meetings.

***Describe the current state of VBP among the ACH's providers.***

Data on the current state of VBP arrangements in the King County ACH region comes from the 2017 Provider VBP Survey. Twenty-two King County providers responded, and of those, 10 (45%) reported that they receive Medicaid revenue through Health Care Payment Learning & Action Network (HCP-LAN) categories 2C–4B. Included among the providers who responded are the major health systems (e.g., MultiCare Health System and CHI Franciscan Health) and community health centers (e.g., International Community Health Services, Neighborcare Health, and HealthPoint) that serve the south Seattle and the south King County regions where there are higher proportions of Medicaid clients.

While King County Behavioral Health Organization (BHO) network providers were not included in the 2017 Provider VBP Survey, all BHO contracted providers receive Medicaid revenue through some of the HCP-LAN 2C–4B categories. The King County BHO is currently working with Health Management Associates to develop capacities within the BHO network to move further along the continuum of HCP-LAN categories and participate in VBP contracting.

***Has the ACH obtained additional information beyond what the survey included? If so, were these findings consistent or inconsistent with the survey results?***

KCACH also conducted its own provider survey to document interest in and preparedness for potential Medicaid Transformation projects. It did not directly ask about Value-Based Payment arrangements, so the question of consistency is not applicable. However, it did demonstrate provider interest in participating in MTP projects that are critical to achieving the quality metrics associated with VBP arrangements. The need to improve data sharing and to have interoperable data systems were identified as cross-cutting for all the projects. The KCACH provider survey asked respondents about which projects providers had interest in participating, including EHR characteristics, Bi-

directional Integration, Care Coordination, and workforce challenges. Survey questions can be found [here](#).

Additionally, the King County BHO is contracted with Health Management Associates, a consulting firm, to support the transition of behavioral health organizations to VBP arrangements. Attached is a draft Road Map to value-based payment that the King County BHO will be using in partnership with MCOs and the behavioral health network providers. KCACH will be partnering with the King County BHO and MCOs to align this work with Healthier Washington VBP goals and targets and support providers, where needed, to make these transitions.

***How do providers expect their participation in VBP to change in the next 12 months?***

In the 2017 Provider VBP Survey, 8 respondents (36%) reported that they expected the revenue received through HCP-LAN categories 2C–4B would increase by 10% over the next 12 months, and 12 respondents (55%) reported that they expected this type of revenue would increase by more than 10%. If these small numbers are representative of the region as a whole, the KCACH region is on track to reach Healthier Washington’s VBP goals, but it will require that the state and region address identified barriers.

***For your partnering providers, what are the current barriers and enablers to VBP adoption that are driving change?***

Barriers to adoption of VBP arrangements, based on the MCO and Provider VBP Surveys and discussions with partnering providers, include:

- Lack of interoperable data systems.
- Concern about taking on greater risk, particularly for small providers.
- Lack of provider readiness to move to VBP arrangements.

Enablers of VBP include:

- Technical assistance for providers.
- Partnerships and collaboration with payers.
- Education to increase understanding of payment models.
- Interoperable data systems.

***Describe the regional strategies that will support attainment of, and readiness to, achieve statewide VBP targets, including plans for the ACH to partner with MCOs and provider associations.***

The regional strategies that the KCACH will undertake include improving and supporting community-based care coordination, particularly as providers move into VBP arrangements in categories 3 and 4, where links to social determinants of health are essential; and addressing data access and data sharing through health information technology (HIT) and health information exchange (HIE) strategies (see the section below on Population Health Management Systems). KCACH will work with providers and MCOs during the projects’ planning and implementation phases to ensure that project designs are consistent with potential future VBP arrangements and that data and outcome measures are

gathered in a way that can demonstrate the value and return on investment related to project activities.

In addition, the KCACH representatives to the state's Value-based Purchasing Task Force have been added to the Finance Committee to link conversations about project design, VBP and overall sustainability at all levels of planning.

KCACH is committed to educating providers about alternative payment approaches and supporting them in making a successful transition to value-based payment arrangements with local MCOs. To ensure Washington state meets its VBP target goals, KCACH has engaged in the following strategies to date:

- Wide-spread distribution of the statewide VBP targets and the 2017 Provider VBP Survey to King County Medicaid providers, including health and behavioral health organizations;
- Wide-spread distribution of the HCA VBP survey to Governing Board, Demonstration Project Committee, and Design Team members, as well as other Medicaid providers who may not be actively participating on a KCACH committee. Additionally, health system representatives on the Governing Board and Demonstration Project Committee have promoted the VBP survey through announcements and reminders at their provider organization meetings.

In 2018, the education, technical assistance and information sharing efforts around VBP will ramp up to support and advance the statewide VBP targets. Some of the strategies KCACH will engage in in 2018 include:

- Convene monthly provider summits to enhance provider and payer partnerships and collaborations. The first provider summit is scheduled for January 9, 2018. Provider summits will be a mechanism to provide information to providers about VBP, make providers aware of VBP resources, provide targeted trainings to providers on topics related to VBP, and facilitate provider/payer conversations about transitioning to VBP. Provider summits will also provide an opportunity for KCACH, providers, and payers to discuss barriers/challenges to moving to VBP arrangements and develop solutions to mitigate those challenges.
- Improve community based care coordination through the KCACH project portfolio, particularly as providers move into VBP arrangements in categories 3 and 4, where links to social determinants of health are essential. KCACH will invest in stronger, bi-directional partnerships between the healthcare delivery system and community based organizations by supporting a "rationalization" of the various care coordination efforts currently in place, expanding care coordination efforts into the community, and ensuring an individuals full health and social needs can be addressed.
- Address interoperability of data systems, which is an enabler of VBP, by leveraging learnings on data access and data sharing through health information technology (HIT) and health information exchange (HIE) strategies. KCACH will invest resources in population health management infrastructure so that it can support providers with the necessary tools to make informed decisions, and a clear understanding of the requirements to be successful.
- Work with providers and MCOs during the projects' planning and implementation phases to ensure that project designs are consistent with potential future VBP arrangements and that

data and outcome measures are gathered in a way that can demonstrate the value and return on investment related to project activities.

- Partner with King County, the King County BHO, and providers to support the transition to fully integrated managed care. King County government has submitted a binding letter of intent to become a mid-adopter for fully integration managed care, which will further provide financial incentives to transition to a new payment model for integrated physical and behavioral services. KCACH Executive Director is a member of the King County FIMC Leadership Group and will help to support providers through this transition.
- Partner with the King County BHO on implementation of its VBP Road Map for behavioral health organizations. King County has been working with the Medicaid behavioral health network and local MCOs, under contract with Health Management Associates, to develop an achievable pathway to VBP arrangements for behavioral health organizations. KCACH will partner with these and other stakeholders to ensure alignment of strategies and outcomes and to provide additional support, as needed, to achieve the targeted goals.
- Provide a strong linkage between KCACH and the state's MVP Action Team. KCACH representatives to the state's Value-based Purchasing Task Force have been added to the KCACH Finance Committee to link conversations about project design, VBP and overall sustainability at all levels of planning.
- Establish an Incentive Funding Workgroup to specifically look at VBP payment models and contracting options for consideration by the Governing Board. The Incentive Funding Workgroup will be tasked with understanding different payment models and helping to educate providers. This workgroup will have financial representatives from health care providers throughout the region, including MCOs, to ensure provider engagement and acceptance.

***What will be the ACH's role in supporting providers in the transition to VBP arrangements?***

KCACH will provide technical assistance and education and will convene providers to discuss VBP as part of the KCACH provider engagement strategy (see the Governance section, Clinical domain, for details). The aim is to ensure that providers are aware of the state's VBP targets and different VBP models, and to provide access to resources and information on VBP for providers and community-based partners (i.e., non-Medicaid providers). In addition, KCACH may make short-term investments to support providers' transition to VBP business models through revenue loss and other arrangements.

***What are the preliminary considerations and strategies regarding alignment of VBP strategies in all projects?***

Preliminary considerations and strategies include alignment of KCACH projects with MCO activities and other regional initiatives to achieve Healthier Washington outcomes; working with other ACHs to determine where there can be alignment of regional strategies, particularly since many provider systems span multiple ACH regions; and exploring how ACHs can partner together to provide education or technical assistance support for providers.

***Workforce Strategies:***

***Describe the ACH's preliminary considerations and approach to adapting workforce strategies across all selected projects.***

Preliminary considerations include the increasing diversity of King County's population; statewide provider workforce shortages (notably in behavioral health and nursing); provider training to work in integrated, transformed systems; the need for new types of staff; and the potential need to redeploy existing staff.

KCACH's approach will be to work with state and regional partners to advance statewide and regional innovations in workforce, with the regional aims of providing client-centered, whole-person, integrated care; promoting equity; and ensuring community-rooted, culturally responsive, and linguistically appropriate care. More specifically, this approach entails the following:

- Addressing provider shortages by supporting statewide and regional innovations and approaches through KCACH's roles as educator, convener, and facilitator.
- Addressing training needs by working with providers and project teams to further assess and identify strategies and leverage resources to meet cross-cutting and project-specific training needs during the project planning phase.
- Working with the Community/Consumer Voice Committee and Workforce Workgroup to develop and implement strategies to improve cultural competency, access to linguistically appropriate services, and health literacy.
- Developing a targeted subgroup focused on advancing community health workers and peer support specialists as foundational to community-based care coordination and as part of health teams—a cross-cutting need identified for all selected projects.

This work will be guided by a KCACH Workforce Workgroup made up of regional experts in workforce planning, person-centered team-based care, population health, cultural competency, and health literacy.

***Describe how the ACH will identify the workforce necessary to support payment and service delivery transformation activities, and assess current workforce capabilities, capacity, and gaps.***

As an initial step, KCACH convened a Workforce Workgroup to provide input on workforce needs and strategies, and conducted a provider survey among a wide range of medical, behavioral health, and social service providers. The results indicated the following:

- Recruitment is the most significant workforce challenge (51 of 59 organizations).
- Retention (42 of 59 organizations) and training (34 of 59 organizations) were also identified as significant issues.
- Behavioral health staff are the most challenging to recruit.
- Top training needs are related to behavioral health and care coordination/integrated care.

During the planning phase, project Design Teams will complete an assessment of workforce needs that will include workforce questions identified in the project toolkit. This assessment will identify training needs for the existing health care workforce as well as identify new types of workforce (e.g., care coordinators or community health workers) that are needed to help the project achieve success.

Particular workforce issues to be assessed include needs and gaps pertaining to community-based care coordination, cultural competency, health literacy, and health equity.

KCACH will also convene local partners to discuss assessment findings and to gather input on workforce strategies. KCACH will incorporate these issues and needs into KCACH project implementation plans.

***Describe how the ACH is considering and prioritizing the advancement of statewide and regional innovations and approaches in workforce capacity development.***

To support statewide and regional innovations and approaches to addressing provider shortages and other systemic workforce challenges, KCACH representatives will participate throughout the MTP in statewide sharing opportunities or learning collaboratives as they are organized.

KCACH will seek to leverage the many existing resources in King County and the state to address the regional workforce needs. KCACH will prioritize those workforce innovations and activities that support integrated, whole-person care, team-based care, community-based care coordination, cultural competency, health literacy, and the adoption of evidence-based strategies that align with KCACH's selected projects.

An example of how KCACH will collaborate to address cross-cutting workforce development needs is that of community health workers and peer support specialists. During KCACH project portfolio design work, providers and stakeholders across all projects identified the need for support and training around the use of community health workers and peer support specialists in health system transformation. For this particular focus, KCACH will leverage and build upon the Statewide Community Health Worker Task Force, the Washington Department of Health's community health worker training system, Indian Health Service's community health representatives, and King County community health worker initiatives. KCACH will partner with providers

KCACH will also use tools, such as the Healthier Washington "Framework Workforce Planning: Considerations for ACH Leaders (6/28/2017)" and Healthier Washington "Workforce Development Considerations (6-28\_2017)" to guide local workforce development approaches. As project implementation plans are completed, KCACH will work with partnering providers to determine specific workforce needs and develop strategies and activities, including milestones and timelines for completion. Providers, in partnership with the KCACH Workforce Workgroup, will then consider available resources and prioritize select innovations that are likely to be successfully implemented in the region. KCACH will collaborate with other ACHs and the state to prioritize cross-ACH strategies and leverage collective resources whenever possible.

KCACH also intends to build upon and leverage existing workforce initiatives and resources as described below.

***How will the ACH use existing workforce initiatives and resources, including strategies to support team-based care, cultural competency, and health literacy?***

KCACH will seek to leverage the many existing resources in King County and the state for both assessment and implementation of workforce strategies.

To support integrated whole person care, team-based care, and community-based care coordination, KCACH will use the following resources to provide educational and other resources to educate, train, and re-train providers for evolving care models:

- Partnership for Innovation in Mental Health: A collaboration between King County Behavioral Health and Recovery Services Division, two University of Washington departments (Psychiatry and Social Work), and philanthropy. This collaborative will be leveraged to expand training and competency building in whole person, team-based care in community behavioral health settings. The partnership is developing a proof of concept model that, if successful, the KCACH could adopt and use to expand access to team-based care in all community behavioral health centers in the region. Additionally, because this partnership draws on current UW curriculum and training programs, it will improve knowledge and training for future students who are likely to enter the workforce in future years.
- Practice Transformation Support hub: KCACH will leverage the Practice Transformation Support hub to assist with the current state assessment of level of integration in primary care and behavioral health settings in the region. Qualis is already working with a number of primary care and behavioral health providers in the King County region to provide practice coaching for integrated care delivery and KCACH will partner with Qualis to expand enrollment in the region as capacity allows.
- Arcora Foundation: KCACH has developed a partnership with the Arcora Foundation and will leverage the significant amount of work Arcora Foundation has already completed to conceptualize ways to increase access to oral health throughout the project portfolio and especially as it relates to whole person care. KCACH will include representatives from Arcora Foundation and other oral health providers in project planning and implementation design to ensure that oral health needs are addressed as part of whole person care. In addition, KCACH is currently in conversation with the Arcora Foundation regarding ways the KCACH can help support their statewide educational campaign around oral health needs of children.
- University of Washington Northwest Center for Public Health: As KCACH develops its prioritized list of training and TA needs, KCACH will draw on the breadth of workforce trainings available through the UW Northwest Center for Public Health, including potential support to providers for data and quality improvement initiatives, understanding population health management, developing strategies to address the intersections between health and social determinants, etc.

To incorporate strategies and approaches to cultural competency and health literacy trainings, we will use the following resources:

- Public Health – Seattle & King County: PHSKC has developed a curriculum for community health workers that includes specific issues related to cultural competency and health literacy. KCACH will further examine this curriculum, in partnership with providers and stakeholders to determine if it is appropriate to the regional workforce goals. If so, KCACH will partner with PHSKC to identify ways to bring the curriculum into workforce training for CHWs and other paraprofessional staff as appropriate.
- King County's Office of Equity and Social Justice: KCACH will partner with the KC Office of Equity and Social Justice to identify system wide trainings that could be offered to providers

and community based organizations to support cultural competency in the current workforce. KCACH will also explore mechanisms for increasing diversity within the health system workforce.

- U.S. Department of Health & Human Services “Think Cultural Health” education and resources (<https://www.thinkculturalhealth.hhs.gov/clas/standards>): KCACH is committed to ensuring and enhancing the cultural relevancy of services provided in the diverse King County region. KCACH will draw upon the Federal CLAS standards as it moves through the planning and implementation phase of the project portfolio to ensure practice transformation is informed by and aligns with these standards.
- Engagement of the KCACH CCV and the use of the KCACH equity tool: KCACH is contracted with the Healthy King County Coalition to convene the Community and Consumer Voice group. This group has developed an Equity Tool for use in project portfolio development. Each project design team completed the first part of the Equity Tool during the design phase. The CCV will provide in depth training on the Equity Tool to the KCACH Governing Board and all planning committees during the first quarter of 2018. The Equity Tool will be used in all planning and implementation stages of the KCACH project portfolio.

To address recruitment, retention and other related workforce pipeline and career ladder issues, we will use the following resources:

- King County Mental Illness and Drug Dependency 0.1% sales tax workforce strategies: King County Behavioral Health and Recovery Division has local resources that have been dedicated to workforce development for the past 8 years and has included things such as supporting current behavioral health workforce staff to obtain a Chemical Dependency Professional certificate (there is a significant shortage of CDPs in the KC region) as well as provide training to behavioral health providers in select evidence-based approaches. KCACH will partner with KC BHRD to align workforce development strategies and leverage local resources to expand access and capacity within the region.
- Educational entities: King County has a number of educational institutions in the region and KCACH will collaborate with the state, other ACHs and local universities and colleges to consider statewide approaches to workforce capacity issues. For example, KCACH has met with UW Bothell who has developed a proposal for enhanced training curricula for paraprofessionals in the healthcare system as well as current and future bachelor level students in nursing and health sciences to enhance their overall knowledge with behavioral health issues. This type of curriculum development supports a workforce that will be better prepared to deliver integrated whole person care. Additionally, the UW Bothell is also working on strategies to develop a pipeline of students to increase interest in health-related fields. This type of statewide partnership and focus on higher education is an example of how ACHs can collaborate to address workforce capacity issues.

The use of these resources will be reflected in project implementation plans.

***Population Health Management Systems:***

***Describe the ACH’s preliminary considerations and approach for expanding, using, supporting and maintaining population health management systems across all selected projects.***

Preliminary considerations include, at a high level, data needs and strategies at the point-of-care or service level versus at the population health management level; need for a robust health information technology (HIT) and electronic health record (EHR) strategy that supports shared care plans across providers; the burden on and willingness of providers to adopt data practices and systems; the rapidly evolving data, HIT, and health information exchange (HIE) landscape; cost; common data strategies and solutions across ACH regions; and the value and sustainability of data investments.

This will be KCACH's approach:

- Develop a data strategic plan that supports planning, implementation, and monitoring of all selected projects and is informed by consumer, partnering provider, and managed care organization priorities.
- Facilitate partnerships with KCACH stakeholder and partner organizations to support data sharing, linkage, and dissemination.
- Partner with the Health Care Authority Analytics, Interoperability, and Measurement (HCA AIM) team and other ACHs to support development of multi-ACH and statewide data systems and infrastructure.

This work will be guided by the Performance Measurement and Data Committee (PMD), which has multisector representation and guides KCACH's population health management strategy. During the planning phase, the PMD will be reseeded to better represent five distinct stakeholder groups—consumers, health care providers, behavioral health care providers, social service providers, and population health–focused organizations (e.g., government, payers). The PMD meets monthly and is supported by King County government data staff through a services contract with KCACH.

***Describe how the ACH will work with partnering providers to identify population health management systems that are necessary to support payment and service delivery transformation activities, and to assess current population health management systems capabilities, capacity, and gaps.***

The PMD and KCACH contracted staff have been working over the past year to identify the data functions and services that are needed for all projects to be successful. The PMD has developed data frameworks, identified data strategies, and developed an initial set of selection criteria for KCACH data investments. This assessment includes a description of information and service fragmentation from a provider perspective. In addition, the KCACH Provider Survey has identified preliminary gaps and opportunities around provider HIT and HIE capacity, including EHR implementation, care coordination software, and cross-organizational data transfer.

Going forward, by the end of the planning phase, KCACH will complete an assessment of population health management needs. Data staff will work directly with project teams to understand their priorities, document the specific use cases at the point-of-care and service level; and assess current processes and information technology systems in use. Data staff have and will continue to reach out to various stakeholder groups (e.g., health care providers, behavioral health care providers, and social service agencies) for input on existing and needed data systems.

*Describe how the ACH will work with partnering providers, managed care organizations and other ACH stakeholders to expand, use, support, and maintain population health management systems across all projects.*

The PMD will develop a draft data strategic plan and will convene local partners to discuss assessment findings and review data strategies and recommendations to be implemented. The aim will be to finalize the data strategic plan by the end of the planning phase as the projects move into implementation.

In addition, KCACH will participate in the Health Care Authority–backed monthly workgroup to be convened under the HIT/HIE Operational Plan and will seek opportunities to partner with other ACHs and the state on common data strategies and data investments. As needed, KCACH will seek additional technical assistance for KCACH projects and partners.

A portion of the KCACH budget will be dedicated toward data investments that can be used to address HIT and HIE project needs and, importantly, have long-term value (i.e., beyond the MTP).

See Appendices 10 – 16 for additional information on Domain 1.

### **King County Accountable Community of Health Glossary**

ACH	Accountable Community of Health
AI/AN	American Indian/Alaska Native
AIM	Analytics, Interoperability, and Measurement, part of HCA
AIMS	Advancing Integrated Mental Health Solutions, part of University of Washington
AMDG	Agency Medical Directors' Group
BHO	Behavioral Health Organization
BMI	body mass index
BRFSS	Behavioral Risk Factor Surveillance System
CMS	Centers for Medicare & Medicaid Services
CBO	community-based organizations
CCM	chronic care model
CCV	Community/Consumer Voice Committee
CDP	Chronic Disease Prevention and Control Project
CDR	Clinical Data Repository
CEO	chief executive officer
CHARS	Comprehensive Hospital Abstract Reporting System
CHW	Community health worker(s)
CLS	Community Learning Sessions
CMCH	Center for MultiCultural Health
CMS	Centers for Medicare & Medicaid Services
DCHS	Department of Community and Human Services
DPC	Demonstration Project Committee
DPP	Diabetes Prevention Program
DSHS	Department of Social and Health Services

DSRIP	Delivery System Reform Incentive Payment
DT	Design Team
DY1	DSRIP Year 1
ED	emergency department
EHR	electronic health record
FIMC	fully integrated managed care
FFS	fee-for-service
FPL	federal poverty level
FQHC	Federally Qualified Health Centers
G2P	Guidelines to Practice
HCA	Health Care Authority
HCP LAN	Health Care Payment Learning & Action Network
HHSTP	Health and Human Services Transformation Plan
HIE	health information exchange
HIT	health information technology
HKCC	Healthy King County Coalition
HUD	U.S. Department of Housing and Urban Development
IDC	Integration Design Committee
IHCP	Indian Health Care Provider
ILC	Interim Leadership Council
IOM	Institute of Medicine
IT	information technology
ITU	Indian Health Service, tribally operated, or urban Indian health program
JAMA	Journal of the American Medical Association
KCACH	King County Accountable Community of Health
LEAD	Law Enforcement Assisted Diversion
LGBT	Lesbian, Gay, Bisexual, and/or Transgender
LOI	letter of intent
MAT	Medication Assisted Treatment
MCO	managed care organization
MeHAF	Maine Health Access Foundation
MHIP	Mental Health Integration Program
MIDD	Mental Illness and Drug Dependency
MOU	memorandum of understanding
MTP	Medicaid Transformation Project(s)
MVP	Medicaid value-based purchasing
ODD	opioid use disorder
P4P	Pay-for-performance
P4R	Pay-for-reporting
PAL	Partnership Access Line
PCORI	Patient-Centered Outcomes Research Institute
PCP	primary care provider
PHSKC	Public Health – Seattle & King County
PIMH	Partnership for Innovation in Mental Health
PMD	Performance Measurement and Data
PMP	Prescription Monitoring Program

PRISM	Predictive Risk Intelligence System
PSH	Permanent Supportive Housing
QBS	Quality Benchmarking System
RHIP	Regional Health Improvement Plan
RHNI	Regional Health Needs Inventory
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCORE	South Correctional Entity
SIHB	Seattle Indian Health Board
SIM	State Innovation Model(s)
SUD	substance use disorder
TA	technical assistance
TSP	Transition Support Program
UIHI	Urban Indian Health Institute
US	United States
VBP	value-based payment
VOCAL-WA	Voices of Community Activists and Leaders, Washington state chapter
WSHA	Washington State Hospital Association
WSMA	Washington State Medical Association

## SECTION II: PROJECT-LEVEL

**Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).**

### Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
<b>Domain 2: Care Delivery Redesign</b>	
<input checked="" type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
<b>Domain 3: Prevention and Health Promotion</b>	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

### Project Selection & Expected Outcomes

*The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.*

Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following:

- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.
- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.
- Describe the anticipated scope of the project:
  - Describe the project’s anticipated target population. How many individuals does the ACH anticipate reaching through the project?
  - What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
  - How did the ACH consider the level of impact when selecting the project’s anticipated target population? (e.g., geography, subgroups, etc.)
  - How will the ACH ensure that health equity (e.g., demographic, geographic) is addressed in the project design?
- To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH region’s Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region’s overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies

## ACH Response

*Describe the rationale for project selection, and the expected outcomes:*

*Provide justification for selecting this project and how it addresses regional priorities.*

As part of King County's broader care delivery redesign efforts, King County Accountable Community of Health (KCACH) is moving forward with expanding bi-directional integration of physical and behavioral health care, including the integration of oral health and pregnancy intention screening, to offer more comprehensive, whole-person care. This project reflects KCACH's vision of "having a system that provides whole-person, patient-centered care" with a primary strategy of "building a bridge between medical, behavioral health, and community providers," and is a required Medicaid Transformation Project (MTP).

KCACH seeks to achieve four key goals:

- Improve access to behavioral health through enhanced screening, identification, and treatment of behavioral health disorders in primary care settings.
- Improve access to physical health services for individuals with chronic behavioral health conditions through increased screening, identification, and treatment of physical health disorders in behavioral health care settings.
- Improve active coordination of care among medical and behavioral health providers as well as addressing barriers to care.
- Align new bi-directional integration with successful existing community efforts, including addressing the social determinants of health.

KCACH will achieve project goals by using a flexible approach to support providers in implementing any of the evidence-based models identified in HCA's toolkit, to be determined by provider preference and readiness.

Approximately 26% of American adults ages 18 years and older suffer from a diagnosable mental disorder in a given year,<sup>1</sup> and as many as 70% of primary care visits stem from psychosocial issues.<sup>2</sup> For children, approximately 20% of primary care appointments are due to behavioral health complaints.<sup>3</sup> Nationally, mental disorders are identified as the most costly conditions in health care.<sup>4</sup> Individuals living with serious mental illness are at increased risk of having chronic physical health conditions that are underdiagnosed and inadequately treated due to barriers in accessing care.<sup>5</sup> Health care costs for individuals with comorbid chronic medical conditions and chronic behavioral health conditions are 60% to 75% higher than for those who have a chronic medical condition alone; for individuals with chronic substance use disorders and chronic medical conditions, these costs are nearly three times higher. US adults living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions, with cardiovascular risk accounting for 60% of premature deaths in this population.<sup>6</sup>

State-level data indicate that behavioral health disorders are the leading cause of hospitalizations in the King County region, accounting for 18% of hospitalizations, roughly twice as much the next most frequent cause. Regional data also show that there is significant unmet need in treating identified mental health and substance use disorders. For example, in 2015, only 30.1% of Medicaid beneficiaries with an

identified substance use disorder accessed treatment, and less than half (45.7%) of those with a mental health diagnosis received treatment.

The solution to these disparities lies in integrated care. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs. Delivering integrated, whole-person care has been a regional priority for King County since 2013, when the King County Health and Human Services Transformation Plan (HHSTP) was developed in partnership with community stakeholders. The HHSTP called for improving the systems for individuals with complex health and social needs, including integrating physical and behavioral health care and addressing social determinants of health. In 2015, the KCACH Interim Leadership Council (ILC), the precursor to the KCACH Governing Board, convened an Integration Design Committee (IDC) as a formal subcommittee under KCACH to begin design work for practice transformation. Even prior to the MTP, King County recognized that reconnecting the mind and body and providing integrated, client-centered, and culturally and linguistically appropriate care would produce better health outcomes, provide for a better experience, and reduce costly services such as crisis, emergency department, and hospital utilization. KCACH will build on and expand current regional efforts to integrate care, take bi-directional integration to scale, and add a focus on oral health as well as pregnancy intention screening.

Additionally, King County has opted to become a mid-adopter of fully integrated managed care (FIMC) beginning in January 2019. The transition to FIMC will complement this project by offering opportunity for payment models that support integrated care delivery.

***How will this project support sustainable health system transformation for the target population?***

This project will support sustainable health system transformation for the Medicaid population in the following ways:

1. Strengthening providers' ability and capacity to provide client-centered, whole-person care, including stronger alignment with social determinant needs, will improve outcomes for the target population and strengthen the foundation for transforming the delivery system. Investments in training, technology, and workforce capacity will lead to long-term practice transformation.
2. Building on existing efforts, rather than forcing providers to adopt one particular model, will result in higher levels of engagement in and success of this initiative.
3. Addressing the significant unmet need in treating identified mental health and substance use disorders in the region through increased screening and access to care will make a significant contribution to improving care and health for the target population.
4. The transition to FIMC will provide the finance infrastructure to allow for sustained payment models that support integrated care delivery. KCACH will work with managed care organization (MCO) partners to align value-based payment (VBP) with the models and outcomes associated with bi-directional care.

***Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.***

The MTP provides an opportunity to do more than simply provide integrated clinical care. Notable intersections related to the Bi-directional Care Project include the Transitional Care Project, the Chronic Disease Prevention and Control Project, and the Opioid Project. Additionally, care coordination has been identified as a cross-cutting activity that intersects with all projects in the portfolio. Leveraging the work of the full array of projects provides opportunities to engage subpopulations more effectively.

This project builds upon previous work to move toward clinically integrated care in the region. The efforts described below, while moving toward integrated care delivery, have been limited in scope due to many factors, with lack of financial support to scale them across target populations being the predominant factor. Key intersecting initiatives are listed below in Table 14.

**Table 14: Key Intersecting Initiatives**

Existing initiative	Relationship to bi-directional care project
<p><b>Mental Health Integration Program (MHIP):</b> MHIP integrates mental health screening and treatment using the Collaborative Care model in safety-net primary care settings for certain Medicaid, uninsured, and other at-risk populations in King County.</p>	<p>MHIP is a core building block for bi-directional integration. The 2A project will expand MHIP to additional populations not currently covered (current funding limits the population served), to primary care clinics not currently implementing MHIP, and to behavioral health care centers to focus on bi-directional integration.</p>
<p><b>Substance Abuse and Mental Health Services Administration (SAMHSA) Primary and Behavioral Health Care Integration Program:</b> Three pilots in King County focused on improving the physical health status of people with mental illnesses and addictions in community behavioral health settings.</p>	<p>These grant-funded projects served as learning laboratories for bi-directional care within community behavioral health settings. Lessons learned from these grants were the foundation of the Partnership for Innovation in Mental Health and will be used in the planning and implementation of this project.</p>
<p><b>Health Homes:</b> King County recently implemented Health Homes for Medicaid beneficiaries in the region who have a PRISM (predictive risk intelligence system) score of 1.5 or more and have a chronic condition. Key partners include the King County Behavioral Health Organization (BHO), the five Medicaid managed care organizations, the Area Agency on Aging, and several care-coordinating agencies.</p>	<p>When individuals, via bi-directional care screening, meet criteria for Health Homes, they will be referred. In addition, the bi-directional care models developed within the MTP will inform the nature of care within Health Homes.</p>
<p><b>Partnership for Innovation in Mental Health (PIMH):</b> PIMH is a public university–philanthropic partnership focused on developing a model of integrated bi-directional care for individuals with serious mental illness and cardiometabolic disease, with a particular emphasis on diabetes. PIMH is beginning work with two community behavioral health centers in King County.</p>	<p>This effort is explicitly designed—from the perspective of the community behavioral health system—to be a forerunner for the bi-directional care project by developing clinical protocols and addressing barriers to care for the target population. Expansion of this project will also intersect with Project 3D: Chronic Disease Prevention and Control and offer</p>

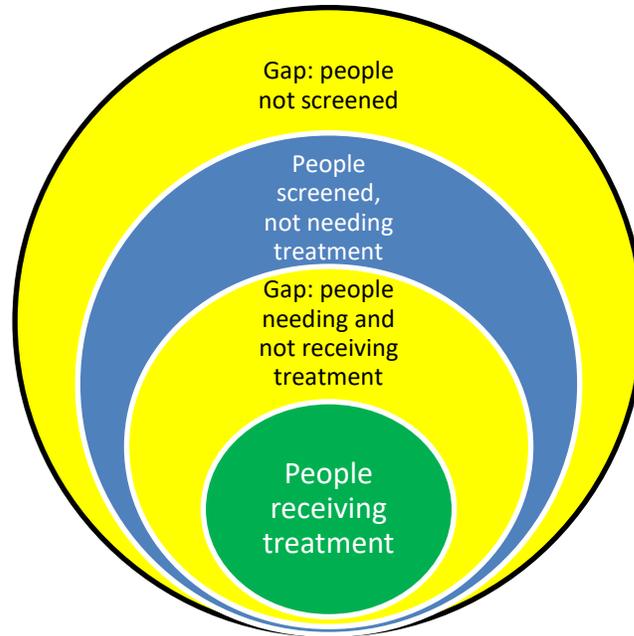
	referral protocols and access to chronic disease management tools to support overall health and well-being.
<b>Best Starts for Kids (BSK):</b> Best Starts for Kids focuses on providing upstream interventions to prevent later negative health, behavioral health, school, and criminal justice outcomes. Programs include direct services and system building to ensure healthy development, developmental screenings for all very young children, early intervention services, system building for infant/early childhood mental health, and early identification and access to treatment for school-age youth through screening and early intervention for mental health and substance abuse in schools, including Screening, Brief Intervention, and Referral to Treatment (SBIRT) in all middle schools.	The screening conducted within Best Starts for Kids–funded sites will help identify health and behavioral health needs and will include referral protocols to bi-directional care.
<b>Screening, Brief Intervention, and Referral to Treatment (SBIRT):</b> The goal of SBIRT is to rapidly identify and refer individuals with—or at risk for—substance use disorders to treatment. Locating SBIRT in primary care centers, hospital emergency rooms, trauma centers, and other community settings provides opportunities for early intervention with at-risk individuals before more severe consequences occur.	Currently in King County, SeaMar, CHI Franciscan Health, two public health clinics, Sound Mental Health, and three Swedish Medical Center clinics are implementing SBIRT. KCACH will coordinate with these and other regional efforts to expand SBIRT to as many sites as possible. KCACH will also explore the usefulness of the same SBIRT algorithm to the integration of oral health into primary care.
<b>Qualis Health’s Healthier Washington Practice Transformation Support Hub:</b> The Practice Transformation Support Hub provides technical assistance regarding integrating bi-directional care into multiple behavioral and primary health care providers in King County. Qualis Health can also provide support for oral health integration into primary care.	KCACH will leverage the support of the Practice Transformation Support Hub to engage primary care and behavioral health providers in making practice transformation, and will continue to expand the number of providers engaging with Qualis Health to make practice transformation.
<b>Partnership Access Line (PAL):</b> PAL is a telephone-based child and adolescent mental health consultation system for primary care providers, staffed by child psychiatrists and a master’s-level social worker who can assist with finding mental health resources regardless of insurance coverage.	PAL is a key resource that helps primary care providers diagnose and effectively treat children and adolescents with common behavioral health conditions in primary care, with a focus on access to bi-directional integrated care. KCACH will support primary care providers to utilize PAL as a mechanism to expand effective integrated care in pediatric settings.

*Describe the anticipated scope of the project:*

**Anticipated target population and number of individuals the ACH anticipates reaching through the project.**

Bi-directional care addresses key care gaps within both primary care and behavioral health settings through screening of the target population to identify targeted conditions, and then ensuring that those with identified conditions are connected to evidence-based treatment and care coordination. Figure 1 shows key components of bi-directional care.

**Figure 1: Population Gaps for Bi-directional Care**



KCACH proposes to first implement bi-directional care for a focused target population to refine implementation strategies, and then scale to remaining populations. Ultimately, the bi-directional care work should reach nearly all the 435,074 Medicaid beneficiaries in King County during the scale-and-sustain phase. However, initial screening efforts will focus on the top 50 providers by Medicaid claims volume—excluding labs/imaging, device companies, ambulance services, pharmacies, and non-behavioral-health specialty practices (e.g., dermatology, ophthalmology). These top 50 providers have been identified, and compose 68% of all Medicaid professional claims (including the excluded entities) in King County. Notably, within this group are 15 community behavioral health agencies, which see 98% of the outpatient encounters within the public behavioral health system in King County. In addition, KCACH will include a specific focus on pediatric settings, working in partnership with the Pediatric Transforming Clinical Practice Initiative (TCPi) to expand integrated care for children and youth. A landscape analysis of providers will be conducted this fall via a letter of intent process and will be used to assess partnering providers' current level of integration via the SAMHSA Practice Assessment Tool or the Maine Health Access Foundation Assessment. The timeline for implementation with various providers will be guided by the extent of integration of the various partnering providers.

The initial target populations for implementing bi-directional care will include individuals within primary care settings who have either a depression diagnosis (with confirmed diagnosis and symptoms tracked using the PHQ-9, or PHQ-A for adolescents) or opioid use disorders (OUDs). HCA's RHNI starter kit shows that there are approximately 39,000 Medicaid individuals who have been diagnosed and/or treated for depression (10% overall; 15% in adults, 3% in youth). Studies suggest that only about 50% of those with depression are identified within primary care, so the actual number of individuals with depression who could be identified through adequate bi-directional care within primary care settings could be much higher than the figures reported.

Within behavioral health settings, the initial target population will be individuals with a diabetes diagnosis. Regional data shows that approximately 15,400 Medicaid recipients have diagnosed diabetes (3% overall; 6% in adults, <1% in youth). This is an important subgroup for focus within behavioral health settings because the prevalence of diabetes is two to three times higher (or approximately 10%–15%) in these populations than in the general population.<sup>7</sup> Using a 12% prevalence rate to estimate prevalence for the approximately 40,000 enrollees in the behavioral health system produces an estimate of 4,800 individuals receiving behavioral health care who are likely to have diabetes. Studies suggest that the rate of prediabetes is approximately three times the rate of those with diagnosed diabetes. As such, the initial target population estimate of those with diabetes and prediabetes in the behavioral health setting is approximately 19,000.

The initial population may include clients with diabetes who are also diagnosed with comorbid physical and behavioral health conditions, but the diabetes, depression, and OUD diagnoses will activate the referral to treatment. These conditions were selected because they have the highest prevalence among disorders that are a focus of the MTP and the bi-directional care disorder-specific metrics; there are evidence-based care protocols for how to intervene and treat the targeted conditions<sup>9</sup>; and regional small-scale projects have shown early success in bending the curve of clinical improvement for depression and metrics associated with chronic conditions. Attention to oral health needs will be included in this project implementation, as dental disease is a complicating condition for diabetes and heart disease and is worsened by many behavioral health medications.

Additionally, behavioral health centers focusing on individuals with diabetes can leverage Project 3D: Chronic Disease Prevention and Control (Project 3D: Chronic Disease) where appropriate. This phased approach will allow providers, community-based organizations, and others to develop and implement best practices within these initial treatment parameters and then extend lessons learned to additional diagnoses and conditions.

After implementation with the initial target populations, KCACH will assess the expansion of the treatment population to additional physical and behavioral health conditions. Specifically, this project will continue to leverage the work of Project 3D: Chronic Disease and integrated care models will be expanded to individuals within behavioral health care settings who are diagnosed with cardiometabolic and respiratory disorders (e.g., heart disease, including hypertension, dyslipidemia, or congestive heart failure; obesity; asthma hypertension or asthma) or have risk factors for these conditions (screened via waist circumference or body mass index (BMI), smoking history, blood pressure, or blood sugar monitoring). Within the primary care setting, the future treatment group will include individuals with anxiety (diagnosed using the GAD-7), other substance use disorders (diagnosed with GAD-7 or SBIRT), and other behavioral health conditions that can be effectively managed in primary care, including bipolar disorders, anxiety and trauma disorders, and chronic pain.

Finally, KCACH will work with partnering providers, MCOs, and other stakeholders, including the Project 2C: Transitional Care Design Team, to develop clinical protocols for individuals who are high utilizers of inpatient medical and psychiatric services, to link with and enhance other existing high-utilizer care coordination initiatives in the region (see below).

### **Project Strategies and Expected Outcomes**

The bi-directional care project (2A) will support providers to implement any of the evidence-based practice models identified in HCA's toolkit, depending upon the providers' state of readiness and the best fit for their organizations. The practice models include the Bree Collaborative recommendations, Collaborative Care, and on-site or enhanced off-site integration of primary care into behavioral health care settings. Importantly, these models include the following key components:

- Population-based screening (to include mental health, substance use, medical vitals, oral health, and pregnancy intention).
- Bi-directional (primary care-behavioral health care) care coordination.
- Measurement-based treatment-to-target: tracking client outcomes over time and actively adjusting care based on progress shown.
- Evidence-based interventions: treatment methods known to positively impact clinical outcomes for the targeted conditions.

In addition, because behavioral health and health care are only modest predictors of health outcomes, and social determinants of health are significant contributors, KCACH will also ensure that social determinants are addressed as part of the intervention process. KCACH will work with consumers and community-based organizations to ensure that community health workers (CHWs) and/or peer support specialists are integrated as part of a multidisciplinary treatment team to assist with care coordination activities and linkages to services and supports. CHWs and/or peer support specialists will also help to engage clients who have an identified need but who have not, for a variety of reasons, accessed care because of barriers such as language or lack of understanding of how to navigate systems.

#### Expected outcomes

Increase in:

- Number of practices trained in and implementing bi-directional care models.
- Mental health and substance use disorder treatment penetration rates.
- Primary care practices meeting Primary Care Medical Home requirements.
- Antidepressant medication management.
- Management of diabetes symptoms.

Reduction in:

- Outpatient emergency department visits.
- Diabetes symptoms.
- Hospital readmission rates.

***What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?***

KCACH established an Integration Design Committee (IDC) in 2015 that included more than 25 representatives of community health and behavioral health centers, hospitals, MCOs, housing, long-term care providers, and community-based organizations to begin design of clinically integrated care. The IDC met for over a year and presented a recommendation to the KCACH ILC (Interim Leadership Council) in December 2016. In early 2017, the Steering Committee of the IDC hosted two Community Learning Sessions on Project 2A: Bi-directional Integration of Physical and Behavioral Health. More than 150 clinical and community-based organizations and community members attended the sessions. Following the CLSs, KCACH created a new Design Team, which included some members of the original IDC and some new members. The Design Team includes representation from the largest health care systems in the region (hospitals and primary care), the Federally Qualified Health Centers, the American Academy of Pediatrics Washington Chapter, the community behavioral health centers, the King County BHO, the University of Washington Advancing Integrated Mental Health Solutions (UW AIMS) Center, Qualis Health's Healthier Washington Practice Transformation Support Hub, and the five MCOs. These partners are essential to the success of this project as they include most of the primary care and behavioral health providers who see the largest number of Medicaid clients in the region, as well as key Medicaid payers to help think about models that can be sustained through future value-based payment (VBP) arrangements.

KCACH will work in partnership with the Pediatric Transforming Clinical Practice Initiative (TCPI) to conduct specific outreach to pediatric practices to encourage and support their participation in bi-directional integration efforts. This support will include identifying linkages to community-based care coordination to support children receiving their well-child visits. KCACH will also work with MCOs to identify barriers to well-child visits. Collectively, these efforts will help expand integrated physical and behavioral health to children and adolescents, and serve to expand evidence-based integrated pediatric models of care.

***How did the ACH consider the level of impact when selecting the project's anticipated target population? (e.g., geography, subgroups)***

KCACH took into consideration the prevalence of behavioral health and health conditions across the county and by racial/ethnic groups when identifying target populations in which to measure potential impact on communities facing disparities and on addressing county-wide needs. The Design Team also assessed current efforts in the region to determine where KCACH's interventions could add the most value while also leveraging existing community resources and initiatives.

As noted above, there has been extensive work to provide clinically integrated care in the King County region, and the approach of this project is tailored to build on that existing knowledge and infrastructure while initially targeting those individuals with the greatest need. The proposed approach leverages existing bi-directional care coordination programs in some of the largest clinics serving Medicaid clients to expand screening of mental health, substance use disorders, oral health, pregnancy intention, and medical vitals for all clients being seen. KCACH will focus on individuals with depression in primary care settings and individuals with diabetes in behavioral health care settings as initial target populations as these are the two most frequent comorbid conditions seen.

To achieve system-wide change, KCACH will focus on scaling efforts across additional populations and clinics throughout the course of the MTP, enlisting additional providers to provide clinically integrated care and improving penetration. This approach will ensure lasting benefit to the community, not only by supporting bi-directional infrastructure that promotes care coordination, but also by supporting the provider community's efforts to develop evidence-based practice innovations to treat specific client populations.

***How will the ACH ensure that health equity (e.g., demographic geographic) is addressed in the project design?***

KCACH is working to ensure improved health outcomes by addressing root causes and creating an environment that allows for all people to achieve their highest level of health. The biggest predictors of health involve an individual's ethnicity, income level, and neighborhood. Racism and discrimination also play a role in the health of communities, and the Design Team and other stakeholders have considered the ways in which institutions and organizations perpetuate bias and historical trauma.

KCACH is using the Equity Impact Assessment Tool (Equity Tool) developed by the KCACH Community/Consumer Voice Committee (CCV). The 2A Design Team has applied an equity and social justice lens to inform the development of this plan and used the process identified in the Equity Tool to develop the project proposal. This included examining disparities in outcomes by race/ethnicity, gender, geographic location, and income level as well as exploring strategies to engage impacted individuals. The 2A Design Team is committed to deepening this practice during the planning and implementation phase. The project will prioritize interventions that address critical health disparities faced by populations at risk of poorer outcomes—individuals diagnosed with diabetes within a behavioral health care setting, and with depression within primary care. Tribal partners will also be engaged to help with the design and implementation.

As noted above, significant disparities exist in the King County region in relation to certain health conditions, behavioral health, and access to treatment. During the planning phase, the 2A Design Team and others will receive more in-depth training on the use of the Equity Tool and will use it, in partnership with members of the CCV, to continue to apply an equity lens to this work. All strategies described in the project will be assessed for their ability to address systemic and other barriers to accessing services and resources, including barriers related to race/ethnicity, gender, geographic location, and income level. Investments will be targeted toward regions and populations that represent the greatest disparities. Similar approaches to assuring health equity will be used with all target populations.

Some of the largest Medicaid providers in King County include providers who specialize in best practices in the care of minority and foreign-born populations: SeaMar, Asian Counseling and Referral Service, Therapeutic Health Services, HealthPoint, International Community Health Services, Refugee Women's Alliance, and Lutheran Community Services Northwest. These agencies have culturally diverse staff and have established best practices within these populations. KCACH will draw on the expertise of these and other specialty practices as key partners in the planning and implementation phase for this project, to ensure that Medicaid beneficiaries have access to a robust network of culturally relevant providers. KCACH will also work with these agencies to identify groups that historically have not accessed care and to build optimum ways of implementing bi-directional care.

**Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region's overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies.**

Implementation of this project will have lasting impacts and benefits to the King County region through robust and comprehensive practice transformation in major primary care and behavioral health settings. KCACH will support providers in making infrastructure changes to electronic health records (EHRs), workflow, and implementation of evidence-based practices through training and technical assistance support. KCACH will also help practices develop care coordination positions and linkages to community support services, to include mechanisms for information sharing and shared care planning. Infrastructure investments and practice changes will be sustained over time through one-time financial investments in EHRs and other information technology (IT) modifications, as well as through shifts in policies and practices that will become the new norm. Integrated, multidisciplinary care teams, including care coordinators and/or CHWs and/or peer support specialists, will be sustained by working with MCO partners to establish VBP models that support integrated care delivery and provide enough incentive and funding to support successful care models.

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## Implementation Approach and Timing

Using the **Implementation Approach** tabs of the **ACH Project Plan Supplemental Data Workbook**, provide a short description of how the ACH will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH's selected projects.
- In the implementation approach descriptions:
  - Describe the ACHs general approach to accomplishing requirements.
  - Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
  - Specify which evidence-based approach option(s) will be used for the project.
  - If applicable, indicate in italics whether a project milestone can be completed earlier than

the required deadline in the Completion Deadline column.

## Partnering Providers

*Partnering providers may include clinical providers, community-based organizations, county governments, and/or tribal governments and providers, among others. The list of partnering providers may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH must provide a final list and secure commitments from partnering providers.*

Using the **Partnering Providers tabs of the ACH Project Plan Supplemental Data Workbook**, list partnering providers that have expressed interest in supporting the development and implementation of the project.

Based on the ACH's selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook** (applicable workbook tabs must be submitted by December 15, 2017). Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization
- Employer Identification Number (EIN)
- Upload to Financial Executor portal

Describe engagement with partnering providers. In the narrative response, address the following:

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
  - Describe process for ensuring partnering providers commit to serving the Medicaid population.
  - Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented.
- Describe how the ACH is leveraging MCOs' expertise in project implementation, and ensuring there is no duplication.

## ACH Response

*Describe engagement with partnering providers:*

*Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.*

In fall 2015, the King County Department of Community and Human Services, under the direction of the KCACH ILC (the precursor to the KCACH Governing Board) convened a diverse, multisector IDC to begin the design of clinically integrated care for the region. The IDC included representatives from all five Medicaid MCOs, community health centers, hospitals, behavioral health providers, housing providers, long-term care providers, and local government. The IDC met monthly for over a year and developed a set of recommendations for delivering integrated care in the region. Building on this

work, KCACH convened two Community Learning Sessions in spring 2017. Over 150 different providers, community-based organizations, and other stakeholders attended the learning session and from there, additional interested stakeholders were invited to become members of the Design Team. The 2A Design Team has met bi-weekly since June 2017 to guide the development of this project. Most of the partners on the Design Team serve large numbers of Medicaid clients. They include organizations like Harborview Medical Center, MultiCare Health System, Navos Mental Health Solutions, Sound Mental Health, Swedish Medical Center, and Valley Cities Counseling and Consultation. Additionally, KCACH acknowledged the need to enlist additional providers and stakeholders into the work during the planning, implementation, and scale-and-sustain phase. To do this, KCACH will conduct broad formal outreach via medical societies and professional organizations, community and stakeholder forums, tribal meetings, the Behavioral Health Council, and the MCOs.

***Describe the process for ensuring partnering providers commit to serving the Medicaid population.***

Together, the 2A Design Team members, project partners, Demonstration Project Committee, and KCACH Governing Board have outlined and emphasized a collective commitment to serving the Medicaid population. First and foremost, almost all the project's partners have a long-standing commitment to working with and for Medicaid beneficiaries. Secondly, the project emphasizes mobilization of resources and strategies to better support Medicaid beneficiaries with health and behavioral health conditions. Additionally, all project partners must respond to and submit a nonbinding letter of interest to outline their commitment to transform the health care delivery system for Medicaid beneficiaries.

KCACH continues to conduct outreach to Medicaid providers to engage them and seek participation in MTP activities. KCACH conducted a provider survey in August and September 2017 to assess provider interest in participating in this and other projects. Individual follow-up will be done for those providers/health systems and dental practices who serve Medicaid clients but did not respond to the survey. All providers will be invited to participate in the planning phase in 2018 and will be asked to commit to a contract with the KCACH to implement the project.

***Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented.***

Successful bi-directional integration in King County through the MTP will require full participation from a variety of stakeholders. The project aims to promote system transformation through supporting clinicians and clients both within and outside the clinic walls. Buy-in from stakeholders is extremely important to helping this change take place.

A diverse set of partnering providers participated in the 2A Design Team. The 2A Design Team met multiple times per month for more than six months and has worked to ensure continual inclusion of public input in this process. 2A Design Team members include representatives of health systems, medical providers, community-based organizations, advocates, community health workers, and researchers. Additional community partners and stakeholders participated in Community Learning Sessions with the aim of reviewing and providing input into the scope of the project. Approximately 150 partners participated in the Community Learning Session in spring 2017. Ongoing coordination with these and other entities, as well as other MTPs, will occur throughout the planning and implementation phases to ensure buy-in and adoption of strategies by participating providers. KCACH

will do a more targeted approach to formally enlist providers as partnering providers to implement the project in 2018. KCACH will target these efforts using information about where Medicaid individuals are receiving service to reach out to providers serving Medicaid beneficiaries who are not already engaged in the Design Team with appropriate geographic representation.

KCACH is seeking to leverage broad and culturally diverse providers to drive health equity gains. By working with the top 50 providers of Medicaid services, KCACH will be including provider organizations that see large volumes of ethnic and culturally diverse populations—including SeaMar, Asian Counseling and Referral Service, Therapeutic Health Services, HealthPoint, International Community Health Services, Refugee Women’s Alliance, and Lutheran Refugee/Asylum seeker program. KCACH will also work with partner agencies to identify groups that historically have not accessed care to build optimum ways of implementing bi-directional care.

*Describe how the ACH is leveraging MCO’s expertise in project implementation, and ensuring there is no duplication.*

KCACH is leveraging MCO expertise in a number of ways. First, the Medicaid MCOs have a seat on the KCACH Governing Board, the decision-making body for the KCACH and authorizing body for the final project portfolio. All five Medicaid MCOs have also participated on the Demonstration Project Committee and have provided guidance to all Design Teams, including the 2A Design Team, on direction and alignment of projects. Finally, MCOs are actively participating on the 2A Design Team and are providing guidance related to project activities, contractual obligations, and health-system-related project implementation to help ensure that efforts of the MTP align with MCO priorities and activities and do not duplicate. In addition, the Design Team will leverage MCO provider networks already serving Medicaid beneficiaries and work with them to expand that network as needed to ensure appropriate services, supports, and access.

As King County prepares to transition to FIMC, all five Medicaid MCOs are members of the FIMC Leadership Group co-chaired with the King County BHO. This group includes a subset of KCACH Governing Board members and will provide direction and leadership toward implementation of the bi-directional care project, ensuring that investments made by the KCACH align with MCO priorities and goals and complement, rather than duplicate, what MCOs will be doing to support this transition.

## **Regional Assets, Anticipated Challenges and Proposed Solutions**

Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions. In the narrative response, address the following:

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

### **ACH Response**

*Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions:*

***Describe the assets the ACH and regional partnering providers will bring to the project.***

A valuable asset in King County is the significant body of work that has already been done to move toward fully integrated care at both the clinical and financial levels. As noted earlier, there have been many efforts to expand clinical integration in both primary care and behavioral health care settings, which have already led to documented improvements in health and social outcomes, and produced cost savings. Because of this, there are many providers and organizations in the region that can be looked to as experts and champions of this work. Lessons learned have been captured and have informed further integration efforts.

In 2015, KCACH ILC convened a subcommittee called the Physical and Behavioral Health IDC to make recommendations about a pathway to fully integrated care in the region. The IDC made two recommendations to the KCACH ILC about the path to fully integrated care. First, they recommended a clinically integrated system of care that addresses whole-person needs and includes key components in four areas:

- Access and Equity
- Whole-Person Needs Across the Continuum from Prevention to Recovery
- Efficient Use of Resources to Achieve Optimal Outcomes
- System Infrastructure

Second, the IDC recommended the development of a local shared governance structure that aligns and leverages the array of financing and policy levers, including Medicaid, King County local resources, and other public/private resources necessary to support a clinically integrated system of care. The components of the clinically integrated system of care were developed by the IDC after establishing a shared vision of what an integrated system should look like, and after gathering input from experts in the region about providing integrated care.

The second recommendation, which called for establishing a local shared governance structure, has provided the forum for the current FIMC Leadership Group to discuss a framework for full financial integration while leveraging the financial and institutional resources King County contributes to providing a robust continuum of care. The work of the IDC and their recommendations have served as guideposts for the Design Team work and the community-wide engagement that has led to the design and approach of this project. The Leadership Group signed a three-way memorandum of understanding (MOU) between King County, the Medicaid MCOs collectively, and the HCA to guide the path to FIMC and support the submission of a binding letter of intent to transition to FIMC by January 2019.

In addition to what is described above, the King County region brings a long history of innovation related to implementation of integrated care. This includes multiple models of integrated care delivery in primary care and behavioral health settings. The work to integrate care in King County has also attracted the attention of philanthropy through the Partnership for Innovation in Mental Health project to support practice transformation and establish learning collaboratives for integrated care.

***Describe the challenges or barriers to improving outcomes and lowering costs for the target population through this project.***

Earlier this year, KCACH hosted Community Learning Sessions about the Bi-directional Care Project with over 150 stakeholders (including many providers) and asked about key challenges to successful implementation of this project. The following challenges and barriers were identified:

- **Shortage of human and physical resources** (e.g., workforce, workforce preparation, referral sources):
  - Significant shortage in behavioral health and nursing positions in the region.
  - Implementation of integrated care models that go beyond clinic walls and support addressing social determinants of health such as housing and employment.
  - Lack of available affordable housing units in the region.
- **Inadequate finance and reimbursement mechanisms:**
  - Supporting smaller and specialty providers in practice transformation and transition to VBP arrangements.
  - Lack of VBP models that include care coordination.
  - Need for sustainable financing for linkages to social determinants of health.
- **Lack of communication and data tools:**
  - Development of health information technology/electronic health records (HIT/EHR) and other interoperable technology solutions to support integrated care delivery including population health management, measurement-based care, shared care planning, and information sharing across providers.
  - Identifying and implementing standardized tools and assessments across the providers and systems for continuity of care as well as effective measurement/comparison.

*Describe the ACH strategy for mitigating the identified risks and overcoming barriers.*

KCACH has identified the following strategies to mitigate risks and barriers identified for this project:

- **People/physical resources:**
  - Ensuring widespread engagement of the provider community—KCACH recognizes that successfully implementing bi-directional care requires broad participation of providers to ensure adequate capacity and access to bi-directional care for the targeted population.
  - Domain 1 workforce infrastructure investments to support integrated care delivery, including training, technical assistance, and funding for additional positions (e.g., care coordinators).
  - KCACH will make Domain 1 workforce investments that support care coordination and strong bi-directional partnerships between health/behavioral health clinics and community-based organizations to strengthen the ability to address social determinants of health.
- **Finance/reimbursement mechanisms:**
  - Leveraging the King County BHO’s ongoing efforts to develop a VBP framework for behavioral health services to assist providers, especially smaller and specialty providers, to make the transition to FIMC.
  - Leveraging current assets and expertise of MCO partners and transition to FIMC to support sustainable finance models.
- **Communications/data tools:**

- KCACH will assess provider readiness for implementing bi-directional care models and make investments in providers to support IT changes necessary to move to measurement-based care.
- KCACH will make Domain 1 IT investments that support care coordination and strong bi-directional partnerships between health/behavioral health clinics and community-based organizations to strengthen the ability to address social determinants of health.

## Monitoring and Continuous Improvement

Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request. In the narrative response, address the following:

- Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?
- Describe the ACH's plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?
- Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.

### ACH Response

*Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request:*

*Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?*

To ensure activities are linked to desired outputs, process metrics, and outcome metrics (both short- and long-term), KCACH will develop a logic model for the portfolio at the start of the planning phase. Pay-for-reporting (P4R) and pay-for-performance (P4P) measures provide a strong basis for monitoring successes and challenges, and the logic model may highlight additional metrics necessary to ensure a comprehensive monitoring strategy.

The Regional Health Needs Inventory's [presentation](#) of measure attribution by project illustrates the overlapping P4P monitoring needs across the project portfolio. KCACH will develop a similar online tool for P4R measures to identify opportunities for improved efficiency in monitoring common and/or related measures (see Section I, Population Health Management, Appendix 5). KCACH will also create a combined P4R and P4P monitoring online tool that reflects the logic model.

Key principles for monitoring include a focus on accuracy, efficiency, and minimizing participating provider burden. KCACH will establish processes to rapidly communicate successes and challenges to implementing partners and work with them to address problems and build on successes. KCACH will identify delays in project implementation using a continuous improvement approach and P4R measures that relate to timely implementation of projects (e.g., number of partners participating and number implementing each selected model or approach). Specifically, project implementation delays

will be identified as differences between relevant P4R measures and targets or expected outcomes as defined by the project implementation plan (yet to be developed). Additionally, KCACH will identify factors contributing to delays from a system/organizational perspective and address them in a timely manner through communication and coordination between KCACH and participating providers.

*Describe the ACHs plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?*

To monitor day-to-day/real-time performance and support partnering providers to achieve continuous improvement, KCACH will likely use a web-based, dynamically updated project monitoring tool (e.g., Tableau) to facilitate both internal and external conversations around project performance. As KCACH develops its project implementation plan in 2018, predictive analytics will be used to determine process and outcome metric milestones over a more frequently monitored timeline than that required by the State and the Centers for Medicare and Medicaid Services (CMS). These predictive analytics could be used to check the course of any given project and activity and determine its progress. By quantifying such project milestone gaps, KCACH staff and participating providers can use a continuous quality improvement framework to make needed adjustments to project implementation and ongoing operations.

KCACH will also convene regular forums with participating providers to discuss successes and challenges evident in the data. This will include learning session collaboratives—facilitated sessions where providers can share lessons learned about clinical and operational issues. KCACH will also continue to host a community meeting with providers to discuss important KCACH developments and identify resources.

This project’s monitoring and continuous improvement approach will focus on the following measures and metrics:

1. **Training/technical assistance (TA) to partnering providers.** KCACH will track numbers of providers trained in integrated care delivery (both primary care and behavioral health) to total Medicaid providers in the region.
2. **Whole-person care teams.** KCACH will track number of clients served, hospital and emergency department (ED) visits, improvement on metrics associated with target population (e.g., lowered A1c3 for individuals with diabetes being served by behavioral health), and linkages to community-based services and supports that address social determinants of health.
3. **Mental health and substance use disorder treatment penetration rates.** KCACH will track improved access to behavioral health treatment and plan to monitor the number of clients served, readmissions, length of stay, and linkage to or utilization of outpatient medical care or long-term care services and supports.

Lastly, KCACH will seek TA with expertise in quality improvement science and with project-specific subject matter expertise to support partnering providers. Examples of organizations that could provide this type of TA include Qualis Health, the UW AIMS Center, and the Arcora Foundation. TA will be prioritized for providers who are struggling to meet performance goals.

*Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.*

KCACH will use a continuous quality improvement approach to identify project initiatives or strategies that are not working or not achieving desired outcomes. Specifically, the predictive analytics process will identify short-term process and outcome milestones that can support continuous quality improvement processes with participating providers. In addition to the project milestones, KCACH will develop alert thresholds that will indicate when a project or strategy is off course and needs extra attention. KCACH will work within a project’s logic model to make adjustments where possible. In the scenario where a project or strategy continues to have significant problems despite repeated attempts to solve them, KCACH will consider and request more substantial modifications based on the factors contributing to the unexpected or undesirable performance issues.

KCACH, via the clinical innovations manager, will work with providers to identify any additional resources, training, TA, or other supports needed to improve care. For example, KCACH will seek TA with expertise in quality improvement science and with project-specific subject matter expertise to support partnering providers to be successful in their efforts. Finally, during the planning phase, KCACH will engage in a plan-do-check-adjust continuous improvement process as plans move into the implementation phase.

### **Project Metrics and Reporting Requirements**

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

### **Relationships with Other Initiatives**

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

## Project Sustainability

Describe the ACH's strategy for long-term project sustainability, and its impact on Washington's health system transformation beyond the Demonstration period.

### ACH Response

*Describe the ACH's strategy for long-term project sustainability.*

This project will be sustained through several mechanisms. First, the project will make strategic IT infrastructure investments to ensure that providers have the technology capacities needed to make the types of practice transformation required (i.e., EHR, measurement-based care, shared care planning). These infrastructure investments will be long-term and once complete will remain in place beyond the length of the MTP. Second, KCACH will invest in workforce capacity through training, technical assistance, and practice coaching to help provider organizations make policy and programmatic changes in care delivery that will become the new norm. This includes creating mechanisms and pathways for integrated care coordination that supports not only coordination among clinical providers but provides a strong bi-directional partnership with community-based organizations, which will refer people into care and establish primary health homes and will assist clinics and clients in addressing their social needs. Finally, this project will be sustained through the design and implementation of FIMC for the King County region and through partnerships with MCOs to establish models of care that can be sustained through VBP arrangements. This is also true for oral health integration. Given the forthcoming move to managed dental administration, there is a window of opportunity to drive that process with population oral health outcomes while investing in a dental disease severity strategy as part of this project.

*Describe the project's impact on Washington's health system transformation beyond the Demonstration period.*

A limiting factor that impeded past efforts from being scaled was the lack of financial resources required for providers to transition to clinically integrated care. The MTP creates the opportunity for significant, one-time investments in infrastructure and practice changes to support ongoing integrated care delivery. These investments will continue to support the system well past the end of the MTP. In addition, the transition to FIMC in the King County region provides an opportunity to create payment structures that further support integrated care delivery at the provider level and ensure an ongoing focus on whole-person, population-based care.

Because there is a strong foundation of existing integration efforts to build on, KCACH estimates that by the end of the MTP, the majority of Medicaid providers in the region will have the capacity to provide clinically integrated care, ensuring the greatest reach and impact to Medicaid beneficiaries and other populations so that they receive whole-person, integrated care and can have social issues addressed seamlessly through community-based care coordination.

This can occur if penetration of the bi-directional care practices reaches the bulk of both primary care and behavioral health care settings, as RHNI starter kit data show that 76% of adults and 89% of children and youth have established primary medical care, and an additional (semi-overlapping) 40,000 are seen within the behavioral health system. To reach the remaining individuals, KCACH will work with other initiatives (e.g., Mental Health First Aid, BSK levy) that are providing information and education to day care workers, service providers, educators, and the public on how to identify behavioral health and health care needs and how to connect identified individuals to treatment. This will help to bring additional individuals into regular sources of integrated care.

### King County Accountable Community of Health Glossary

ACH	Accountable Community of Health
AI/AN	American Indian/Alaska Native
AIM	Analytics, Interoperability, and Measurement, part of HCA
AIMS	Advancing Integrated Mental Health Solutions, part of University of Washington
AMDG	Agency Medical Directors' Group
BHO	Behavioral Health Organization
BMI	body mass index
BRFSS	Behavioral Risk Factor Surveillance System
CMS	Centers for Medicare & Medicaid Services
CBO	community-based organizations
CCM	chronic care model
CCV	Community/Consumer Voice Committee
CDP	Chronic Disease Prevention and Control Project
CDR	Clinical Data Repository
CEO	chief executive officer
CHARS	Comprehensive Hospital Abstract Reporting System
CHW	Community health worker(s)
CLS	Community Learning Sessions
CMCH	Center for MultiCultural Health
CMS	Centers for Medicare & Medicaid Services
DCHS	Department of Community and Human Services
DPC	Demonstration Project Committee
DPP	Diabetes Prevention Program
DSHS	Department of Social and Health Services
DSRIP	Delivery System Reform Incentive Payment
DT	Design Team
DY1	DSRIP Year 1
ED	emergency department
EHR	electronic health record
FIMC	fully integrated managed care
FFS	fee-for-service
FPL	federal poverty level
FQHC	Federally Qualified Health Centers
G2P	Guidelines to Practice
HCA	Health Care Authority
HCP LAN	Health Care Payment Learning & Action Network

HHSTP	Health and Human Services Transformation Plan
HIE	health information exchange
HIT	health information technology
HKCC	Healthy King County Coalition
HUD	U.S. Department of Housing and Urban Development
IDC	Integration Design Committee
IHCP	Indian Health Care Provider
ILC	Interim Leadership Council
IOM	Institute of Medicine
IT	information technology
ITU	Indian Health Service, tribally operated, or urban Indian health program
JAMA	Journal of the American Medical Association
KCACH	King County Accountable Community of Health
LEAD	Law Enforcement Assisted Diversion
LGBT	Lesbian, Gay, Bisexual, and/or Transgender
LOI	letter of intent
MAT	Medication Assisted Treatment
MCO	managed care organization
MeHAF	Maine Health Access Foundation
MHIP	Mental Health Integration Program
MIDD	Mental Illness and Drug Dependency
MOU	memorandum of understanding
MTP	Medicaid Transformation Project(s)
MVP	Medicaid value-based purchasing
ODU	opioid use disorder
P4P	Pay-for-performance
P4R	Pay-for-reporting
PAL	Partnership Access Line
PCORI	Patient-Centered Outcomes Research Institute
PCP	primary care provider
PHSKC	Public Health – Seattle & King County
PIMH	Partnership for Innovation in Mental Health
PMD	Performance Measurement and Data
PMP	Prescription Monitoring Program
PRISM	Predictive Risk Intelligence System
PSH	Permanent Supportive Housing
QBS	Quality Benchmarking System
RHIP	Regional Health Improvement Plan
RHNI	Regional Health Needs Inventory
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCORE	South Correctional Entity
SIHB	Seattle Indian Health Board
SIM	State Innovation Model(s)
SUD	substance use disorder
TA	technical assistance
TSP	Transition Support Program

UIHI	Urban Indian Health Institute
US	United States
VBP	value-based payment
VOCAL-WA	Voices of Community Activists and Leaders, Washington state chapter
WSHA	Washington State Hospital Association
WSMA	Washington State Medical Association

## SECTION II: PROJECT-LEVEL

**Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).**

### Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
<b>Domain 2: Care Delivery Redesign</b>	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input checked="" type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
<b>Domain 3: Prevention and Health Promotion</b>	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

### Project Selection & Expected Outcomes

*The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.*

Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following:

- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.
- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.
- Describe the anticipated scope of the project:
  - Describe the project's anticipated target population. How many individuals does the ACH anticipate reaching through the project?
  - What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
  - How did the ACH consider the level of impact when selecting the project's anticipated target population? (e.g., geography, subgroups, etc.)
  - How will the ACH ensure that health equity (e.g., demographic, geographic) is addressed in the project design?
- To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH region's Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region's overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies.

## ACH Response

*Describe the rationale for project selection, and the expected outcomes:*

*Provide justification for selecting this project and how it addresses regional priorities.*

The King County Accountable Community of Health (KCACH) is proposing to focus on three populations with evidence-based strategies to improve transitional care services, reduce avoidable hospital utilization, and ensure beneficiaries are getting the right care in the right place:

1. Medicaid beneficiaries returning to the community from jail.
2. Medicaid beneficiaries with serious mental illness or substance use disorder who have been discharged from inpatient care.
3. High-risk Medicaid beneficiaries transitioning from hospitals, including older adults and people with disabilities.

Consistent with the KCACH vision, implementation of the 2C: Transitional Care Project for the above populations will improve health outcomes for vulnerable populations, ensure continuity of care, and redirect resources available to focus on long-term prevention and promotion rather than short-term crisis responses. The “transition period”—the days and weeks following a person’s discharge from an institutional setting such as a hospital, psychiatric hospital, or jail—is a time of great vulnerability and risk. Proven, evidence-based programs have shown that in-person guidance and support during this time can make the difference between a safe landing back in the home and community versus a preventable rebound back to a high-cost, high-intensity institutional setting.

Supporting people to make successful transitions out of institutions is fundamental to the KCACH vision of shifting from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities. As illustrated below, the approaches outlined for the three target populations address the KCACH regional priorities, which include achieving healthy communities and populations through delivering whole-person care; reducing inequities; creating stronger, bi-directional partnerships between clinical settings and community-based organizations; and lowering costs.

**1. Jail Transitions:** Regional data demonstrates that significant disparities exist in the arrest rates for individuals with behavioral health needs. Nearly half (45%) of the King County Medicaid enrollees arrested in 2016 had a need for drug or alcohol use treatment.<sup>1</sup> Medicaid enrollees with a co-occurring mental illness and substance use disorder were over five times more likely to be arrested. Adult Medicaid beneficiaries with a serious mental illness were 1.8 times more likely to be arrested than those without a serious mental illness.<sup>2</sup>

Furthermore, significant disparities exist for individuals from different races/ethnicities. Although most of the Medicaid beneficiaries who were arrested in King County were white (5,235), American Indian/Alaska Natives and Blacks were disproportionately more likely to be arrested. For example, while Blacks make up 6% of the King County population, they made up 28% of arrests (3,216).

For individuals who have four or more bookings in one year (Familiar Faces initiative), the situation is even more challenging. Over 94% have behavioral health and/or substance use disorders and fewer than half have any active behavioral health treatment. More than 90% of Familiar Faces have chronic medical conditions and more than half have an indication of homelessness. These individuals are also more likely to be disproportionately people of color.

**2. Transitions from Inpatient Care for Medicaid Clients with serious mental illness or substance use disorders:** Data from the Regional Health Needs Inventory (RHNI) demonstrates the significant need for enhanced transitional care services for individuals with behavioral health conditions. In 2016 in King County, there were 2,660 admissions to stand-alone psychiatric hospitals and inpatient psychiatric units and beds within medical hospitals. Additionally, there were 16,479 Medicaid inpatient admissions in 2015 for behavioral health conditions (including mental health and substance use disorders (SUD)) in all King County hospitals (excluding pregnancy- and delivery-related admissions). The leading causes of hospitalizations in King County include mental health conditions, substance use disorders, injury, and poisoning. This target population was chosen because a disproportionately large percentage of hospital admissions and readmissions are connected to behavioral health needs.

**3. High-risk Medicaid Clients Discharged from Hospitals:** Data from the RHNI illustrates that the Medicaid population in King County has an all-cause hospital readmission rate of 17%,<sup>3</sup> which is 70% higher than the rate for commercially insured.<sup>4</sup> A study of patients readmitted to the hospital in Washington state found that half had not had an outpatient visit within 30 days of being discharged. Several King County hospitals serving large numbers of Medicaid beneficiaries had readmission rates in the fourth quartile (worse).<sup>5</sup> Given this room for improvement, the Transitional Care Project's third focus population is high-risk Medicaid clients discharged from general hospitals.

Leading causes of non-pregnancy or childbirth-related hospitalizations among Medicaid adults in King County are mental illness, heart disease, septicemia, and unintentional injuries. While the second strategy described above will address transitions for individuals with psychiatric diagnoses, this third strategy will specifically identify those Medicaid individuals who are highest utilizers of inpatient hospitalization for other chronic conditions. This will include older adults and those requiring long-term services and support. This population has been identified by the Washington State Hospital Association (WSHA) as having longer lengths of stay and utilization of inpatient hospital resources due to lack of support in the community to assist with safe discharges. Focusing on transitional care support for this population is consistent with current work under way by the Washington State Department of Social and Health Services (DSHS), Aging and Disability Support Administration. Although individuals who are dually eligible for Medicaid and Medicare ("duals") are excluded from the Medicaid Transformation Project (MTP), KCACH will partner with the regional Area Agency on Aging to develop access points for enhanced transitional care services. KCACH will also leverage an existing Emergency Medical Services program that provides transitional care follow-up in the form of home assessment for falls prevention for individuals who have called 911 and/or visited an emergency room due to a fall.

***How will this project support sustainable health system transformation for the target population?***

All three strategies outlined above offer the opportunity to improve lives while at the same time

contributing to broader system transformation. This project will support sustainable health system transformation for the Medicaid population in the following ways:

- Investing in evidence-based transitional care models to improve the overall quality of care and build strong linkages to community-based organizations, resulting in more stable transitions that maintain individuals in community settings (e.g., preventing readmission).
- Investments in training, technology, and workforce capacity, leading to long-term practice transformation.
- Decreasing unnecessary readmissions and reincarcerations to make the county-wide health and justice systems more effective and efficient, resulting in savings to the health care and criminal justice systems. Over time, savings can be reinvested in the community to focus on upstream work to address the social determinants of health and well-being.
- Increasing access to multidisciplinary care teams that are equipped to provide client-centered, whole-person care, upon transition from more intensive institutional settings.
- Increasing access to community-based care coordination upon transition from more intensive institutional settings, including stronger alignment with social determinant needs, to improve outcomes for the target population and strengthen the foundation for transforming the delivery system.

*Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.*

The activities and approaches for this project will not duplicate existing efforts. Rather, they will scale up small pockets of excellence—approaches that have been tested through pilot projects and have generated evidence of effectiveness, but for which there has not been large-scale application across the county or sustainable funding. For example:

1. **Target population 1.** For Medicaid clients transitioning from jail, less than 1% currently benefit from transitional support, typically provided by re-entry case management services funded by local resources. In addition, jail release planners generally are not able to meet people at the moment of release and provide the “warm handoff” to community-based service providers or health homes necessary to achieve successful outcomes. This project will leverage the limited capacity of re-entry case management to expand to include a larger portion of the jailed population, especially those with behavioral health conditions, as well as extend access to other jail facilities. KCACH will partner with managed care organizations (MCOs) who are looking to partner with jails to identify Medicaid beneficiaries and assist with linking them to appropriate health care coverage upon discharge to ensure that efforts complement and do not duplicate.
2. **Target population 2.** For Medicaid clients transitioning from psychiatric hospitals, only about one-third have access to a Peer Bridger program and Transitional Support Program in a limited number of hospitals. This project will leverage the limited capacity of the Peer Bridger program and Transitional Support Program to expand to include a larger number of individuals discharging from psychiatric facilities.
3. **Target population 3.** For high-risk Medicaid enrollees transitioning from hospitals, the vast majority receive only basic discharge instructions prior to leaving the hospital. More intensive models that include in-person and phone follow-up with patients after they return home are only

available on an episodic basis when grant funding is secured. This project will leverage existing transitional care projects, including those focused on individuals who have high utilization of inpatient and emergency department services that are currently under way to expand to reach more individuals and work with additional hospitals.

As these examples show, while there are currently transitional programs in place, their limited capacity does not meet the needs of the region. This project proposes to take promising practices to scale while coordinating and aligning with other existing efforts to support successful transitions for the target populations without duplicative service. Some of the local services the Transitional Care Project will coordinate with and leverage include:

- **Post-hospital respite locations.** King County has a very limited number of beds available to individuals leaving medical hospitals with ongoing medical needs who have no place to stay after discharge. The Transitional Care Project will coordinate with this existing resource as needed for individuals transitioning from inpatient settings who are unable to directly return to a safe home.
- **Medical support in coordination with supportive housing.** Across King County, several housing programs serving individuals coming out of homelessness with mental health and substance use disorders have begun to bring in medical care for their residents. KCACH's Transitional Care Project will coordinate with these efforts and tailor services to individual clients, facilitating "warm hand-offs" to community-based resources when already in place.
- **Transitional care innovations led by the King County Area Agency on Aging (Aging & Disability Services).** These activities include enrollment in health homes and care coordination organizations; transitional care coordination with providers of long-term services and supports; and participation in a statewide community learning collaborative on care transitions. The Transitional Care Project will coordinate with these services.

*Describe the anticipated scope of the project:*

*Anticipated target population and number of individuals the ACH anticipates reaching through the project.*

KCACH is proposing to focus on three populations with evidence-based strategies to improve transitional care services, reduce avoidable hospital utilization, and ensure beneficiaries are getting the right care in the right place:

**Target Population 1—Medicaid clients returning to the community from jail**

In 2016, 11,718 (6.2%) of 187,703 adult Medicaid enrollees (ages 18 to 64) were arrested. The anticipated reach of this project in 2018 will be 2,100 Medicaid individuals. This represents a 10% reduction in Medicaid adults arrested in the year.

**Target Population 2—Medicaid clients with serious mental illness or substance use disorder discharged from inpatient care**

In 2015, 1,713 Medicaid enrollees had a psychiatric inpatient admission, and 16% of these individuals were readmitted within 30 days of discharge. The anticipated reach of this project for this population

is approximately 700 individuals. The project estimates this reach based on a goal of serving 40% of the individuals in this target population, twice the number served today.

**Target Population 3—High-risk Medicaid clients transitioning from hospitals, including older adults and people with disabilities.**

In 2016, 6,374 Medicaid clients were high-risk (PRISM score of 1.5 or more) and had at least one inpatient admission. With 35 care coordinators trained and an estimated caseload per month of 50 (includes a mix of new and ongoing patients), the total anticipated reach over one year (with approximately 10 referrals per month) will be 3,150 Medicaid beneficiaries, assuming 75% of eligible individuals enroll in services.

**Project Strategies and Expected Outcomes**

**Target Population 1—Medicaid clients returning to the community from jail**

The jail transitions strategy will provide two high-intensity, time-limited interventions that provide support to individuals as they leave jail. Intensity of care will be tapered as the individual establishes connections to appropriate community services.

- Expand the re-entry case management using the [APIC model](#) for Medicaid beneficiaries leaving King County jail facilities.
- Utilize community health workers (CHWs)/peer support specialists—peers with lived experience in the criminal justice system and/or behavioral health recovery—to work with individuals as they transition out of jail back into their community. This strategy will enhance the APIC model by including a “warm handoff”—CHWs or peers will meet an individual at release and accompany them to their first appointment to establish a relationship with a medical or behavioral health provider (a health home).

Although 80% of individuals booked into jail are released within 72 hours, jails do not currently offer release planning to individuals who stay for less than 72 hours due to lack of capacity as well as logistical challenges associated with the quick turnaround. This is a gap in transitional care that KCACH will address by adapting the APIC model to offer release planning within the first few hours of booking.

These strategies will be implemented in phases. The South Correctional Entity (SCORE) in Des Moines, Washington is a potential starting point for this work. At SCORE, 84% of inmates have Medicaid coverage at intake. Ninety-two percent of inmates enter SCORE with an uncontrolled chronic condition and about a quarter of that group has had an emergency room visit in the three months preceding being booked into SCORE. In addition, over three-quarters of SCORE’s inmates are on drug treatment/detoxification. While the vast majority of chronic conditions (90%) are controlled in jail with a treatment plan, a strong transitional care plan is critical to ensuring health does not deteriorate upon release.

Expected outcomes

The long-term goals for this strategy are to ensure that individuals being released from jail:

- Are connected to primary physical and behavioral health providers.

- Have connections to key social supports in their communities.
- Are enrolled or re-enrolled in Medicaid.
- Receive tailored and coordinated services.
- Avoid re-arrest and/or admission to another institutional setting (diversion from future criminal justice involvement).

Reaching 2,100 Medicaid beneficiaries in 2018 with a successful intervention would reduce the number of Medicaid adults arrested by 10%. This assumes a 15%–20% dropout rate and no re-arrests in 60% of program participants.

**Target Population 2—Medicaid clients with serious mental illness or substance use disorder discharged from inpatient care**

By focusing on transitions out of stand-alone psychiatric hospitals, inpatient psychiatric units, and beds within medical hospitals, this strategy aims to stabilize individuals in their community and reduce unnecessary future hospitalizations. In 2015, 1,713 Medicaid enrollees had a psychiatric inpatient admission, 16% of these individuals were readmitted within 30 days of discharge.

KCACH will expand the Peer Bridger program and the Transitional Support Program (TSP) for Medicaid clients discharged from psychiatric inpatient stays or psychiatric hospitals using the APIC model. The goal is to increase access to psychiatric transition support for all Medicaid or Medicaid-eligible individuals being discharged from King County hospitals for admissions related to psychiatric or substance use (both involuntarily detained and voluntary admissions). TSP provides a multidisciplinary team that is not hospital-based to assist hospital discharge staff and clients to develop and implement an individually tailored transition plan and facilitate post-discharge engagement in community-based support. Both the Peer Bridger program and TSP have a history of proven outcomes. For example, in the past, the Peer Bridger program reduced hospital days by 23.4 days per person one year after psychiatric hospital discharge. Inpatient admissions fell from an average of 1.6 per participant in the year preceding Peer Bridger program enrollment to 0.8 (a 50% reduction) per participant the year after implementation.

Expected outcomes

Through these approaches, KCACH expects to:

1. Reduce psychiatric admissions and readmissions (anticipated reduction is 30%–40%).
2. Reduce total number of psychiatric hospital days.
3. Increase enrollment in Medicaid.
4. Increase mental health and substance use disorder treatment penetration.
5. Improve overall health for participants.

**Target Population 3—High-risk Medicaid clients transitioning from hospitals, including older adults and people with disabilities.**

This initiative will expand both the APIC model and the Care Transitions Intervention/Coleman Model. The Coleman Model provides a four-week program for individuals with complex care needs and family caregivers to work with a coach and learn disease self-management skills and other tools to ensure their needs are met during the transition from hospital (or other facility) back home. In this strategy, KCACH will utilize a care coordinator (Transitions Coach®) to engage clients and their family caregivers

before release from a hospital or other setting to develop a comprehensive transition plan and assess community services and supports that are needed to ensure success. Once discharged, the care coordinator will conduct follow-up home visits with accompanying phone calls to improve self-management skills and ensure continuity across the transition back to the home and community.

The intervention sessions and follow-up will be documented in a common data system as described in Domain 1 to allow for seamless sharing of information and coordination through a single, shared care plan. This includes recording patient activation measures during each encounter, so readmission risk is regularly evaluated in the virtual care plan system (Coleman Model).

#### Expected outcomes

Implementing both APIC and the Coleman Model will result in the following outcomes:

1. Reduced hospital readmissions.
2. Fewer complications following discharge.
3. Reduced unplanned medical appointments post-discharge.
4. Increased family and client engagement in post-discharge treatment.
5. Significant use of shared care plans to ensure information sharing and coordination of services.
6. Improved overall health for participants.

While the total anticipated reach over one year will be 3,150 Medicaid beneficiaries, as a lower bound estimate, if 90 beneficiaries are enrolled and have a 30% reduction in readmission rate, there will be 27 people with reduced readmission within 30 days per care coordinator. The 35-member training cohort can be expected to result in 945 fewer readmissions.

#### ***What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?***

For all three target populations, multiple partnering providers have been engaged in the design process. Key partnering providers have hosted meetings, including Aging & Disability Services and Navos Mental Health Solutions. A diverse set of partnering providers participated in the Transitional Care Design Team, which drafted this project plan. The Design Team met multiple times per month for more than six months. Design team members include representatives from MCOs, hospitals, behavioral health providers, Federally Qualified Health Centers, individuals with lived experience in the criminal justice system, community-based organizations, correctional facilities, fire departments, philanthropy, recidivism policy advisors, and other representatives from relevant county and city agencies. Ongoing coordination with these and other entities, as well as other programs, will occur throughout the planning and implementation phases to ensure that additional capacity and spread of transition strategies are coordinated.

A number of different partnering providers are key to the success of this project and it will take significant work to ensure coordinated infrastructure that allows for seamless transitions from various institutions. Key partners include hospitals, jails, community health and behavioral health centers, community-based organizations (CBOs), and MCOs. In order to create successful transitions, multiple partners must work together and share information to produce strong outcomes.

***How did the ACH consider the level of impact when selecting the project's anticipated target population? (e.g., geography, subgroups)***

KCACH considered regional data and stakeholder subject matter expertise in the development of anticipated target populations. Preliminary target populations have been identified with the goal of reaching sufficient numbers of people to make needed performance metrics improvements, as well as to begin to address underlying issues of inequity in transitions of care. Evaluation findings from pilot projects improving transitions from jail and psychiatric inpatient stays suggest that more comprehensive implementation and greater scale can improve system metrics. Similarly, evaluations from past care coordination after hospital discharge show improvements can be made in readmission rates using the Coleman Model. All three target populations are served by partnering providers that have been working with the Transitional Care Design Team throughout 2017 and are ready to move to implementation rapidly in 2018.

Equity was a major driver in the selection of the three target populations and the anticipated level of impact. As illustrated above, there is an over-representation of people of color in the criminal justice system. Individuals with psychiatric diagnoses have faced a long history of discrimination and forced institutionalization. And finally, older adults and people with disabilities face widespread ageism and barriers to access and engagement in their communities. The ability of this project to address these inequities by supporting these populations to stay out of institutions and reach their full potential in their own homes and communities was a major consideration in the level of impact that this project seeks to achieve.

***How will the ACH ensure that health equity (e.g., demographic geographic) is addressed in the project design?***

KCACH is working to ensure improved health outcomes by addressing root causes and creating an environment that allows for all people to achieve their highest level of health. The biggest predictors of health involve an individual's race/ethnicity, income level, and neighborhood. Racism and discrimination also play a role in the health of communities, and the Design Team and other stakeholders have considered the ways in which institutions and organizations perpetuate bias and historical trauma.

KCACH is using the Equity Impact Assessment Tool (Equity Tool), developed by the KCACH Community/Consumer Voice Committee (CCV). The Transitional Care Design Team has applied an equity and social justice lens to inform the development of this plan. The Design Team utilized the process identified in the Equity Tool to develop the project proposal. This included examining disparities in outcomes by race/ethnicity, gender, geographic location, and income level as well as exploring strategies to engage impacted individuals. The Design Team is committed to deepening this practice during the planning and implementation phase. The project will prioritize interventions that address disparities faced by populations at risk of poorer outcomes—the jail population, people with mental health and substance use disorders, and high-risk people discharged from hospitals. Tribal partners will also be engaged to help with the design and implementation.

As noted earlier, significant disparities exist in the King County region. During the planning phase, the Transitional Care Design Team and others will receive more in-depth training on the use of the Equity

Tool and will use it, in partnership with members of the CCV, to continue to apply an equity lens to this work. All strategies described in the project will be assessed for their ability to address systemic and other barriers (including race/ethnicity, gender, geographic location, and income level) to accessing services and resources. Investments will be targeted toward regions and populations that represent the greatest disparities. Similar approaches to assuring health equity will be used with all target populations.

Some of the largest Medicaid providers in King County include providers who specialize in best practices in the care of minority and foreign-born populations including SeaMar, Asian Counseling and Referral Service, Therapeutic Health Services, HealthPoint, International Community Health Services, Refugee Women’s Alliance, Lutheran Community Services Northwest These agencies have culturally diverse staff and have established best practices within these populations. KCACH will draw on the expertise of these and other specialty practices as key partners in the planning and implementation phase for this project to ensure Medicaid beneficiaries have access to a robust network of culturally relevant providers. KCACH will also work with these agencies to identify groups that historically have not accessed care to build optimum ways of implementing bi-directional care.

***Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region’s overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies.***

Building and sustaining a robust transitional care infrastructure and continuum will enhance overall population health in King County and improve the delivery system. Facilitating smooth and effective transitions will ensure that people are not bouncing in and out of hospitals, jails or other facilities, but rather, have strong supports to achieve and maintain stability in the community. Providing individuals leaving institutions with strong transitional services and supports will reduce avoidable hospital utilization, ensure people are getting the right care in the right settings, reduce costs, and improve quality.

Establishing these programs for the highest need populations can demonstrate the applicability of these models for broader populations. In hospital settings, staff trained in the Coleman Model will have a heightened awareness regarding support during discharge that will impact their work with all clients. Additional workforce such as re-entry case management and community-based care coordinators will facilitate strong, bi-directional partnerships between the clinical health care delivery system and community-based services; focus on person-centered care; address social determinants of health, and help individuals set recovery goals.

#### **References**

<sup>1, 2</sup> Medicaid: Healthier Washington Data Dashboard, <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>. Accessed November 13, 2017.

<sup>3</sup> Medicaid: Healthier Washington Data Dashboard, <https://www.hca.wa.gov/about-hca/healthier-washington/data-dashboard>. Accessed November 13, 2017.

<sup>4</sup> Washington Health Alliance. (2015). *2015 Washington State Common Measure Set for Health Care Quality and Cost: Performance Results for Accountable Communities of Health Report*. <https://www.wacommunitycheckup.org/reports/>.

<sup>5</sup> Washington Health Alliance. (2014). *Hospital Readmissions and Outpatient Care: A Report on Hospital Readmissions and Post-Discharge Care for Commercially Insured Patients in Washington State*. <http://wahealthalliance.org/wp-content/uploads/2015/01/Hospital-Readmissions-and-Outpatient-Care.pdf>.

## Implementation Approach and Timing

Using the **Implementation Approach tabs of the ACH Project Plan Supplemental Data Workbook**, provide a short description of how the ACH will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH's selected projects.
- In the implementation approach descriptions:
  - Describe the ACHs general approach to accomplishing requirements.
  - Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
  - Specify which evidence-based approach option(s) will be used for the project.
  - If applicable, indicate in italics whether a project milestone can be completed earlier than the required deadline in the Completion Deadline column.

## Partnering Providers

*Partnering providers may include clinical providers, community-based organizations, county governments, and/or tribal governments and providers, among others. The list of partnering providers may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH must provide a final list and secure commitments from partnering providers.*

Using the **Partnering Providers tabs of the ACH Project Plan Supplemental Data Workbook**, list partnering providers that have expressed interest in supporting the development and implementation of the project.

Based on the ACH's selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook** (applicable workbook tabs must be submitted by December 15, 2017). Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization
- Employer Identification Number (EIN)
- Upload to Financial Executor portal

Describe engagement with partnering providers. In the narrative response, address the following:

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
- Describe process for ensuring partnering providers commit to serving the Medicaid population.
- Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented.  
Describe how the ACH is leveraging MCOs' expertise in project implementation, and ensuring there is no duplication.

## ACH Response

*Describe engagement with partnering providers:*

*King County ACH Project Plan (January 31, 2018)*

***Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.***

KCACH invited interested parties to a Community Learning Session (CLS) in March 2017 and 50 individuals attended. Following this session, the Community Health Council of King County convened a combined Design Team for Project 2B: Community-based Care Coordination and Project 2C: Transitional Care, and this group of 60+ individuals met bi-weekly until June. As mentioned above, multiple partnering providers who have among the highest Medicaid claims in King County have been engaged in the design process for all three target populations. They include organizations such as Harborview Medical Center, MultiCare Health System, Navos Mental Health Solutions, Sound Mental Health, Swedish Medical Center, and Valley Cities Counseling and Consultation. Design Team members include representatives from MCOs, individuals with lived experience in the criminal justice system, community-based organizations serving targeted populations, legal organizations, and representatives from relevant county and city agencies. Four of the five top hospitals for Medicaid admissions, emergency department visits, and outpatient visits participated in the Design Team. These represent more than half of all hospital utilization by Medicaid beneficiaries.

***Describe the process for ensuring partnering providers commit to serving the Medicaid population.***

Together, the Transitional Care Design Team members, project partners, Demonstration Project Committee, and KCACH Governing Board outlined and emphasized a collective commitment to serving the Medicaid population. First and foremost, almost all the project's partners have a long-standing commitment to working with and for Medicaid beneficiaries. Secondly, the project emphasizes mobilization of resources and strategies to better support Medicaid beneficiaries with health and behavioral health conditions. Additionally, all project partners must respond to and submit a nonbinding letter of interest to outline their commitment to transform the health care delivery system for Medicaid beneficiaries.

KCACH continues to conduct outreach to Medicaid providers to engage them and seek participation in MTP activities. KCACH conducted a provider survey in August and September 2017 to assess provider interest in participating in this and other projects. Individual follow-up will be done for those providers/health systems and dental practices who serve Medicaid beneficiaries but did not respond to the survey. All providers will be invited to participate in the planning phase in 2018 and will be asked to commit to a contract with the KCACH to implement the project.

***Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented.***

Successful integration and implementation of KCACH's care transitions project requires active participation by clinical organizations and CBOs from the very beginning. KCACH formed a Transitional Care Design Team to guide project plan development. Design Team meetings are open and transparent; interested individuals can participate in person and virtually over a webcast. The Design Team used Community Learning Sessions and electronic communications to increase opportunities for essential partners/stakeholders representing various sectors to provide input into project development. This feedback has informed the initial project scope and development of the Transitional Care Project.

Representatives from various sectors also participate in the Governing Board and the Demonstration Project Committee, which provide guidance and oversight to the various Design Teams to ensure an integrated project portfolio that builds upon the strengths and resources of each project and relevant community initiatives, to avoid duplicative efforts, and to ensure sustainability of the proposed strategies. Outreach to community-based organizations as well as consumers and individuals with lived experience will continue to be a focus as planning progresses.

KCACH is seeking to leverage broad and culturally diverse providers to drive health equity gains. By working with the top 50 providers of Medicaid services, KCACH will be including provider organizations that see large volumes of ethnic and culturally diverse populations—including SeaMar, Asian Counseling and Referral Service, Therapeutic Health Services, HealthPoint, International Community Health Services, Refugee Women’s Alliance, Lutheran Refugee/Asylum seeker program KCACH will also work with partner agencies to identify groups that historically have not accessed care to build optimum ways of implementing transitional care.

***Describe how the ACH is leveraging MCO’s expertise in project implementation, and ensuring there is no duplication.***

KCACH is leveraging MCO expertise in a number of ways. First, the Medicaid MCOs have a seat on the KCACH Governing Board, the decision-making body for the KCACH and authorizing body for the final project portfolio. All five Medicaid MCOs have also participated on the Demonstration Project Committee and have provided guidance to all Design Teams, including the Transitional Care Design Team on direction and alignment of projects. Finally, MCOs actively participated on the Transitional Care Design Team and are providing guidance related to project activities, contractual obligations, and health-system-related project implementation to help ensure efforts of the MTP align with MCO priorities and activities and do not duplicate. In addition, the Design Team will leverage MCO provider networks already serving Medicaid beneficiaries and work with them to expand that network as needed to ensure appropriate services, supports, and access.

United Healthcare, in particular, has been a partner in King County’s Familiar Faces initiative and has been working with local government, criminal justice, health care, and community partners to pilot a Transitional Care Project focused on utilizing CHWs to assist with the transition of Medicaid beneficiaries from the jail. Lessons learned from implementation of the Familiar Faces initiative have been used to inform the design of the overall KCACH transitional care strategy.

### **Regional Assets, Anticipated Challenges and Proposed Solutions**

Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions. In the narrative response, address the following:

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

### **ACH Response**

*Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions:*

*Describe the assets the ACH and regional partnering providers will bring to the project.*

A key asset in the King County region is the significant body of work that has already been done to create stronger, seamless care transitions from institutional facilities back to community. Some examples of assets that this project will leverage include:

- The Familiar Faces initiative: an initiative started under the King County Health and Human Services Transformation Project, the Familiar Faces initiative strives to improve the system for individuals with mental health and/or substance use disorders who are booked four or more times in jail in a twelve-month period. The Familiar Faces initiative has been working on a pilot with United Healthcare to improve care transitions for Medicaid beneficiaries leaving the jail. There are numerous lessons learned from this pilot that will be applied to implementation of the Transitional Care Project.
- Peer Bridger program: The Peer Bridger model utilizes the skills of peer support specialists to meet individuals while hospitalized due to a mental illness and assist with a successful transition back into the community and linkage to community-based services and supports.
- Transition Support Program (TSP): TSP provides a multidisciplinary team to assist individuals in making a successful transition from involuntary psychiatric hospitalization back to the community.
- Health Homes: King County recently implemented Health Homes for high-risk Medicaid individuals in the region. KCACH will work in partnership with MCOs and Care Coordination Organizations to support successful transitions and diversions from hospital and jails and ensure that the Transitional Care Project compliments and does not duplicate the activities of Health Homes.
- Housing First (1811 Eastlake) demonstration: This project provided housing and clinical services, and served individuals with chronic alcohol use and showed excellent clinical and hospital cost outcomes.
- The King County Care Partners program used a Coleman model approach to work with people after hospitalization and showed significantly improved outcomes in engagement with primary and specialty care and reduction in hospitalizations.
- The respite care at Jefferson Terrace provides a place with supportive services for homeless individuals after discharge from hospital settings.
- SCORE, where KCACH will begin work for the first target population, has a list of community assets that re-entry case management will use for referrals and to make strong connections.

*Describe the challenges or barriers to improving outcomes and lowering costs for the target population through this project.*

KCACH has identified the following challenges that may impact the success of this project:

- **Shortage of human and physical resources** (e.g., workforce, workforce preparation, referral sources): Lack of community-based resources during transition: For transitions to function smoothly, respite care and permanent supportive housing are critical needs

for the health care system. The shortage of available spaces for placements in the community is causing backlogs throughout the system including longer, unnecessary stays in hospital settings.

- Lack of adequate and affordable housing: The lack of adequate and affordable housing stock and structural barriers to housing for vulnerable populations with criminal records, and bad credit and US Department of Housing and Urban Development (HUD) homelessness requirements that exclude anyone who has been in an institution for 90 days or longer pose significant challenges for implementation of this project because housing is a key determinant of overall health and well-being.
- Workforce capacity issues: Challenges associated with hiring, training, and getting jail clearance for individuals with lived experience in the criminal justice system could impact the ability to implement successful jail transition programs.
- **Inadequate finance and reimbursement mechanisms:**
  - Inadequate financial incentives to sustain project: Operational challenges could be encountered, such as a lack of sustainable funding or value-based payment (VBP) arrangement to support the workforce needed to successfully implement transitions across settings. Furthermore, lack of resources to adequately train CHWs and peer support specialists will make them less effective in providing the services and supports necessary for success.
- **Lack of communication and data tools:**
  - Institutional racism: Addressing institutional racism and racial disproportionality may be a challenge in the project's efforts to ensure a culturally responsive approach to communities of color and marginalized communities.
  - Communication: Past lack of sustained and efficient cross-sector collaboration, cooperation, and communication around transition points, especially transition from jail settings, have presented challenges.

*Describe the ACH strategy for mitigating the identified risks and overcoming barriers.*

Foundational elements across all three target populations will help address the following risks and barriers:

- **People/physical resources:**
  - Ensuring comprehensive assessment of individual needs prior to discharge and strong support and assistance and connection to community-based services before and after discharge can address some of the needs of the target populations.
  - Supporting an expanded Peer Bridger program will help mitigate some of the operational challenges for employing people with lived experience.
- **Finance/reimbursement mechanisms:**
  - KCACH has an advocacy role to play to increase payment for and supply of permanent supportive housing in King County.
  - Creative and innovative models and strategies are needed to develop more affordable housing—for example, braiding multiple funding sources to incentivize building more affordable housing, by KCACH paying for services within affordable housing or by partnering with capital investors.
- **Communication/data tools:**
  - A multisector approach can foster better cooperation and collaboration. Developing

mechanisms for shared care plans can facilitate information sharing and coordination across sectors.

## Monitoring and Continuous Improvement

Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request. In the narrative response, address the following:

- Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?
- Describe the ACH's plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?
- Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.

### ACH Response

*Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request:*

*Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?*

To ensure activities are linked to desired outputs, process metrics, and outcome metrics (both short- and long-term), KCACH will develop a logic model for the portfolio at the start of the planning phase. The pay-for-reporting (P4R) and pay-for-performance (P4P) metrics provide a strong basis for monitoring successes and challenges, and the logic model may highlight additional metrics necessary to ensure a comprehensive monitoring strategy.

The RHNI's [presentation](#) of measure attribution by project illustrates the overlapping P4P monitoring needs across the project portfolio. KCACH will develop a similar online tool for P4R measures to identify opportunities for improved efficiency in monitoring common and/or related measures (see Section I, Population Health Management, Appendix 5). KCACH also will create a combined P4R and P4P monitoring online tool that reflects the logic model.

Key principles for monitoring include a focus on accuracy, efficiency, and minimizing participating provider burden. KCACH will establish processes to rapidly communicate successes and challenges to partnering providers and work with them to address problems and build on successes. KCACH will identify delays in project implementation using a continuous quality improvement approach and P4R measures that relate to timely implementation of projects (e.g., number of partners participating and number implementing each selected approach). Specifically, project implementation delays will be identified as differences between relevant P4R metrics and targets or expected outcomes as defined by the project implementation plan (yet to be developed). Additionally, KCACH will identify factors contributing to delays from a system/organizational perspective and address them in a timely manner through communication and coordination between KCACH and participating providers.

*Describe the ACHs plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?*

To both monitor day-to-day/real-time performance and support partnering providers to achieve continuous improvement, KCACH will likely use a web-based, dynamically updated project monitoring tool (e.g., Tableau) to facilitate both internal and external conversations around project performance. As KCACH develops its project implementation plan in 2018, KCACH will use predictive analytics to determine process and outcome metric milestones over a more frequently monitored timeline than that required by the State and the Centers for Medicare and Medicaid Services (CMS). These predictive analytics could be used to check the course of any given project and activity and determine its progress. By quantifying such project milestone gaps, KCACH staff and participating providers can use a continuous quality improvement framework to make needed adjustments to project implementation and/or ongoing operations.

KCACH will also convene regular forums with participating providers to discuss successes and challenges evident in the data. This will include learning session collaboratives—facilitated sessions where providers can share lessons learned about clinical and operational issues. KCACH will also continue to host a community meeting with providers to discuss important KCACH developments and identify resources.

This project’s monitoring and continuous improvement approach will focus on the following metrics:

- **Jail transitions.** KCACH will track jail bookings and jail days and connection to outpatient mental health, substance use, or medical care services. KCACH may also monitor inpatient admissions and emergency department (ED) visits.
- **Psychiatric hospitalization transitions.** KCACH will track number of clients served, readmissions, length of hospital stay (in days), and linkage to outpatient and community services and supports upon discharge.
- **Hospital inpatient admissions and length of stay for high-risk patients.** KCACH will monitor the number of clients served, readmissions, length of stay, and linkage or utilization of outpatient medical care or long-term care services and supports.

Lastly, KCACH will seek technical assistance (TA) with expertise in quality improvement science and with project-specific subject matter expertise to support partnering providers. Examples of organizations that could provide this type of TA include Qualis Health, the UW AIMS Center, and the Arcora Foundation. TA will be prioritized for providers who are struggling to meet performance goals.

*Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.*

KCACH will use a continuous quality improvement approach to identify project initiatives or strategies that are not working or not achieving desired outcomes. Specifically, the predictive analytics process will identify short-term process and outcome milestones that can support continuous quality improvement processes with participating providers. In addition to the project milestones, KCACH will

develop alert thresholds that will indicate when a project or strategy is off course and needs extra attention. KCACH will work within a project’s logic model to make adjustments where possible. In the scenario where a project or strategy continues to have significant problems despite repeated attempts to solve them, KCACH will consider and request more substantial modifications based on the factors contributing to the unexpected or undesirable performance issues

### Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

### Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

## Project Sustainability

Describe the ACH's strategy for long-term project sustainability, and its impact on Washington's health system transformation beyond the Demonstration period.

### ACH Response

#### *Describe the ACH's strategy for long-term project sustainability.*

During the course of the MTP, the cost of interventions to support care transitions will be offset by project incentive payments. Over time, this investment will generate significant savings to health care payers through reduced emergency room visits, inpatient hospital utilization, and readmissions. Local government also stands to benefit, assuming the census in the jails is reduced or grows more slowly than current trends.

After the MTP, payers will need to be incentivized to invest a portion of their savings to sustain the transition support deemed effective and to provide ongoing workforce support to continue implementation. This could be achieved through optional or mandatory provisions in MCO contracts and incentives to local government to redirect savings.

In addition to this strategy, long-term sustainability will also be developed through strategies for braided funding as well as VBP arrangements that use local resources to complement Medicaid-funded services and create shared savings. Long-term sustainability will depend on the results of performance measurements and the interventions' association with cost savings and/or population health and patient experience. Sustainability also will depend on KCACH partners' ability to align and braid funding from multiple sources into a more connected, higher-functioning system.

#### *Describe the project's impact on Washington's health system transformation beyond the Demonstration period.*

Opportunities for sustainability and a lasting impact on Washington's health system transformation include the following:

- A reduction in readmission rates and an improvement in health for the populations targeted by the project, demonstrating the value of a strong transitional care program and leading to broader adoption of such efforts in the state.
- Using re-entry case management and CHWs to demonstrate the efficacy of non-traditional health workers, leading to more widespread use of such workers and increased career pathways.
- Payment models adjusted to include payment for CHW time and interventions, such as accompanying clients to appointments.
- The value of a coordinated approach could facilitate an increase in bundled payments, VBP, and other types of reimbursement models.
- If demonstrated success of the Transitional Care Project offsets costs in other areas, such as criminal justice costs to King County government, savings could be redirected to invest further in transitional care activities as well as the community-based services and supports necessary to make this project successful (e.g., affordable housing).

## King County Accountable Community of Health Glossary

ACH	Accountable Community of Health
AI/AN	American Indian/Alaska Native
AIM	Analytics, Interoperability, and Measurement, part of HCA
AIMS	Advancing Integrated Mental Health Solutions, part of University of Washington
AMDG	Agency Medical Directors' Group
BHO	Behavioral Health Organization
BMI	body mass index
BRFSS	Behavioral Risk Factor Surveillance System
CMS	Centers for Medicare & Medicaid Services
CBO	community-based organizations
CCM	chronic care model
CCV	Community/Consumer Voice Committee
CDP	Chronic Disease Prevention and Control Project
CDR	Clinical Data Repository
CEO	chief executive officer
CHARS	Comprehensive Hospital Abstract Reporting System
CHW	Community health worker(s)
CLS	Community Learning Sessions
CMCH	Center for MultiCultural Health
CMS	Centers for Medicare & Medicaid Services
DCHS	Department of Community and Human Services
DPC	Demonstration Project Committee
DPP	Diabetes Prevention Program
DSHS	Department of Social and Health Services
DSRIP	Delivery System Reform Incentive Payment
DT	Design Team
DY1	DSRIP Year 1
ED	emergency department
EHR	electronic health record
FIMC	fully integrated managed care
FFS	fee-for-service
FPL	federal poverty level
FQHC	Federally Qualified Health Centers
G2P	Guidelines to Practice
HCA	Health Care Authority
HCP LAN	Health Care Payment Learning & Action Network
HHSTP	Health and Human Services Transformation Plan
HIE	health information exchange
HIT	health information technology
HKCC	Healthy King County Coalition
HUD	U.S. Department of Housing and Urban Development
IDC	Integration Design Committee
IHCP	Indian Health Care Provider
ILC	Interim Leadership Council
IOM	Institute of Medicine

IT	information technology
ITU	Indian Health Service, tribally operated, or urban Indian health program
JAMA	Journal of the American Medical Association
KCACH	King County Accountable Community of Health
LEAD	Law Enforcement Assisted Diversion
LGBT	Lesbian, Gay, Bisexual, and/or Transgender
LOI	letter of intent
MAT	Medication Assisted Treatment
MCO	managed care organization
MeHAF	Maine Health Access Foundation
MHIP	Mental Health Integration Program
MIDD	Mental Illness and Drug Dependency
MOU	memorandum of understanding
MTP	Medicaid Transformation Project(s)
MVP	Medicaid value-based purchasing
ODD	opioid use disorder
P4P	Pay-for-performance
P4R	Pay-for-reporting
PAL	Partnership Access Line
PCORI	Patient-Centered Outcomes Research Institute
PCP	primary care provider
PHSKC	Public Health – Seattle & King County
PIMH	Partnership for Innovation in Mental Health
PMD	Performance Measurement and Data
PMP	Prescription Monitoring Program
PRISM	Predictive Risk Intelligence System
PSH	Permanent Supportive Housing
QBS	Quality Benchmarking System
RHIP	Regional Health Improvement Plan
RHNI	Regional Health Needs Inventory
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCORE	South Correctional Entity
SIHB	Seattle Indian Health Board
SIM	State Innovation Model(s)
SUD	substance use disorder
TA	technical assistance
TSP	Transition Support Program
UIHI	Urban Indian Health Institute
US	United States
VBP	value-based payment
VOCAL-WA	Voices of Community Activists and Leaders, Washington state chapter
WSHA	Washington State Hospital Association
WSMA	Washington State Medical Association

## SECTION II: PROJECT-LEVEL

**Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).**

### Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
<b>Domain 2: Care Delivery Redesign</b>	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
<b>Domain 3: Prevention and Health Promotion</b>	
<input checked="" type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input type="checkbox"/>	3D: Chronic Disease Prevention and Control

### Project Selection & Expected Outcomes

*The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.*

Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following:

- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.
- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.
- Describe the anticipated scope of the project:
  - Describe the project’s anticipated target population. How many individuals does the ACH anticipate reaching through the project?
  - What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
  - How did the ACH consider the level of impact when selecting the project’s anticipated target population? (e.g., geography, subgroups, etc.)
  - How will the ACH ensure that health equity (e.g., demographic, geographic) is addressed in the project design?
- To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH region’s Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region’s overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies

## ACH Response

*Describe the rationale for project selection, and the expected outcomes:*

*Provide justification for selecting this project and how it addresses regional priorities.*

This project proposes a multipronged approach encompassing four essential components—prevention, treatment, overdose prevention, and recovery—to address a rising epidemic of opioid use, misuse, and abuse in King County.

Addressing opioid use is a regional priority for King County, and a required Medicaid Transformation Project (MTP). Similar to trends across the country, King County has experienced increasing rates of opioid-overdose deaths in the last decade. One-quarter of drug overdose deaths in Washington occur in King County—more than any other county in the state.<sup>1</sup> Nearly half of King County drug overdose deaths are attributable to opiates.<sup>2</sup> Furthermore, regional data demonstrate racial and ethnic disparities in drug overdose deaths. Compared to the King County average, the rate of fatal overdose is significantly higher among American Indians/Alaska Natives and Blacks, as well as residents of high-poverty neighborhoods.<sup>3</sup> Among Medicaid beneficiaries in King County, estimates are that only 35% of individuals diagnosed with an opioid use disorder (OUD) in 2016 are receiving medication-assisted treatment (MAT). This gap in access to treatment is even greater across racial groups, with 38% of non-Latino White Medicaid beneficiaries and 28% of non-Latino Black Medicaid beneficiaries receiving MAT.

In 2016, King County, in partnership with the city of Seattle and the city of Burien, formed the Heroin and Prescription Opiate Task Force (Opiate Task Force). Through a six-month, multisector collaborative process, the Opiate Task Force engaged stakeholders to evaluate regional needs and evidence-based practices to address the opioid crisis. This work resulted in recommendations to pursue strategies to prevent OUD, prevent overdose, improve access to treatment, and provide other supportive services. Throughout this work, the Opiate Task Force applied an equity and social justice lens, recognizing the inequities experienced by communities of color as a result of the “War on Drugs,” and focusing attention to ensure that strategies to address opioid use reduce rather than exacerbate racial disparities. The MTP enables the King County Accountable Community of Health (KCACH) to address a regional health priority that was identified prior to the MTP, and to build upon and accelerate strategies recommended by the Opiate Task Force.

*How will this project support sustainable health system transformation for the target population?*

This project will support sustainable health system transformation for the Medicaid population in the following ways:

1. Support providers to prescribe opioids appropriately and increase the number of providers trained on Washington State Agency Medical Directors Group (AMDG) Interagency Guideline of Prescribing Opioids for Pain, thereby resulting in a decrease in the number of Medicaid beneficiaries on high-dose chronic opioid therapy and patients with concurrent sedative prescriptions.
2. Increase access to MAT and overall substance use disorder treatment, resulting in an increase

in treatment penetration, and supporting individuals to receive treatment and recover from addiction. This includes low-barrier access to buprenorphine that provides for treatment on demand and work with managed care organization (MCO) partners to identify value-based payment (VBP) models that support easier access to MAT.

3. Support community partners and other stakeholders through training and distribution of naloxone kits, resulting in a decrease in opioid-related deaths.
4. Provide ongoing recovery support for Medicaid beneficiaries with OUD and linkage to a primary health home, resulting in long-term stabilization to help individuals achieve their full potential.

***Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.***

Building on and expanding the work of the Opiate Task Force, KCACH convened a broad range of partners engaged in opioid-related work throughout the county to form a Design Team. The Opioid Project Design Team included a range of hospitals (e.g., CHI Franciscan Health, Harborview Medical Center, and Valley Medical Center), behavioral health providers (e.g., Asian Counseling and Referral Service, Community Psychiatric Clinic, and Downtown Emergency Services Center), community health centers (e.g., HealthPoint, Neighborcare Health, Country Doctor Community Health Center), as well as community-based organizations (e.g., Friends of Youth) and managed care plans. There is significant overlap in membership of the Design Team and the Opiate Task Force to ensure that efforts complement each other and do not duplicate. The Design Team crafted the proposed project to fill current gaps, avoid duplication, leverage existing efforts, and target areas that require additional focus and resources in the four core areas discussed below: prevention, treatment, overdose prevention, and recovery. The Design Team considered all available funding sources to determine which strategies would be implemented under the MTP and which strategies could be implemented with other local funding sources. KCACH will continue to partner and collaborate with the Opiate Task Force throughout the planning and implementation of the project to ensure efforts are coordinated and not duplicated across the multiple strategies and funding sources, leveraging local resources as much as possible to maximize impact and achieve outcomes.

***Describe the anticipated scope of the project:***

***Anticipated target population and number of individuals the ACH anticipates reaching through the project.***

The target population for this project is the approximately 12,000 Medicaid beneficiaries with OUD and those additional beneficiaries where some service is rendered that would indicate a possible OUD, for example showing up with signs/symptoms of OUD in emergency departments, needle exchanges, primary care offices, etc. These individuals may not yet be diagnosed with an OUD but through system engagement can be screened and diagnosed with an OUD and then provide a pathway to treatment.

This project is not designed to support overall preventative screening for all beneficiaries. However, the coordination of this project with project 2A: Bi-directional Integration of Physical and Behavioral Health through Practice Transformation will include elements of preventative screening for individuals with potential substance use disorders, including OUD.

Below are the details of the project scope, partnering providers, and anticipated outcomes in each of the four core strategies of this project.

### **Project Strategies and Expected Outcomes**

#### **Strategy 1—Prevention: Improving Provider Prescribing Practices**

This strategy will offer providers additional support related to prescribing practices, accessing critical patient information and history at the point of care, and increasing non-opioid pain management strategies. According to the American Society of Addiction Medicine, in 2016, 80% of new heroin users started with misuse of prescription medicine.<sup>4</sup> Although data demonstrate that the prescribing of opioids and deaths related to prescription opioids in King County has decreased slightly over time, both are still too high.<sup>5</sup> In addition, statewide, only 30% of prescribers with a Drug Enforcement Administration license and only 51% of pharmacists are registered for the state's Prescription Monitoring Program (PMP).<sup>6</sup>

This strategy will:

- Distribute Washington State Medical Association (WSMA)/Washington State Hospital Association (WSHA)/ HCA opioid-prescribing variance reports that include feedback and comparison metrics. This allows prescribers to evaluate their prescribing practices relative to others in the state and to update and improve their practice with available information and training on the AMDG prescribing guidelines. KCACH will partner with local dental societies, MCOs, and the Arcora Foundation to include dentists in this strategy to improve their prescribing practices.
- Increase the use of the Prescription Monitoring Program (PMP) by physicians and dentists by facilitating integration of the PMP with electronic health record (EHR) systems and offsetting the administrative costs associated with manually checking the PMP (for those unable to integrate) to better inform prescribing practices.
- Promote adoption of the [Six Building Blocks](#) for opioid pain management by primary care providers and dentists and promote access to the team of Six Building Blocks experts and practice coaches for individual consultation and assistance with implementation within primary care practices.
- Support adoption of non-opioid pain management strategies where appropriate.

Through this effort, KCACH anticipates reaching the vast majority of prescribers in the county, especially those serving Medicaid beneficiaries, and, by extension, influencing the Medicaid population to gradually reduce the number of Medicaid beneficiaries and general King County population diagnosed with an OUD.

#### Expected outcomes

Increase in:

- Number of prescribers aware of their prescribing patterns and trained on the AMDG prescribing guidelines.
- Number of prescribers registered and querying the PMP.

- Access to non-opioid pain management strategies.

Reduction in:

- Prescription-opioid-related inpatient stays.
- Prescription-opioid-related outpatient emergency department visits.
- High-dose prescription-opioid chronic therapy.
- Concurrent sedative prescriptions.

### **Strategy 2—Treatment: Recognizing OUD, Linking, and Expanding Access to Treatment**

This strategy directly connects with KCACH's Project 2A: Bi-directional Integration, focused on delivering integrated, whole-person care by ensuring that Medicaid beneficiaries are screened for mental health and substance use disorder (SUD), including OUD, in primary care settings and can be linked to appropriate treatment. In recent years, physicians and dentists have reported low levels of readiness to identify SUD and assist patients in accessing treatment.<sup>7,8</sup> This has been echoed by multiple service providers engaged in the King County Opiate Task Force. When the path to accessing treatment is not clear, providers are less apt to attempt to engage in screening for a potential OUD. Once providers are more confident in being able to offer needed resources and linkage to treatment, they are more likely to engage in screening activities and engage in brief interventions. Enhanced care coordination is another underlying component of this strategy to ensure that the full range of needs for individuals with OUD can be addressed in an efficient and timely manner.

This project will expand access to buprenorphine, an evidence-based treatment for OUD, that can be prescribed by a variety of prescribers in office-based settings. Research demonstrates that appropriate use of MAT, including buprenorphine, can reduce OUD mortality by 50%. Although some clinical OUD treatment is available, access to MAT remains challenging for many individuals. While providing more MAT treatment throughout the county is important, based on the recommendations of the Opiate Task Force, KCACH will emphasize low-barrier access to MAT treatment for those in the community who are least likely to access traditional services. For instance, some populations do not have the same access to buprenorphine treatment as others and providing services in communities where people live is essential. To expand access to MAT, KCACH will consider new ways of initiating treatment, building capacity, and supporting care coordination. KCACH will also explore developing processes to divert individuals experiencing OUD from the criminal justice system so that they may access MAT treatment and recovery services in the community.

This strategy will:

- Provide clinicians, including dentists, with education and resources to support screening for OUD as part of a robust client-centered care approach, and create access and referral pathways to appropriate treatment. Many evidence-based SUD treatment programs have been implemented throughout King County. Provider education about the new resources and how to access them will be key. Special consideration will be given to culturally appropriate resources. Further, KCACH will work with providers to implement the Six Building Blocks, noted above.
- Build on care coordination infrastructure to ensure that the health and social needs of individuals with OUD are met through connection and linkage to a primary health home and an integrated care team.

- Establish low-barrier access points for treatment induction, coordination, and maintenance of care at behavioral health centers, community health centers, emergency departments, and other sites frequented by individuals with OUD seeking MAT.

Expected outcomes

- Increase provider confidence in recognizing and screening for OUD and connecting individuals to appropriate treatment, which will help increase substance use disorder treatment penetration for opioids.
- Increase the number of individuals with OUD who are receiving MAT and supportive services by initiating treatment in a variety of medical and behavioral health settings, and connecting individuals with community providers for ongoing maintenance and care.

**Strategy 3 – Overdose Prevention: Expanding Distribution of Naloxone**

In King County, heroin use continues to increase, resulting in a growing number of fatalities. In 2013, heroin overtook prescription opioids as the primary cause of opioid-overdose deaths. By 2014, heroin-involved deaths in King County totaled 156, their highest number since at least 1997 and a substantial increase since the lowest number recorded, 49, in 2009.<sup>9</sup> While death rates were not quite as high in 2015 and 2016, deaths continue to be a major public health problem in King County. This project will therefore expand training and distribution of naloxone kits to prevent opioid-overdose deaths.

Naloxone can reverse the effects of prescription-opioid and heroin overdose. Implementing naloxone distribution strategies throughout the county has the potential to reduce overdoses and save lives. This project targets individuals who are at risk for opioid abuse or who have a history of opioid-related overdoses as well as the individuals and service providers who are likely to come into contact with them. The number of individuals anticipated to be reached through this project is unclear; the impact of naloxone distribution will be quantified during the project planning phase.

Naloxone distribution to Medicaid beneficiaries diagnosed with OUD will build upon the efforts under way through the Opiate Task Force, which has already distributed over 2,800 naloxone kits within King County. Additional kits have also been distributed by Medicaid-funded behavioral health providers. Ongoing efforts to reach more of the 12,000 Medicaid beneficiaries and those who interact with them will continue. The goal is to reach as many as possible and to replenish supplies that expire after long periods of non-use.

Expected outcomes

- Reduce opioid-overdose deaths by providing at-risk individuals, and those who frequently interact with them, with take-home naloxone kits and supporting education.

**Strategy 4—Recovery: Promoting Long-Term Stabilization and Whole-Person Care**

This strategy directly connects with KCACH’s Project 2A: Bi-directional Integration, focused on delivering integrated, whole-person care by ensuring that Medicaid beneficiaries are screened for medical, mental health, and substance use disorders, including OUD, in primary care and behavioral health settings, and that they have access to an integrated, multidisciplinary care team through a primary health home. Implementation of this project will also include strong connections and referral pathways to Project 3D: Chronic Disease Prevention and Control and Project 2C: Transitional Care,

where appropriate. The overall goal of this strategy is to promote the long-term stability of individuals with or in recovery from OUD to support them to achieve their full potential. Experience has shown that the treatment system demonstrates improved flexibility, strength, and integrity when recovery principles are expressed throughout the transformation process and across all levels of the system. KCACH will engage in a thoughtful planning process that incorporates recovery principles in its opioid treatment and recovery plan. Peer support specialists will be included as a fundamental component of recovery and of the care team.

KCACH is committed to developing a workforce that ensures access to recovery supports through peer support specialists and/or community health workers for ongoing care coordination and linkages to social services that help individuals achieve and maintain long-term recovery.

#### Expected outcomes

- Increased number of individuals with primary health home receiving whole-person care.

#### ***What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?***

KCACH's Opioid Project work began at a February 2017 Community Learning Session, at which there was strong support and enthusiasm from the provider community. Approximately 80 individuals representing a wide range of health and behavioral health as well as community-based organizations expressed interest in the Opioid Project. Following the Community Learning Session, KCACH formed a Design Team, and members met, together or in subgroups, weekly or bi-weekly throughout the spring and summer of 2017. The Design Team has engaged a number of key partners throughout King County, including physicians, dentists, behavioral health providers, SUD providers, hospitals, community members, MCOs, human services (county and community-based), public health, state hospital and medical associations, and outcomes and quality organizations (see Workbook for complete list of agencies and organizations involved thus far).

Each of these organizations has a significant role to play in the design and implementation of this project both because of their deep knowledge of the subject matter and because of the role they play in transforming the delivery system. For example, physicians, dentists, and major health systems are necessary to help spread training and education about the AMDG prescribing guidelines and to establish policies within their organizations that support these prescribing practices. Health and behavioral health centers are essential partners for the development of low-barrier induction sites and increased access to MAT. For example, the King County Behavioral Health Organization (BHO) has recently been working with behavioral health providers to support psychiatrists to prescribe MAT, including buprenorphine, and to develop multidisciplinary care teams, including a nurse care manager, to treat the whole person. Hospitals, community-based organizations, and other providers will be critical referral sources and will provide care coordination to support the overall goals of the project.

#### ***How did the ACH consider the level of impact when selecting the project's anticipated target population? (e.g., geography, subgroups, etc.)***

KCACH took into consideration the prevalence of OUD across the county and by racial/ethnic group in identifying target populations in order to measure potential impact on communities facing disparities in addition to addressing county-wide needs. The Design Team also assessed current efforts in the region to determine where KCACH's interventions could add the most value while leveraging existing community resources and initiatives.

***How will the ACH ensure that health equity (e.g., demographic geographic) is addressed in the project design?***

KCACH is working to ensure improved health outcomes by addressing root causes and creating an environment that allows for all people to achieve their highest level of health. The biggest predictors of health involve an individual's ethnicity, income level, and neighborhood. Racism and discrimination also play a role in the health of communities, and the Design Team and other stakeholders have considered the ways in which institutions and organizations perpetuate bias and historical trauma.

KCACH is using the Equity Impact Assessment Tool (Equity Tool) developed by the KCACH Community/Consumer Voice Committee (CCV). The Design Team for this project utilized the process identified in the Equity Tool to develop the project proposal. This included examining disparities in outcomes by race/ethnicity, gender, geographic location, and income level as well as exploring strategies to engage individuals impacted by OUD. Individuals with lived experience, including peer support specialists, will be included on future planning and implementation teams to ensure that project design is driven by those most impacted by system transformation. Tribal partners will also be engaged to help with the design and implementation.

As noted earlier, significant disparities exist in the King County region in to opioid deaths and access to treatment. During the planning phase, this Design Team and others will receive more in-depth training on the use of the Equity Tool and will use it, in partnership with members of the CCV, to continue to apply an equity lens to this work. All strategies described in the project will be assessed for their ability to address systemic and other barriers (including race/ethnicity, gender, geographic location, and income level) to accessing services and resources. Investments will be targeted toward regions and populations that represent the greatest disparities. Similar approaches to ensuring health equity will be used with all target populations.

Some of the largest Medicaid providers in King County include providers who specialize in best practices in the care of minority and foreign-born populations: SeaMar, Asian Counseling and Referral Service, Therapeutic Health Services, HealthPoint, International Community Health Services, Refugee Women's Alliance, and Lutheran Community Services Northwest. These agencies have culturally diverse staff and have established best practices within these populations. KCACH will draw on the expertise of these and other specialty practices as key partners in the planning and implementation phase for this project to ensure that Medicaid beneficiaries have access to a robust network of culturally relevant providers. KCACH will also work with these agencies to identify groups that historically have not accessed care to build optimum ways of implementing bi-directional care and treating opioid addiction.

***Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region's overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies.***

Given the opioid crisis in King County, all four of the strategies described above, especially those focused on prevention and access to treatment, will benefit the Medicaid population. Long-term sustainable change will happen through improving prescriber knowledge of evidence-based approaches to opioid medication prescribing practices and through providing ongoing mechanisms for prescribers to evaluate their prescribing practices on a regular basis. This will decrease the overall reliance on opiates except when clinically indicated. A focus on providers, such that opioids are not prescribed in the first place, can make a significant difference in exposure to opiate medications. Champions will be identified within health systems to continue to promote and spread the use of evidence-based prescribing practices. The emphasis on low-barrier access to MAT and the integration of peer support specialists into the treatment structure will increase access and availability of treatment that is clinically and culturally relevant, thus increasing the likelihood of recovery. KCACH will work with MCO partners to develop VBP models that support and incentivize low-barrier access to MAT. Finally, developing strong bi-directional partnerships among providers and ensuring linkages to primary health homes for individuals in treatment through bi-directional care and community-based care coordination will ensure that individuals recovering from OUD are connected to ongoing services and supports to prevent relapse and promote overall health and well-being.

#### References

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- <sup>2</sup> King County Medical Examiner’s Office (unpublished).
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- <sup>5</sup> Banta-Green, C., et al. (Forthcoming 2017). “Drug Abuse Trends in the Seattle-King County Area: 2016.” Seattle, WA: Alcohol & Drug Abuse Institute, University of Washington.
- <sup>6</sup> Washington State Department of Health. (2017, June 15). *Prescription Monitoring: A Tool in Patient Care*. <https://static1.squarespace.com/static/52a0c420e4b0ffdab6d32159/t/594061812e69cfd8c0925d06/1497391500126/Prescription+Monitoring-A+Tool+in+Patient+Care.pdf>. Accessed August 4, 2017.
- <sup>7</sup> Shapiro, B., D. Coffa, E. McCance-Katz. (2013). “A Primary Care Approach to Substance Misuse.” *American Family Physician* 88(2):113–121.
- <sup>8</sup> Denisco, R.C., et al. (2011). “Prevention of Prescription Opioid Abuse.” *JADA* 142(7):800–810.
- <sup>9</sup> Banta-Green, C., et al. (2015). “Drug Abuse Trends in the Seattle-King County Area: 2014.” Seattle, WA: Alcohol & Drug Abuse Institute, University of Washington. [http://adai.washington.edu/pubs/cewg/Drug%20Trends\\_2014\\_final.pdf](http://adai.washington.edu/pubs/cewg/Drug%20Trends_2014_final.pdf).

## Implementation Approach and Timing

Using the **Implementation Approach** tabs of the **ACH Project Plan Supplemental Data Workbook**, provide a short description of how the ACH will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH’s selected projects.
- In the implementation approach descriptions:
  - Describe the ACHs general approach to accomplishing requirements.
  - Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
  - Specify which evidence-based approach option(s) will be used for the project.

- If applicable, indicate in italics whether a project milestone can be completed earlier than the required deadline in the Completion Deadline column.

### **Partnering Providers**

*Partnering providers may include clinical providers, community-based organizations, county governments, and/or tribal governments and providers, among others. The list of partnering providers may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH must provide a final list and secure commitments from partnering providers.*

Using the **Partnering Providers tabs of the ACH Project Plan Supplemental Data Workbook**, list partnering providers that have expressed interest in supporting the development and implementation of the project.

Based on the ACH’s selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook** (applicable workbook tabs must be submitted by December 15, 2017). Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization
- Employer Identification Number (EIN)
- Upload to Financial Executor portal

Describe engagement with partnering providers. In the narrative response, address the following:

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
  - Describe process for ensuring partnering providers commit to serving the Medicaid population.
  - Describe the process for engaging partnering providers that are critical to the project’s success, and ensuring that a broad spectrum of care and related social services is represented.
- Describe how the ACH is leveraging MCOs’ expertise in project implementation, and ensuring there is no duplication.

### **ACH Response**

*Describe engagement with partnering providers:*

*Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.*

KCACH has convened major Medicaid providers and others to engage stakeholders from throughout the medical, dental, and social services system. KCACH formed a Design Team to develop this project that engaged key partners throughout King County, including physicians, dentists, behavioral health providers, substance use disorder providers, hospitals, community members, MCOs, human services (county and community-based), public health, state hospital and medical associations, and outcomes and quality organizations. KCACH has used Medicaid claims data to identify the hospitals and health care providers that serve the highest numbers of Medicaid beneficiaries in the King County region. Of

the 58 highest-volume Medicaid providers, 21 were engaged with the Opioid Project design, including Harborview Medical Center, Community Psychiatric Clinic, Seattle Children's, University of Washington, SeaMar, a number of clinical labs, and Seattle Indian Health Board, to name a few. Outreach to the remaining large providers, especially those that are key to the successful implementation of this project as described above, will be conducted during the planning phase.

***Describe the process for ensuring partnering providers commit to serving the Medicaid population.***

Together, the Opioid Project Design Team members, project partners, Demonstration Project Committee, and KCACH Governing Board outlined and emphasized a collective commitment to serving the Medicaid population. First and foremost, almost all the project's partners have a long-standing commitment to working with and for Medicaid beneficiaries. Secondly, the project emphasizes mobilization of resources and strategies to better support Medicaid beneficiaries with health and behavioral health conditions. Additionally, all project partners must respond to and submit a nonbinding letter of interest to outline their commitment to transform the health care delivery system for Medicaid beneficiaries.

KCACH continues to conduct outreach to Medicaid providers to engage them and seek participation in MTP activities. KCACH conducted a provider survey in August and September 2017 to assess provider interest in participating in this and other projects. Individual follow-up will be done for those providers, health systems, and dental practices who serve Medicaid beneficiaries but did not respond to the survey. All providers will be invited to participate in the planning phase in 2018 and will be asked to commit to a contract with the KCACH to implement the project.

***Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented.***

Successful integration and implementation of KCACH's Opioid Project requires active participation by clinical and community-based organizations from the very beginning. KCACH formed an Opioid Project Design Team to guide project plan development. To form the Design Team, KCACH leveraged the work of the Opiate Task Force, whose membership complements that of the Design Team and includes tribal governments, first responders, hospitals, public safety, drug courts, public defenders and federal attorneys, civil rights organizations, needle exchange, pharmacy, and community action alliances. From initiation, the Opioid Project Design Team worked to ensure that the process included public input.

Design Team meetings are open and transparent; interested individuals can participate in person and virtually over a webcast. The Design Team used Community Learning Sessions and electronic communications to increase opportunities for essential partners and stakeholders representing various sectors to provide input into project development. This feedback has informed the initial project scope and development of the Opioid Project.

Representatives from various sectors also participate in the Governing Board and the Demonstration Project Committee, which provide guidance and oversight to the various Design Teams to ensure an integrated project portfolio that builds upon the strengths and resources of each project and relevant community initiatives, to avoid duplicative efforts and to ensure sustainability of the proposed strategies. Outreach to community-based organizations as well as consumers and individuals with

lived experience will continue to be a focus as planning progresses. Outreach to corrections and housing and employment providers also will be essential to success.

*Describe how the ACH is leveraging MCO's expertise in project implementation, and ensuring there is no duplication.*

KCACH is leveraging MCO expertise in a number of ways. First, the Medicaid MCOs have a seat on the KCACH Governing Board, the decision-making body for KCACH and the authorizing body for the final project portfolio. All five Medicaid MCOs have also participated on the Demonstration Project Committee and have provided guidance to all Design Teams, including the Opioid Project Design Team, on direction and alignment of projects. Finally, MCOs actively participated on the Opioid Project Design Team and are providing guidance related to project activities, contractual obligations, and health-system-related project implementation to help ensure that MTP efforts align with and do not duplicate MCO priorities and activities. In addition, the Design Team will leverage MCO provider networks already serving Medicaid beneficiaries and work with them to expand that network as needed to ensure appropriate services, supports, and access.

## **Regional Assets, Anticipated Challenges and Proposed Solutions**

Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions. In the narrative response, address the following:

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

### **ACH Response**

*Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions:*

*Describe the assets the ACH and regional partnering providers will bring to the project.*

A key asset in the King County region is the significant body of work that has already been done to address the opioid crisis through the Opiate Task Force. This work is ongoing and provides a framework for the efforts undertaken in this project. Participants are invested in addressing the opioid crisis, and KCACH will leverage those community resources moving forward. Many current medical and behavioral health providers are already engaged in communities where individuals with the greatest need reside. Engaging additional community-based organizations in those hard-hit communities will extend KCACH's reach and increase opportunities for success.

KCACH will consider the distribution of existing funding to identify gaps and leverage resources. For example, local public funding has been allocated to support a number of the Opiate Task Force recommendations. In addition, Valley Cities Counseling and Consultation and Harborview Medical Center recently received federal funding through the State of Washington to develop hub-and-spoke models of buprenorphine treatment. Finally, the King County Mental Illness and Drug Dependency

sales tax funding is being invested in supporting the prevention, treatment, and user health services recommendations of the Opiate Task Force.

Education efforts around the opiate epidemic have already begun in King County, including distribution of educational flyers to health care and other entities. Public Health – Seattle & King County is also planning social media activities to communicate the message of opioid use safety.

Finally, King County has a robust police diversion structure available through the expanded Law Enforcement Assisted Diversion (LEAD) program and a “RideAlong” app that coordinates and collects law enforcement information about approaches and alternatives available for people with behavioral health issues, including OUD. Furthermore, King County government and its associated partners working on the Familiar Faces initiative, an initiative focused on individuals with mental health and/or substance use conditions that have high jail utilization, to develop a single diversion portal that will improve the ability of first responders to divert individuals with behavioral health conditions to community-based services and supports, rather than booking them into jail.

To build on this work, KCACH is developing relationships with MCOs, the WSMA, the Washington WSHA, the Washington State Dental Association, the Bree Collaborative, and criminal justice partners to inform implementation planning so that MTP activities complement other regional efforts. These partnerships will assist KCACH in working with providers to understand prescribing practices, deliver training about pain management, and develop resources related to non-opioid pain management strategies.

***Describe the challenges or barriers to improving outcomes and lowering costs for the target population through this project.***

KCACH anticipates a number of challenges throughout the Opioid Project planning and implementation phases:

- **Shortage of human and physical resources** (e.g., workforce, workforce preparation, referral sources):
  - Engagement of prescribers to utilize PMP: There are no identified mechanisms to incentivize the use of the PMP by prescribers so that they can monitor their own prescribing practices. Engaging this group of prescribers and getting them to commit to practice transformation, including changing prescribing practices to align with the AMDG guidelines, will be difficult.
  - Non-opioid pain management strategies: Developing meaningful strategies to support non-opioid pain management approaches and getting prescribers to change their prescribing practices to align with AMDG guidelines will also be challenging.
- **Inadequate finance and reimbursement mechanisms:**
  - Behavioral health provider rate decreases: Among the greatest challenges is promoting system change related to the problem of OUD and increasing access to treatment at a time when many behavioral health providers are experiencing potential Medicaid rate decreases, which could result in significant workforce reductions and a decrease in available treatment capacity.
  - Lack of financial incentives: Behavioral health providers have indicated that financial incentives to expand MAT do not currently exist and would be necessary to create

increased capacity.

- **Lack of communication and data tools:**

- Addressing health disparities: Ensuring MAT expansion reaches those individuals and communities that have the greatest need in a manner that reduces overall health inequities will be difficult, especially since capacity to increase access is not available in all regions.

*Describe the ACH strategy for mitigating the identified risks and overcoming barriers.*

KCACH will use the following strategies to mitigate the identified challenges described above:

- **People/physical resources:**

- KCACH will use its community-based care coordination network as well as community-based organizations to ensure efficient and timely access to MAT resources.
- KCACH will work with resources such as the UW TelePain Service, MCOs, and dental and medical organizations to identify and integrate non-opioid pain resources and options into benefits for patients.

- **Finances/reimbursement mechanisms:**

- KCACH will work with the King County BHO and MCOs (once transitioned to fully integrated managed care) to address behavioral health rates and to develop VBP models that support effective treatment expansion.

- **Communication/data tools:**

- KCACH will partner with WSMA, WSHA, Washington State Dental Association, the Bree Collaborative, and others as the provisions of recently enacted HB 1427 and HB 2730 are implemented to incentivize PMP utilization. Market pressure may also influence EHR vendors to build in PMP and EHR integration to make PMP utilization simpler for prescribers.
- To ensure MAT treatment is expanded throughout the county in an equitable manner, receipt of MAT will be assessed by subgroup (e.g., by age, race/ethnicity, and geography). The KCACH will collaborate with behavioral health providers and community-based organizations to develop a strategy to improve access to MAT in underserved communities (e.g., using peer support specialists, community health workers, and other community-based care coordination to facilitate MAT referrals as suggested in other projects).

## Monitoring and Continuous Improvement

Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request. In the narrative response, address the following:

- Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?
- Describe the ACH's plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?

- Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.

## ACH Response

*Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request:*

*Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?*

To ensure activities are linked to desired outputs, process metrics, and outcome metrics (both short- and long-term), KCACH will develop a logic model for the portfolio at the start of the planning phase. Pay-for-reporting (P4R) and pay-for-performance (P4P) metrics provide a strong basis for monitoring successes and challenges, and the logic model may highlight additional metrics necessary to ensure a comprehensive monitoring strategy.

The Regional Health Needs Inventory's [presentation](#) of measure attribution by project illustrates the overlapping P4P monitoring needs across the project portfolio. KCACH will develop a similar online tool for P4R measures to identify opportunities for improved efficiency in monitoring common and/or related measures (see Section I, Population Health Management, Appendix 5). KCACH will also create a combined P4R and P4P monitoring online tool that reflects the logic model.

Key principles for monitoring include a focus on accuracy, efficiency, and minimizing participating provider burden. KCACH will establish processes to rapidly communicate successes and challenges to implementing partners and work with them to address problems and build on successes. KCACH will identify delays in project implementation using a continuous quality improvement approach and P4R measures that relate to timely implementation of projects (e.g., number of partners participating and number implementing each selected approach). Specifically, project implementation delays will be identified as differences between relevant P4R metrics and targets or expected outcomes as defined by the project implementation plan (yet to be developed). Additionally, KCACH will identify factors contributing to delays from a system/organizational perspective and address them in a timely manner through communication and coordination between KCACH and participating providers.

*Describe the ACHs plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?*

To both monitor day-to-day/real-time performance and support partnering providers to achieve continuous improvement, KCACH will likely use a web-based, dynamically updated project monitoring tool (e.g., Tableau) to facilitate both internal and external conversations around project performance. As KCACH develops its project implementation plan in 2018, predictive analytics will be used to determine process and outcome metric milestones over a more frequently monitored timeline than that required by the State and the Centers for Medicare and Medicaid Services. These predictive analytics could be used to check the course of any given project and activity and determine its progress. By quantifying such project milestone gaps, KCACH staff and participating providers can use

a continuous quality improvement framework to make needed adjustments to project implementation and/or ongoing operations.

KCACH will also convene regular forums with participating providers to discuss successes and challenges evident in the data. This will include learning session collaboratives—facilitated sessions where providers can share lessons learned about clinical and operational issues. KCACH will also continue to host a provider community meeting with providers to discuss important KCACH developments and identify resources.

The Opioid Project’s monitoring and continuous improvement approach will focus on the following measures and metrics:

- **Prevention:** KCACH will track the number of providers trained and/or given educational information about the AMDG guidelines; changes in prescribing practices by provider; and use of the PMP including modifications to EHRs.
- **Treatment:** KCACH will track MAT and other SUD penetration rates.
- **Overdose Prevention:** KCACH will track the numbers of naloxone kits distributed and individuals trained; and number of opiate-related deaths.
- **Recovery:** KCACH will track linkage to and engagement with a primary health home, peer support-related service provision, and improved health outcomes.

Lastly, KCACH will seek technical assistance (TA) with expertise in quality improvement science and with project-specific subject matter expertise to support partnering providers. Examples of organizations that could provide this type of TA include Qualis Health, the UW AIMS Center, and the Arcora Foundation. TA will be prioritized for providers who are struggling to meet performance goals.

*Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.*

KCACH will use a continuous quality improvement approach to identify project initiatives or strategies that are not working or not achieving desired outcomes. Specifically, the predictive analytics process will identify short-term process and outcome milestones that can support continuous quality improvement processes with participating providers. In addition to the project milestones, KCACH will develop alert thresholds that will indicate when a project or strategy is off course and needs extra attention. KCACH will work within a project’s logic model to make adjustments where possible. In the scenario where a project or strategy continues to have significant problems despite repeated attempts to solve them, KCACH will consider and request more substantial modifications based on the factors contributing to the unexpected or undesirable performance issues. KCACH, via the clinical innovations manager, will work with providers to identify any additional resources, training, TA, or other supports needed to improve care. For example, KCACH will seek TA with expertise in quality improvement science and with project-specific subject matter expertise to be available to support partnering providers to be successful in their efforts. Finally, during the planning phase, KCACH will engage in a plan-do-check-adjust continuous improvement process as plans move into the implementation phase.

## Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

### Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

### Project Sustainability

Describe the ACH’s strategy for long-term project sustainability, and its impact on Washington’s health system transformation beyond the Demonstration period.

#### ACH Response

*Describe the ACH’s strategy for long-term project sustainability.*

This project aims to build a sustainable approach to preventing OUD, treating it when it occurs, and preventing overdoses and deaths. KCACH will plan for long-term project sustainability throughout the MTP period. Opportunities for sustainability include the following:

- Sustainability of transformation in prescribing practices will occur through robust and comprehensive training of as many physicians, dentists, and other prescribers who prescribe pain medication on the AMDG guidelines and partnering with providers to develop policies in line with these guidelines. Informed providers will make more evidence-based decisions when it comes to prescribing and treating pain, thus reducing the overall rate and incidence of opiate use and abuse. Additionally, modifications to EHRs to accommodate integration of PMP to help inform prescribing practices are one-time investments that provide ongoing

return to avoid overprescribing and reduce the potential of opioids with concurrent sedatives.<sup>1</sup> Finally, providing providers with effective and efficient non-opioid pain management supports can help avoid initial opioid prescriptions. Once these non-opioid pain management strategies are learned, they can be offered to new and existing clients.

- The Quality Benchmarking System is a tool provided free of charge to member hospitals by the WSHA Patient Safety program. It is a secure web-based application that allows hospitals to input data and then track, compare, and analyze the data for use in quality improvement. KCACH may consider collaboration with WSHA to explore this option. Since it is already used, it may provide an additional opportunity for sustainability of this work.
- KCACH will work closely with MCOs and other partners to consider how payment models can be developed to sustain these new structures, particularly around low-barrier access to MAT. Both the care coordination and bi-directional integration of care strategies can also promote sustainability of expanded treatment approaches.

***Describe the project's impact on Washington's health system transformation beyond the Demonstration period.***

The initiative to develop MAT treatment infrastructure will develop resources that currently are not available and eventually will be Medicaid reimbursable, leading to sustainability. Although MAT is already a covered benefit through Medicaid, the project will help to eliminate the staffing and capacity barriers to developing new MAT programs.

Developing naloxone distribution mechanisms will lead to an ongoing practice of distributing this overdose prevention medication through health, behavioral health, housing, criminal justice, and other organizations. This practice coupled with enhanced treatment and conservative prescribing practices will prevent deaths, treat OUD, and prevent the disorder in the first place.

**Reference**

<sup>1</sup> Guy, G.P., Jr., K. Zhang, M.K. Bohm, et al. (2017). "Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015." *Morbidity and Mortality Weekly Report* 66:697–704. doi: <http://dx.doi.org/10.15585/mmwr.mm6626a>; A. Schuchat, D. Houry, G.P. Gery. "New Data on Opioid Use and Prescribing in the United States." *JAMA*. Published online July 6, 2017.

## King County Accountable Community of Health Glossary

ACH	Accountable Community of Health
AI/AN	American Indian/Alaska Native
AIM	Analytics, Interoperability, and Measurement, part of HCA
AIMS	Advancing Integrated Mental Health Solutions, part of University of Washington
AMDG	Agency Medical Directors' Group
BHO	Behavioral Health Organization
BMI	body mass index
BRFSS	Behavioral Risk Factor Surveillance System
CMS	Centers for Medicare & Medicaid Services
CBO	community-based organizations
CCM	chronic care model
CCV	Community/Consumer Voice Committee
CDP	Chronic Disease Prevention and Control Project
CDR	Clinical Data Repository
CEO	chief executive officer
CHARS	Comprehensive Hospital Abstract Reporting System
CHW	Community health worker(s)
CLS	Community Learning Sessions
CMCH	Center for MultiCultural Health
CMS	Centers for Medicare & Medicaid Services
DCHS	Department of Community and Human Services
DPC	Demonstration Project Committee
DPP	Diabetes Prevention Program
DSHS	Department of Social and Health Services
DSRIP	Delivery System Reform Incentive Payment
DT	Design Team
DY1	DSRIP Year 1
ED	emergency department
EHR	electronic health record
FIMC	fully integrated managed care
FFS	fee-for-service
FPL	federal poverty level
FQHC	Federally Qualified Health Centers
G2P	Guidelines to Practice
HCA	Health Care Authority
HCP LAN	Health Care Payment Learning & Action Network
HHSTP	Health and Human Services Transformation Plan
HIE	health information exchange
HIT	health information technology
HKCC	Healthy King County Coalition
HUD	U.S. Department of Housing and Urban Development
IDC	Integration Design Committee
IHCP	Indian Health Care Provider
ILC	Interim Leadership Council
IOM	Institute of Medicine

IT	information technology
ITU	Indian Health Service, tribally operated, or urban Indian health program
JAMA	Journal of the American Medical Association
KCACH	King County Accountable Community of Health
LEAD	Law Enforcement Assisted Diversion
LGBT	Lesbian, Gay, Bisexual, and/or Transgender
LOI	letter of intent
MAT	Medication Assisted Treatment
MCO	managed care organization
MeHAF	Maine Health Access Foundation
MHIP	Mental Health Integration Program
MIDD	Mental Illness and Drug Dependency
MOU	memorandum of understanding
MTP	Medicaid Transformation Project(s)
MVP	Medicaid value-based purchasing
ODD	opioid use disorder
P4P	Pay-for-performance
P4R	Pay-for-reporting
PAL	Partnership Access Line
PCORI	Patient-Centered Outcomes Research Institute
PCP	primary care provider
PHSKC	Public Health – Seattle & King County
PIMH	Partnership for Innovation in Mental Health
PMD	Performance Measurement and Data
PMP	Prescription Monitoring Program
PRISM	Predictive Risk Intelligence System
PSH	Permanent Supportive Housing
QBS	Quality Benchmarking System
RHIP	Regional Health Improvement Plan
RHNI	Regional Health Needs Inventory
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCORE	South Correctional Entity
SIHB	Seattle Indian Health Board
SIM	State Innovation Model(s)
SUD	substance use disorder
TA	technical assistance
TSP	Transition Support Program
UIHI	Urban Indian Health Institute
US	United States
VBP	value-based payment
VOCAL-WA	Voices of Community Activists and Leaders, Washington state chapter
WSHA	Washington State Hospital Association
WSMA	Washington State Medical Association

## SECTION II: PROJECT-LEVEL

**Section II (including selection of the relevant project from the menu) will need to be duplicated for each project selected (at least a minimum of four).**

### Transformation Project Description

Select the project from the menu below and complete the Section II questions for that project.

Menu of Transformation Projects	
<b>Domain 2: Care Delivery Redesign</b>	
<input type="checkbox"/>	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation (required)
<input type="checkbox"/>	2B: Community-Based Care Coordination
<input type="checkbox"/>	2C: Transitional Care
<input type="checkbox"/>	2D: Diversions Interventions
<b>Domain 3: Prevention and Health Promotion</b>	
<input type="checkbox"/>	3A: Addressing the Opioid Use Public Health Crisis (required)
<input type="checkbox"/>	3B: Reproductive and Maternal and Child Health
<input type="checkbox"/>	3C: Access to Oral Health Services
<input checked="" type="checkbox"/>	3D: Chronic Disease Prevention and Control

### Project Selection & Expected Outcomes

*The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.*

Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following:

- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.
- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.
- Describe the anticipated scope of the project:
  - Describe the project's anticipated target population. How many individuals does the ACH anticipate reaching through the project?
  - What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?
  - How did the ACH consider the level of impact when selecting the project's anticipated target population? (e.g., geography, subgroups, etc.)
  - How will the ACH ensure that health equity (e.g., demographic, geographic) is addressed in the project design?
- To support broad-reaching, system-wide transformation, projects must improve the efficiency and quality of care for the ACH region's Medicaid population. Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region's overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies.

## ACH Response

*Describe the rationale for project selection, and the expected outcomes:  
Provide justification for selecting this project and how it addresses regional priorities.*

The Chronic Disease Prevention and Control Project (CDP) integrates health system and community approaches to improve chronic disease management and control. Focusing on populations experiencing the greatest burden of chronic disease in King County, the target populations are child and adult Medicaid beneficiaries with or at risk for two high-prevalence and high-cost complexes: chronic respiratory disease (including asthma) and cardiovascular disease (including diabetes).

This project is a regional priority because chronic diseases are a leading cause of death and disability in King County, as well as a major contributor to overall health care costs and expenditures. In King County, 6 of the top 10 leading causes of death in 2015, and 4 of the top 10 leading causes of hospitalizations in 2010–2014 were due to a chronic condition.

Although chronic conditions are a leading cause of death and disability in King County, their development and/or negative health impacts are not equally experienced among individuals. An individual's level and quality of health is dependent upon where in King County the individual resides. For example, some census tracts in northeastern King County rank among the best in the nation for certain health conditions (e.g., ischemic heart disease) compared to other US counties. Other census tracts, such as those in southwestern King County, rank among the counties with the very worst rates of early death and diminished quality of life. Social determinants of health put certain populations (e.g., southwest King County residents) at greater risk for developing chronic conditions, such as asthma or diabetes. With one in five King County residents receiving Medicaid, many of whom reside in the southwestern region of the county, there is a staggering human and economic toll felt by Medicaid beneficiaries as a result of the negative health impacts of these conditions.

As physical and behavioral health care become integrated, along with strong care coordination for at-risk populations, there is an opportunity to incorporate a robust strategy for chronic disease control and prevention using the chronic care model (CCM). This evidence-based approach aids health system transformation because it “identifies the essential elements of a health care system that encourage high-quality chronic disease care” (The Chronic Care Model: Model Elements). There is increasingly strong evidence indicating oral disease is also a complicating factor in chronic disease management. Specifically, periodontal disease causes a systemic inflammatory response that if left unaddressed can impede progress in improving other chronic diseases. Activities that link CDP to Project 2A: Bi-directional Integration, including addressing oral health needs, will strengthen the project overall.

Woven into this foundation is a community health worker (CHW) model for chronic disease treatment and prevention that is based on the region's 20-year experience with the model, particularly in asthma and diabetes. The King County Asthma Program has shown a positive return on investment, due to lower use of rescue medication and fewer urgent care visits and hospitalizations resulting from CHW education and support to individuals and caregivers on proper use of medication, reduction of triggers in the home, and appropriate use of the health care system. For each dollar invested in the asthma program, Medicaid saved \$1.90.<sup>1</sup>

This project aims to reduce the impact or prevent the onset of complications connected to chronic conditions among high-risk individuals. It will develop a chronic disease management incentive payment program, initially focusing on disease bundles (e.g., a respiratory bundle and a cardiovascular bundle, including diabetes). Bundles would include a range of services including self-management programs, CHW services, and activities outside the clinic walls that support prevention and effective management of the selected chronic disease conditions. Ultimately, the bundles would be part of value-based payment (VBP) arrangements aimed at achieving chronic disease quality and outcome measures.

***How will this project support sustainable health system transformation for the target population?***

This project will support sustainable health system transformation for the Medicaid population in the following ways:

1. The CDP uses CHWs as a bridge between clinical and community-based strategies and providers. CHWs will be integrated in an individual's clinical care team and provide services (e.g., home health visits and connecting people to resources) that will mitigate the health care access, socioeconomic, and social support barriers experienced by individuals, all of which are critical social determinants of health. They will ensure bi-directional communication and offer supports that meet client concerns beyond the medical office.
2. The CDP supports chronic disease control and prevention with the CCM, a model utilizing CHWs with more than 20 years of proven efficacy in chronic disease prevention and treatment.
3. The project will support practice transformation that aligns with value based payment (VBP) arrangements focused on achieving chronic disease quality and outcome measures.
4. Over time, these strategies will have a widespread influence on the region's health system. KCACH will partner with managed care organizations (MCOs) to develop chronic disease bundles that can be sustained through VBP arrangements for both clinical and community-based providers. This will transform how care is provided and paid for, sustaining the model for all client populations, including the project's target population and all Medicaid beneficiaries.

***Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region.***

There are no other existing state or local efforts to develop a cardiovascular or respiratory disease bundle. The inclusion of community-based resources and services also makes this effort unique.

As described in the "Partnering Providers" response below, a wide range of provider groups participated in CDP planning, which supports coordination and leveraging of existing efforts. The CDP Design Team has coordinated with local efforts including Communities of Opportunity and Best Starts for Kids in reaching out to garner consumer input and interest in the project. In addition, the CDP will engage additional providers and community-based organizations (CBOs) during the planning phase and work to leverage any identified efforts focused on chronic disease management.

The multi-stakeholder Design Team will help reduce the likelihood of duplication of efforts and will engage regional partners (described in the Regional Partner Assets section), including the organizations currently supporting the use of both community and clinical resources (e.g., King County *Promotora* Network, Housing and Health Implementation Group, regional ethnic health boards, and the CHW Workgroup). KCACH will draw on the experience of the Community Health Worker Program of Public

Health – Seattle & King County (PHSKC) and partner with Federally Qualified Health Centers (FQHCs), housing authorities, and CBOs employing CHWs in clinical sites for lessons learned related to CDP implementation.

*Describe the anticipated scope of the project:*

*Anticipated target population and number of individuals the ACH anticipates reaching through the project.*

The sickest individuals already receive more intense case management from their health providers, while individuals who are highly activated more consistently manage their conditions with minimal assistance. The CDP will target individuals with poor health outcomes in between these extremes to improve their ability to manage their condition and avoid having their health deteriorate. Target Medicaid beneficiaries include adults and children with a high-impact chronic disease profile and one of two high-prevalence, high-cost complexes—chronic respiratory disease and cardiovascular disease (including type 2 diabetes).

Regional Health Needs Inventory (RHNI) data are not sufficient to identify the highest utilizers/highest-cost members, geographies with the highest utilizers, or highest-volume providers in hotspot geographies. Claims data alone do not support further definition of the target population. For example, claims and surveillance data disagree about the number of County residents with asthma and diabetes, with claims typically underestimating chronic disease prevalence, given that such data only represent individuals who actively use health care services (Table 15).

**Table 15. Medicaid Claims Versus Population-Based Surveillance Estimates of Chronic Disease Rates**

	Medicaid Claims, 2015 <sup>a</sup>	Population-Based Surveillance, 2014-2015 <sup>b</sup>
Adults with Asthma	8,074	31,195
Adults with Diabetes	14,980	18,283

Notes: Data from <sup>a</sup> Healthier Washington Dashboard; <sup>b</sup> Behavioral Risk Factor Surveillance System.

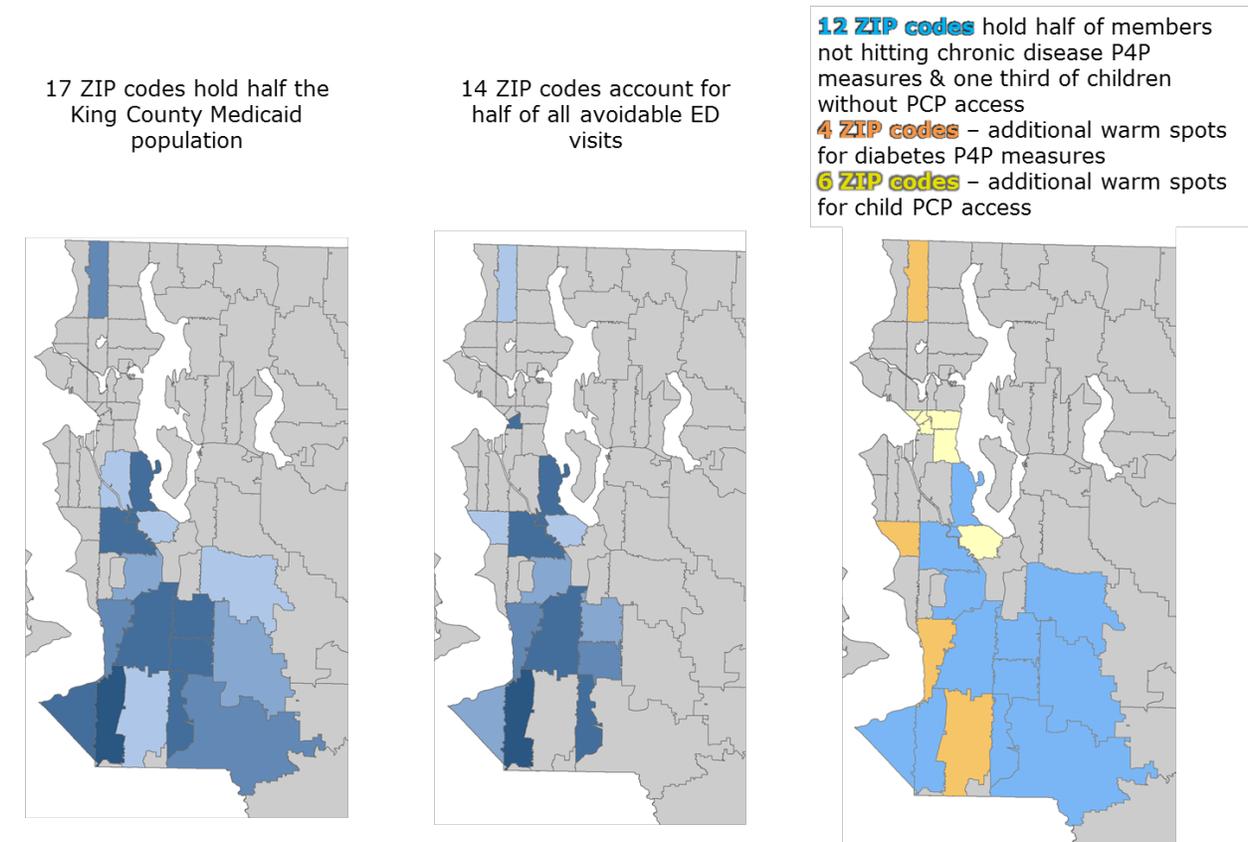
The CDP Design Team will continue to analyze state-provided and local population health and provider data to better identify the CDP target population of Medicaid recipients with diagnoses that include cardiovascular (diabetes and cardiovascular disease) and respiratory diseases (asthma and chronic obstructive pulmonary disease).

Medicaid claims data are sufficient to identify population-level disparities in chronic disease-specific clinical quality measures (i.e., pay-for-performance [P4P] metrics). For example, among Medicaid beneficiaries ages 18 to 64 with a claims-based diabetes diagnosis in the previous two years, members who did not have a blood sugar test in 2015 were:

- About twice as likely to be under age 35.
- About twice as likely to be American Indian/Alaska Native.
- About twice as likely to have a substance use disorder (SUD) treatment need.
- About twice as likely to have co-occurring mental illness and SUD.

Place is also a powerful predictor of the need for improved chronic disease prevention and management. The CDP Design Team noted a spatial correlation between the King County neighborhoods that comprise half of the county’s Medicaid clients, avoidable emergency department (ED) visits and CDP P4P measures (Figure 2). The CDP Design Team is identifying the parameters that will determine highest priority zip codes based on prevalence of target chronic disease populations and areas with the highest hospital and emergency department utilization for these and related conditions. Additional consideration will determine clinical and community providers who would be best positioned to launch this project during the Medicaid Transformation Project (MTP) period.

**Figure 2. Spatial Correlation Between Medicaid Enrollment, Avoidable ED Visits, and CDP P4P Measures**



Notes: CDP, Chronic Disease Prevention; ED, Emergency Department, PCP, primary care provider; P4P, pay for performance. PMD analysis based on Medicaid enrollment data and Healthier Washington Dashboard data.

The CDP Design Team is combining the equity-focused target population setting approach described above with a performance gap analysis to best identify how target populations can both address known health disparities and support King County Accountable Community of Health (KCACH) to reach its performance targets under the MTP. One key consideration in supporting the CDP to reach its P4P targets is to ensure that it partners with providers serving large numbers of Medicaid clients currently not hitting the P4P measures. Like the target population approach used by the bi-directional care project, the CDP will begin by partnering with highest-volume Medicaid providers, and over time will scale up to include additional providers and chronic diseases. As described in the Involvement of

Partnering Providers section below, health care providers that have expressed interest in partnering with the CDP cover 55%, 61%, and 37% of ED visits, hospitalizations, and outpatient/professional claims among King County Medicaid beneficiaries, respectively. Additionally, these partnering providers provide services to residents of the zip codes shown in Figure 2. This wide initial provider reach will be crucial as the CDP continues to identify its target population through using claims and provider data.

Finally, the CDP Design Team is using information about Medicaid beneficiaries with co-occurring behavioral health and chronic physical conditions to better understand opportunities for aligning target population settings with the bi-directional care project. As described above, the CDP will focus on both adults and children with one of two high-prevalence, high-cost complexes—chronic respiratory disease and cardiovascular disease (including type 2 diabetes). The CDP Design Team has noted a correlation between age and the likelihood of Medicaid beneficiaries having a co-occurring behavioral health and chronic disease. For example, Medicaid beneficiaries ages 30 to 59 make up 30% of the King County Medicaid population, but make up more than half (57%) of Medicaid beneficiaries with a mental health diagnosis or SUD treatment need and one or more chronic conditions. In contrast, Medicaid beneficiaries ages 12 to 29 make up 34% of the King County Medicaid population, but almost half (47%) of Medicaid beneficiaries with a mental health diagnosis or SUD treatment need only. Finally, children ages 0 to 19 make up half (50%) of Medicaid beneficiaries with one or more chronic conditions (and no behavioral health concerns). As expected, given the relationship between age and risk of chronic illness, in considering potential alignment of strategies with bi-directional care, chronic disease management will be particularly important for middle-age adults (ages 30 to 59) versus chronic disease prevention for younger adults (ages 12 to 29).

The total number of individuals that the KCACH anticipates initially reaching through the CD project is difficult to determine. As noted in the project proposal, there are significant discrepancies in the numbers derived through Medicaid claims data and those reported through surveillance data. However, using 2016 Medicaid claims data as a starting point, KCACH is proposing to reach approximately 7,600 children and adults experiencing chronic respiratory and/or cardiovascular diseases in the initial implementation phase of the MTP. This estimate is based on the number of Medicaid individuals who had one or more ED visits or hospitalizations where the primary diagnosis was a chronic disease (i.e., asthma, diabetes, COPD, ischemic heart disease or hypertension).

During the planning phase in early 2018, KCACH will work with the HCA and other ACHs to further refine a standardized approach to determining target populations, especially for those ACHs also implementing 3D: Chronic Disease Prevention and Control.

### **Project Strategies and Expected Outcomes**

This project strategy proposes to:

- Use CHWs to offer individuals additional support in culturally and linguistically appropriate ways. CHWs provide support where participants are most likely to be receptive and enable clinical providers to ensure that clients improve on all relevant metrics.
- Use panel data and registries to find, educate, provide care for, and track individuals, focusing on self-management support and available community resources. Participant data will be stratified by disease, risk, and family need.

- Redefine the composition of the care team to include additional client supports, such as social workers, pharmacists, registered dieticians, and CHWs.
- Mobilize community resources to form partnerships with health and behavioral health providers and developing, if needed, a referral system between community and clinical providers.
- Provide a mechanism for community-based patient self-management that will help individuals stay active, informed, and engaged in their care plan and result in more productive interactions with the health system and improved outcomes.
- Implement ICD-10 codes to track disease severity and use for VBP in the future.

#### Expected outcomes

As conceived, the CDP will look to reduce avoidable hospital and/or ED utilization by transforming the manner in which care is provided to and received by the project-defined at-risk population. This would result in:

- Redefining the health care team and including individualized client supports, enabling individuals to become activated and better able to manage their conditions over time and improve their self-management and/or health outcomes.
- CHWs provide support where participants are most likely to be receptive and enable clinical providers to ensure that patients improve on all relevant metrics.
- Development of a cohesive and non-duplicative referral system between community and clinical providers.
- Sustainable funding platform for community-based client self-management services and/or care team members.
- Development of a structure and function to manage and monitor populations of individuals with chronic illness to assure risk factors are treated and complications are identified for early intervention, thereby resulting in the identification and closing of high-priority gaps and reducing or avoiding the impact on downstream hospital and ED costs for the target population.

#### ***What types of partnering providers are involved in this project thus far, and why are they critical to the success of the project?***

Successful integration of the CCM in King County through the MTP will require full participation from a variety of stakeholders. The project aims to promote system transformation through supporting clinicians and clients both within and outside the clinic walls. Buy-in from stakeholders is extremely important to helping this change take place.

A diverse set of partnering providers participated in the CDP Design Team. The CDP Design Team met multiple times per month for more than six months and has worked to ensure continual inclusion of public input in this process. CDP Design Team members include representatives of health systems, health providers, community organizations, advocates, community health workers, and researchers.

Additional community partners and stakeholders participated in Community Learning Sessions with the aim of reviewing and providing input into the scope of the project. Approximately 30 partners participated in the Community Learning Session in the spring and another 45 in the summer of 2017.

These providers are critical to the success of the CDP project because they include organizations most likely to come into contact with individuals experiencing the identified chronic diseases and/or help support individuals with chronic disease to succeed in their community. Ongoing coordination with these and other entities, as well as other MTPs, will occur throughout the planning and implementation phases to ensure buy-in and adoption of strategies by participating providers.

***How did the ACH consider the level of impact when selecting the project's anticipated target population? (e.g., geography, subgroups, etc.)***

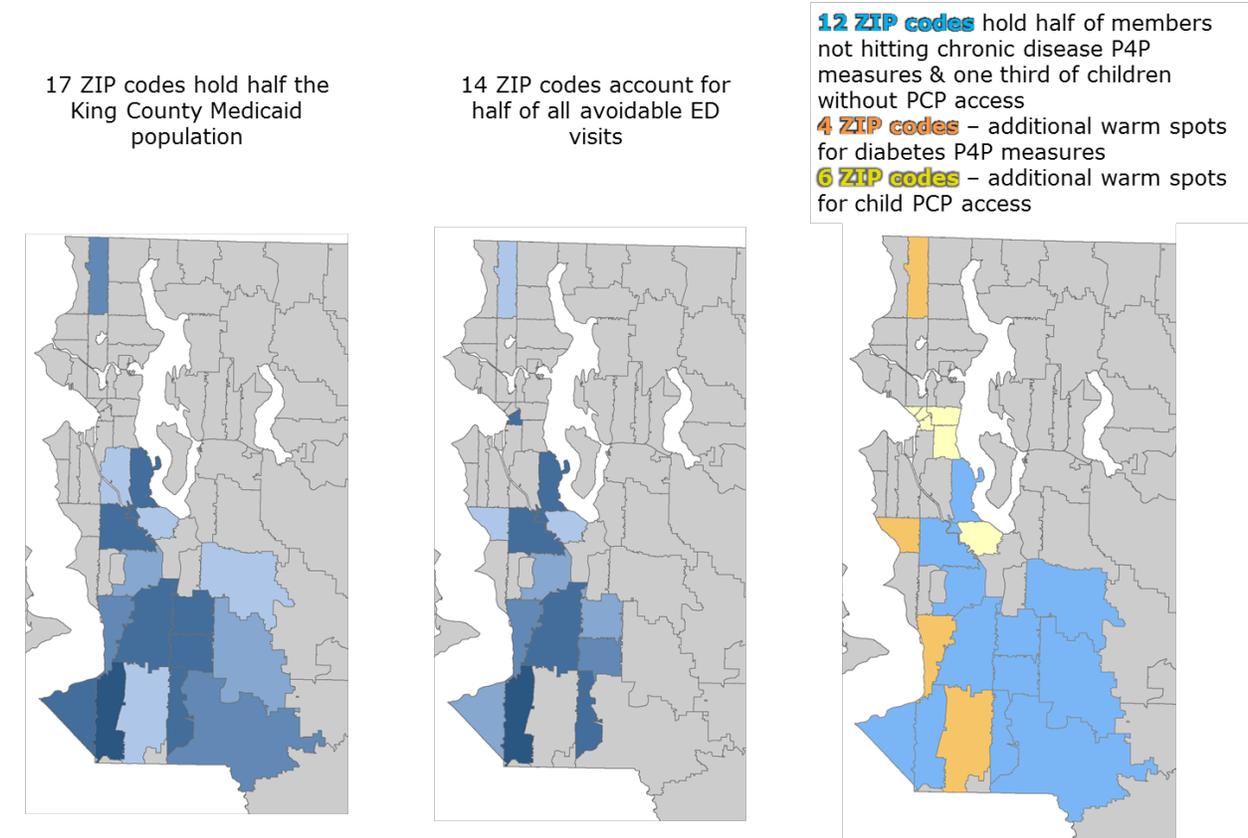
As described above, the selection of the target population is based upon who would most benefit from implementation of the evidence-based approaches—targeting those populations who are at highest risk of experiencing disproportionate outcomes, and regions where there are high proportions of Medicaid beneficiaries (e.g., people of color with uncontrolled chronic disease, who show up in ED for their chronic disease condition, and who live in south King County). The impact of this project on the target population will be better control of chronic conditions as measured by appropriate screening and testing and appropriate use of medication. KCACH also expects to see, because of better controlled chronic conditions, a reduction in inpatient hospitalization and outpatient ED.

Several important considerations contributed to KCACH's selecting Chronic Disease Prevention and Control as part of the project portfolio and selecting children and adults with respiratory disease and adults with cardiovascular disease as the initial target populations. First, RHNI data indicate that individuals with uncontrolled chronic diseases have a significantly high rate of avoidable ED visits, suggesting that implementation of evidence-based approaches that help to prevent and control chronic disease would have a significant impact on emergency room utilization and hospitalization rates. Ultimately, the aim of the CDP is to assure that individuals receive high quality treatment that includes chronic disease management support. Many of the sickest individuals already receive intensive case management from their health providers (via Health Homes and other intensive case management strategies), while individuals who are highly activated more consistently manage their conditions with minimal assistance. Therefore, the primary target of the CDP is individuals with poor controlled respiratory and cardiovascular diseases, who fall in between these two extremes, to improve their ability to manage their condition and avoid having their health deteriorate. That said, all chronic disease patients will benefit from quality improvement efforts to assure that providers are following evidence-based guidelines and practices.

Second, KCACH recognizes that place is also a powerful predictor of the need for improved chronic disease prevention and management. The CDP Design Team noted a spatial correlation between the King County neighborhoods that comprise half of the county's Medicaid clients, avoidable emergency department (ED) visits and CDP P4P measures (Figure 2). To achieve the target performance measures (P4P), KCACH proposes to target those geographies and providers where there is the most to gain from this work. Using this equity-focused target population approach, KCACH aims to reduce health disparities and improve chronic disease self-management for individuals who have historically not been served well by the healthcare system. (Note, the colored areas below also represent where there are

greater proportions of people of color and low-income populations that experience disparate health outcomes.)

**Figure 2. Spatial Correlation Between Medicaid Enrollment, Avoidable ED Visits, and CDP P4P Measures (i.e. Hot Spot mapping) – reprinted for reviewer convenience**



*Notes:* CDP, Chronic Disease Prevention; ED, Emergency Department, PCP, primary care provider; P4P, pay for performance. PMD analysis based on Medicaid enrollment data and Healthier Washington Dashboard data.

Finally, the CDP Design Team used information about Medicaid beneficiaries with co-occurring behavioral health and chronic physical conditions to better understand opportunities for aligning target populations across the CDP and the bi-directional care project. As described above, the CDP will focus on both adults and children with one of two high-prevalence, high-cost complexes—chronic respiratory disease and cardiovascular disease (including type 2 diabetes). The CDP Design Team has noted a correlation between age and the likelihood of Medicaid beneficiaries having a co-occurring behavioral health and chronic disease. For example, Medicaid beneficiaries ages 30 to 59 make up 30% of the King County Medicaid population, but make up 57% (73,698) of Medicaid beneficiaries with a mental health diagnosis or SUD treatment need and one or more chronic conditions. As expected, given the relationship between age and risk of chronic illness, in considering potential alignment of strategies with bi-directional care, chronic disease management will be particularly important for middle-age adults (ages 30 to 59) versus chronic disease prevention for younger adults (ages 12 to 29).

The selection of the Chronic Disease project and specific target populations also provides alignment with the KCACH's intention to engage evidence-based practices that meaningfully strengthen community-clinical linkages. For example, poor housing conditions are an important contributor to asthma episodes in children. Addressing housing quality as part of a coordinated and integrated approach to health and well-being results in a transformed system that is likely to produce better outcomes and address the whole needs of individuals involved.

***How will the ACH ensure that health equity (e.g., demographic geographic) is addressed in the project design?***

KCACH is working to ensure improved health outcomes by addressing root causes and creating an environment that enables all people to achieve their highest level of health. The biggest predictors of health involve an individual's ethnicity, income level, and neighborhood. Racism and discrimination also play a role in the health of communities, and the Design Team and other stakeholders have considered the ways in which institutions and organizations perpetuate bias and historical trauma.

KCACH is using the Equity Impact Assessment Tool (Equity Tool), developed by the KCACH Community/Consumer Voice Committee (CCV). The Chronic Disease Design Team has applied an equity and social justice lens to inform the development of this plan. The Design Team utilized the process identified in the Equity Tool to develop the project proposal. This included examining disparities in outcomes by race/ethnicity, gender, geographic location, and income level as well as exploring strategies to engage impacted individuals. The Design Team is committed to deepening this practice during the planning and implementation phase. Tribal partners will also continue to be engaged to help with the design and implementation.

Addressing significant health status and access-to-care issues is core to this effort, as indicated by the inclusion of CHWs in the individual's health care team. CHWs are uniquely positioned to be liaisons between systems (e.g., health, social service, legal, housing), the individual, and their family. CHW skills as advocates, outreach workers, and care coordinators have been demonstrated to help individuals and communities mitigate these challenges. The Institute of Medicine's (IOM) 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, recommends integrating trained CHWs into multidisciplinary health care teams using community-based, comprehensive approaches.<sup>2</sup> The IOM specifically urged the use and evaluation of CHWs among medically underserved, and racial and ethnic minorities.

As noted above, significant disparities exist in the King County region. During the planning phase, the Chronic Disease Design Team and others will receive more in-depth training on the use of the Equity Tool and will use it, in partnership with members of the CCV, to continue to apply an equity lens to this work. All strategies described in the project will be assessed for their ability to address systemic and other barriers (including race/ethnicity, gender, geographic location, and income level) to accessing services and resources. Investments will be targeted toward regions and populations that represent the greatest disparities. Similar approaches to assuring health equity will be used with all target populations.

Some of the largest Medicaid providers in King County include providers who specialize in best practices in the care of minority and foreign-born populations including SeaMar, Asian Counseling and Referral Service, Therapeutic Health Services, HealthPoint, International Community Health Services, Refugee Women's Alliance, and Lutheran Community Services Northwest. These agencies have culturally diverse

staff and have established best practices within these populations. KCACH will draw on the expertise of these and other specialty practices as key partners in the planning and implementation phase for this project to ensure Medicaid beneficiaries have access to a robust network of culturally relevant providers. KCACH will also work with these agencies to identify groups that historically have not accessed care to build optimum ways of implementing bi-directional care.

*Describe how the ACH will ensure the selected project will have lasting impacts and benefit the region's overall Medicaid population, regardless of chosen target population(s) or selected approaches/strategies.*

The CDP is a tool to push transformation through the adoption of VBP and greater integration of culturally responsive care for all Medicaid beneficiaries. The increased use of CHWs is expected to encourage primary and chronic care service use for county residents (beyond Medicaid beneficiaries) facing access barriers. Increased use of cost-effective services will improve outcomes. Adoption of best practices by clinical providers paired with VBP will promote integration of community supports with physical and behavioral health services for the improved health of all county residents. The long-term impacts are full integration of CHWs into the local health care system, allowing the region to maximize effectiveness and improve the health and well-being of King County individuals, families, and communities.

Implementation of this project will have lasting impacts and benefits to the King County region through a robust and comprehensive practice transformation in clinical, home, and community-based settings. Through training and technical assistance, KCACH will support providers in making infrastructure changes to electronic health records (EHRs), workflow, workforce, and implementation of evidence-based practices to better identify and manage chronic conditions. KCACH will also help practices develop and/or integrate into care coordination processes, community support service linkages, and evidence-based disease management programs (e.g. DPP, CDSMP, etc.), to include mechanisms for information sharing and shared care planning. Infrastructure investments and practice changes will be sustained over time through one-time financial investments in EHRs and other information technology (IT) modifications, as well as through shifts in policies and practices that will become standard practice across the region. Integrated, multidisciplinary care teams, including care coordinators and/or CHWs and/or peer support specialists, will be sustained by working with MCO partners to establish VBP models that support integrated care delivery and disease management supports as well as provide enough incentive and funding to sustain successful care models.

#### References

<sup>1</sup> Campbell JD, Brooks M, Hosokawa P, Robinson J, Song L, Krieger J. Community Health Worker Home Visits for Medicaid-Enrolled Children with Asthma: Effects on Asthma Outcomes and Costs. *Am J Public Health*. 2015; 105:2366-2372.

<sup>2</sup> Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/10260>.

## Implementation Approach and Timing

Using the **Implementation Approach** tabs of the **ACH Project Plan Supplemental Data Workbook**, provide a short description of how the ACH will accomplish each set of project milestones in Stage 1, Stage 2, and Stage 3.

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH’s selected projects.
- In the implementation approach descriptions:
  - Describe the ACHs general approach to accomplishing requirements.
  - Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
  - Specify which evidence-based approach option(s) will be used for the project.
  - If applicable, indicate in italics whether a project milestone can be completed earlier than the required deadline in the Completion Deadline column.

**Partnering Providers**

*Partnering providers may include clinical providers, community-based organizations, county governments, and/or tribal governments and providers, among others. The list of partnering providers may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH must provide a final list and secure commitments from partnering providers.*

Using the **Partnering Providers tabs of the ACH Project Plan Supplemental Data Workbook**, list partnering providers that have expressed interest in supporting the development and implementation of the project.

Based on the ACH’s selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook** (applicable workbook tabs must be submitted by December 15, 2017). Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization
- Employer Identification Number (EIN)
- Upload to Financial Executor portal

Describe engagement with partnering providers. In the narrative response, address the following:

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
- Describe process for ensuring partnering providers commit to serving the Medicaid population.
- Describe the process for engaging partnering providers that are critical to the project’s success, and ensuring that a broad spectrum of care and related social services is represented. Describe how the ACH is leveraging MCOs’ expertise in project implementation, and ensuring there is no duplication.

ACH Response
<p><i>Describe engagement with partnering providers:</i></p> <p><i>Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.</i></p>

The Chronic Disease Prevention and Control Project (CDP) has enjoyed robust participation by both clinical and community-based Medicaid providers who were involved in both the Design Team and the Community Learning Sessions. Additionally, core Design Team staff have been actively discussing with providers on a one-on-one basis to learn about their resources and possible linkages to this project. The information gleaned is archived, shared with the Design Team, and/or incorporated in the template. Examples of participating providers include Sea Mar, Molina Healthcare, United Healthcare, HealthPoint, Qualis Health, University of Washington, Center for MultiCultural Health, YWCA, YMCA, Sound Generations, Seattle Indian Health Board, Kaiser Permanente, and Mercy Housing Northwest. Many of these are some of the largest providers of Medicaid in the King County region.

As noted in Table 16, health care providers who have expressed interest in partnering with the CDP represent 55%, 61%, and 37% of total ED visits, hospitalizations, and outpatient/professional claims among King County Medicaid clients.

**Table 16. CDP Health Care Provider Partners and King County Medicaid Beneficiary Claims per ED Visits, Hospital Admissions, and Outpatient/Professional Claims**

Partnering health provider	ED visits	Hospital admissions	Outpatient & professional claims
Asian Counseling and Referral Service	-	-	53,555
Assured Independence	-	-	71
Catholic Community Services	-	-	16,216
CHI Franciscan Health	18,420	2,919	13,211
CHS Division of Public Health	-	-	84,396
Community Psychiatric Clinic	-	-	153,108
Country Doctor Community Health Center	-	-	18,351
Harborview Medical Center	23,540	5,188	144,348
HealthPoint	-	-	136,885
International Community Health Services	-	-	32,226
Kaiser Permanente WA	-	-	62,585
Navos Mental Health Solutions	-	740	207,949
Neighborcare Health	-	-	29,294
Northwest Kidney Centers	-	-	5,823
Odessa Brown Children's Clinic	-	-	2,498
Providence St. Joseph Health	1,547	773	32,986
SeaMar	-	-	86,802
Seattle Children's	13,801	2,087	99,113
Swedish Medical Center	39,061	11,346	253,697
Therapeutic Health Services	-	-	300,350
Transitional Resources	-	-	3,572
Valley Cities Counseling and Consultation	-	-	117,629
Valley Medical Center Clinic Network	33,964	6,822	212,585
<b>All partners combined</b>	<b>130,333</b>	<b>29,875</b>	<b>2,067,250</b>
<b>All providers serving King County</b>	<b>236,084</b>	<b>49,279</b>	<b>5,545,215</b>

<b>Percent covered by partners</b>	<b>55%</b>	<b>61%</b>	<b>37%</b>
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Data source: Provider Report Files, HCA AIM team, September 2017, based on 2016 fee-for-service claims (HCA Division of Behavioral Health & Recovery) and managed care encounters (MCO + BHO)

In addition to health care providers, a wide range of social service agencies and community-based organizations have expressed interest in partnering with the CDP, including the Center for MultiCultural Health, Chinese Information and Service Center, Neighborhood House, Recovery Cafe, Seattle Human Services Department Aging and Disability Services division, Somali Health Board, South Correctional Entity, University of Washington Health Promotion Research Center, WAPI Community Services, YMCA of Greater Seattle, and YWCA of Seattle, King, Snohomish. KCACH aims to work with King County 2-1-1 referral data (through the Crisis Clinic) to better understand demographic and geographic disparities regarding access to and referral to social services.

***Describe the process for ensuring partnering providers commit to serving the Medicaid population.***

Together, the CDP Design Team members, project partners, Demonstration Project Committee, and KCACH Governing Board outlined and emphasized a collective commitment to serving the Medicaid population. First and foremost, almost all the project’s partners have a long-standing commitment to working with and for Medicaid beneficiaries. Secondly, the project emphasizes mobilization of resources and strategies to better support Medicaid beneficiaries with health and behavioral health conditions. Additionally, all project partners must respond to and submit a nonbinding letter of interest to outline their commitment to transform the health care delivery system for Medicaid beneficiaries.

KCACH continues to conduct outreach to Medicaid providers to engage them and seek participation in MTP activities. KCACH conducted a provider survey in August and September 2017 to assess provider interest in participating in this and other projects. Individual follow-up will be done for those providers/health systems and dental practices who serve Medicaid beneficiaries but did not respond to the survey. All providers will be invited to participate in the planning phase in 2018 and will be asked to commit to a contract with the KCACH to implement the project.

***Describe the process for engaging partnering providers that are critical to the project’s success, and ensuring that a broad spectrum of care and related social services is represented.***

Successful integration and implementation of KCACH’s CDP requires active participation by clinical and community-based organizations. KCACH convened a CDP Design Team to guide project plan development. The Design Team worked to ensure the process included public input. Workgroup members were identified and recruited via a wide-ranging dialogue with clinical and community partners and stakeholders. The Design Team includes robust representation from health, quality improvement, and community organizations, Medicaid MCOs, advocates, providers, member representatives, and researchers. As project planning and implementation moves forward, additional key partners such as dental providers will be added to support the project. Due to their various roles in serving Medicaid populations and in ensuring health equity for all King County residents, many of these organizations, including MCOs, have invested human capital and support staff in the various Design Teams and project development.

The group’s meetings are open and transparent; interested individuals can participate in person and virtually over a webcast. Meeting minutes and recordings are also readily available. The Design Team used Community Learning Sessions and electronic communications to increase opportunities for essential partners/stakeholders representing various sectors to provide input into project development. This feedback informed the initial project scope and development of the CDP.

KCACH is seeking to leverage broad and culturally diverse providers to drive health equity gains. By working with the top 50 providers of Medicaid services, KCACH will be including provider organizations that see large volumes of ethnic and culturally diverse populations—including SeaMar, Asian Counseling and Referral Service, Therapeutic Health Services, HealthPoint, International Community Health Services, Refugee Women’s Alliance, and the Lutheran Refugee/Asylum seeker program. KCACH will also work with partner agencies to identify groups that historically have not accessed care in order to build optimum ways of implementing chronic disease care.

*Describe how the ACH is leveraging MCO’s expertise in project implementation, and ensuring there is no duplication.*

KCACH is leveraging MCO expertise in several ways. First, the Medicaid MCOs have a seat on the KCACH Governing Board, the decision-making body for the KCACH and authorizing body for the final project portfolio. All five Medicaid MCOs have also participated on the Demonstration Project Committee and have provided guidance to all Design Teams, including the CDP Design Team on direction and alignment of projects. Finally, MCOs actively participated on the CDP Design Team and are providing guidance related to project activities, contractual obligations, and health-system-related project implementation to help ensure efforts of the MTP align with MCO priorities and activities and do not duplicate. In addition, the Design Team will leverage MCO provider networks already serving Medicaid beneficiaries and work with them to expand that network as needed to ensure appropriate services, supports, and access.

## **Regional Assets, Anticipated Challenges and Proposed Solutions**

Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions. In the narrative response, address the following:

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

### **ACH Response**

*Describe regional assets that will be brought to the project, as well as anticipated challenges with the project and proposed solutions:*

*Describe the assets the ACH and regional partnering providers will bring to the project.*

Existing stakeholder groups represent various components of the CCM, contributing cross-disciplinary teams that link community and clinical resources: King County *Promotora* Network (CHWs); Housing

and Health Implementation Group (ACH State Innovations Model project); various ethnic health boards (e.g., Seattle Indian Health Board and Somali Health Board); Guidelines to Practice Asthma Quality Improvement; and the CHW Workgroup (Patient-Centered Outcomes Research Institute, funded by Kaiser Permanente).

Partner assets include:

- The Community Health Worker Program of PHSKC has 20 years of experience working with a CHW model that has improved asthma, diabetes, and hypertension health outcomes and has shown a return on investment for the asthma program. PHSKC’s CHW program has been high-quality comparative effectiveness trials, producing evidence-based programming. PHSKC’s evidence-based asthma program has been adopted nationally and has won national awards.
- FQHCs and housing authorities have grant-funded CHW staff co-located in their residential and public housing sites to support chronic disease and health management and increase access to primary and behavioral health services.
- Several CBOs employ CHWs who work with partners at clinical sites (e.g., Global to Local, Mercy Housing Northwest). For example, there are several Chronic Disease Self-Management (CDSM) and Diabetes Prevention Program (DPP) efforts led by CBOs (e.g., Mercy Housing Northwest and YMCA). The YMCA is working with local purchasers to include DPP as part of employee benefit packages for participating employees.
- KCACH partners include several leaders in evidence-based clinical quality improvement programs. For example, Healthy Hearts Northwest (MacColl Center), and Spirometry 360 provide asthma training and quality.
- The Arcora Foundation provides policy direction and technical assistance in oral health/dental needs for the Medicaid population. They will support this project through linkage to the Oral Health in Primary Care evidence-based model in HCA’s toolkit—this model supports integration and chronic disease management and will be supported by Qualis Health and Arcora Foundation.

***Describe the challenges or barriers to improving outcomes and lowering costs for the target population through this project.***

KCACH has identified a number of challenges and barriers to achieving the project outcomes including:

- **Shortage of human and physical resources** (e.g., workforce, workforce preparation, referral sources):
  - Purposes of empanelment (quality reporting and VBP supporting continuity in patient/care team relationships and matching panel demand for care with care team capacity).
  - Evolving scope of work for CHWs and other “non-traditional” care team members.
- **Finances/reimbursement mechanisms:**
  - Adding CHW positions to clinic teams and in community settings is expensive, since these services are non-billable. Adding capacity for self-management programs will also take resources. MTP funds can be invested into expanding the CHW workforce; sustainability beyond the five-year MTP period is unknown.
- **Communication/data tools:**

- Need to determine the optimal organizational framework for care coordination.
- Health IT features that support care management rely heavily on electronic health records (EHR) reporting functionality or reports from a clinical database in which EHR data are stored.
- Multidirectional, open communication is necessary between the beneficiary, care team, and community support network.

***Describe the ACH strategy for mitigating the identified risks and overcoming barriers.***

KCACH will use the following strategies to mitigate the identified challenges described above:

- **People/physical resources:**
  - Direct MTP funding to community-based organizations and clinical providers.
  - Develop a scope of work for the role of CHWs, pharmacists, registered dietitians, and social workers in self-management support, and how the health team is coordinated.
  - Develop protocols and a training plan to prepare the workforce to deliver these new protocols in a consistent and high-quality manner.
- **Finances/reimbursement mechanisms:**
  - Document current financial flows and reimbursement structures.
  - Engage payers (MCOs and state and county administrators) to develop new reimbursement methods based on disease bundles (e.g., respiratory and cardiovascular bundle, including diabetes).
  - Engage in ACH-level strategies to build infrastructure and transition to a VBP model that considers the number of payers involved, population for whom VBP is intended to influence, how providers are paid, and overall market structure.
  - Align payment and reimbursement reform approaches (e.g., reinvestment pool) toward sustainable funding for services and/or staffing previously categorized as non-Medicaid billable (e.g., CHWs, Diabetes Prevention Program, care coordination).
- **Communication/data tools:**
  - Organizational leadership support that optimizes health IT systems that allow care teams and chronic illness care managers to see what they are doing. (NextGen, a preventive asthma template, is proof-of-concept of interagency communication between CHWs and clinical practice).
  - Engage technical assistance in development of an appropriate data platform at the project and ACH levels.
  - Exchange information via:
    - Health information exchange for data transmission or storage/point-of-data access.
      - Patient locator: identifies each patient who receives care, and points the individual seeking information to its source.
    - Personal health record copy of key clinical information, stored on an electronic device or secure website that patients can access readily.
      - Use electronic communication systems (e.g., EHR, patient portals) that enhance communication by provider teams (including CHWs) and patients prior to and in the exam room and/or clinic.

## Monitoring and Continuous Improvement

Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request. In the narrative response, address the following:

- Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?
- Describe the ACH's plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?
- Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.

### ACH Response

*Describe the ACH's process for project monitoring and continuous improvement, and how this process will feed into a potential Project Plan modification request:*

*Describe the ACH's plan for monitoring project implementation progress. How will the ACH address delays in implementation?*

To ensure activities are linked to desired outputs, process metrics, and outcome metrics (both short- and long-term), KCACH will develop a logic model for the portfolio at the start of the planning phase. The pay-for-reporting (P4R) and pay-for-performance (P4P) metrics provide a strong basis for monitoring successes and challenges, and the logic model may highlight additional metrics necessary to ensure a comprehensive monitoring strategy.

The RHNI's [presentation](#) of measure attribution by project illustrates the overlapping P4P monitoring needs across the project portfolio. KCACH will develop a similar online tool for P4R measures to identify opportunities for improved efficiency in monitoring common and/or related measures (see Section I, Population Health Management, Appendix 5). KCACH also will create a combined P4R and P4P monitoring online tool that reflects the logic model.

Key principles for monitoring include a focus on accuracy, efficiency, and minimizing participating provider burden. KCACH will establish processes to rapidly communicate successes and challenges to implementing partners and work with them to address problems and build on successes. KCACH will identify delays in project implementation using a continuous quality improvement approach and P4R measures that relate to timely implementation of projects (e.g., number of partners participating and number implementing each selected model or approach). Specifically, project implementation delays will be identified as differences between relevant P4R measures and targets or expected outcomes as defined by the project implementation plan (yet to be developed). Additionally, KCACH will identify factors contributing to delays from a system/organizational perspective and address them in a timely manner through communication and coordination between KCACH and participating providers.

*Describe the ACHs plan for monitoring continuous improvement. How will the ACH support partnering providers to achieve continuous improvement? How will the ACH monitor day-to-day*

*performance and understand, in real-time, whether the ACH is on the path to reaching their expected outcomes?*

To both monitor day-to-day/real-time performance and support partnering providers to achieve continuous improvement, KCACH will likely use a web-based, dynamically updated project monitoring tool (e.g., Tableau) to facilitate both internal and external conversations around project performance. As KCACH develops its project implementation plan in 2018, KCACH will use predictive analytics to determine process and outcome metric milestones over a more frequently monitored timeline than that required by the State and the Centers for Medicare and Medicaid Services. These predictive analytics could be used to check the course of any given project and activity and determine its progress. By quantifying such project milestone gaps, KCACH staff and participating providers can use a continuous quality improvement framework to make needed adjustments to project implementation and/or ongoing operations.

KCACH will also convene regular forums with participating providers to discuss successes and challenges evident in the data. This will include learning session collaboratives—facilitated sessions where providers can share lessons learned about clinical and operational issues. KCACH will also continue to host a provider community meeting with providers to discuss important KCACH developments and identify resources.

The CDP's monitoring and continuous improvement approach will focus on the following measures and metrics:

- **Clinical preventive services:** measures that track enhanced integration between primary care, specialty medical care, behavioral health care, and pharmacy.
- **Clinical-community linkages:** degree of CHW integration in client caregiver teams, percentage of beneficiaries with high-impact chronic disease profile included in cross-sector client registry.
- **Beneficiary and caregiver supports:** measures that track expansion of CHW role in working with beneficiaries to manage chronic disease.

Lastly, KCACH will seek technical assistance (TA) with expertise in quality improvement science and with project-specific subject matter expertise to support partnering providers. Examples of organizations that could provide this type of TA include Qualis Health, the UW AIMS Center, and the Arcora Foundation. TA will be prioritized for providers who are struggling to meet performance goals.

*Describe how the ACH will identify and address project initiatives or strategies that are not working or are not achieving desired outcomes.*

KCACH will use a continuous quality improvement approach to identify project initiatives or strategies that are not working or are not achieving desired outcomes. Specifically, the predictive analytics process will identify short-term process and outcome milestones that can support continuous quality improvement processes with participating providers. In addition to the project milestones, KCACH will develop alert thresholds that will indicate when a project or strategy is off course and needs extra attention. KCACH will work within a project's logic model to make adjustments where possible. In the scenario where a project or strategy continues to have significant problems despite repeated

attempts to solve them, KCACH will consider and request more substantial modifications based on the factors contributing to the unexpected or undesirable performance issues. KCACH, via the clinical innovations manager, will work with providers to identify any additional resources, training, TA, or other supports needed to improve care. For example, KCACH will seek TA with expertise in quality improvement science and with project-specific subject matter expertise to be available to support partnering providers to be successful in their efforts. Finally, during the planning phase, KCACH will engage in a plan-do-check-adjust continuous improvement process as plans move into the implementation phase.

### Project Metrics and Reporting Requirements

Attest that the ACH understands and accepts the responsibilities and requirements for reporting on all metrics for required and selected projects. These responsibilities and requirements consist of:

- *Reporting semi-annually on project implementation progress.*
- *Updating provider rosters involved in project activities.*

YES	NO
X	

### Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*
- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

### Project Sustainability

Describe the ACH’s strategy for long-term project sustainability, and its impact on Washington’s health system transformation beyond the Demonstration period.

#### ACH Response

*Describe the ACH’s strategy for long-term project sustainability.*

The structure of the CDP strategies will lead to their long-term sustainability, especially as the MTP moves toward VBP arrangements. With the development of a VBP structure, services and staffing that

were previously not supported by Medicaid (e.g., CHWs, care coordination, and chronic disease self-management) will become integrated into how care is provided and funded, similar to how Medicaid funds clinical practices (e.g., referrals to specialists and physical therapy).

The CDP will contribute to the MTP's long-term sustainability by:

- Utilizing panel data and registries to find, educate, care, and track patients by disease, risk, self-management, community, and family need.
- Redefining the composition of the care team to include additional client supports such as social workers, pharmacists, registered dietitians, and community health workers.
- Providing a mechanism for sustainable self-management support for individuals to help them stay engaged in their care plan, result in more productive interactions with the health system, improve outcomes, mobilize community resources, and strengthen a referral system between community and clinical providers.
- Developing an incentive payment program (i.e., chronic disease management) that initially centers on identified chronic disease bundles.
- Developing sustainable funding for services and/or staffing that were previously categorized as non-Medicaid billable (e.g., CHWs, Diabetes Prevention Program, and care coordination).
- Focusing on community and clinical provider capacity building, workforce development, and addressing the social determinants of health.

***Describe the project's impact on Washington's health system transformation beyond the Demonstration period.***

The CDP will help providers incorporate community-based care coordination and chronic disease management into how they do business so that this practice becomes "the new norm." CHWs and other program elements will reduce clinical costs, and the savings can be funneled back into the program, including paying for services currently not funded by Medicaid. During the project, KCACH and its partners will track services and outcomes to identify how financial support for CHWs affects what services are used and whether health is improved. This information can be used to build VBP arrangements that will support ongoing chronic disease management activities after the project ends.

CDP strategies can be incorporated into care delivery across disease conditions and payers. The CDP and other KCACH projects will transform how care is provided for all individuals and create a healthier county and state population by incorporating CHWs as key treatment team partners in care delivery and building strong partnerships between clinical care teams and community-based services. CHWs will help bring people into care, improve the cultural and linguistic responsiveness of care, and support self-management. These improvements will help reduce costs, allowing further investment in appropriate care that values outcomes over number of services for all people seeking care in Washington.

The CDP will track health care utilization and resulting costs of the individuals who participate in CHW home visits. As the project shows cost savings and more appropriate utilization, the MCOs will be engaged to determine the feasibility of including CHW services in their benefit package for Medicaid enrollees.

## King County Accountable Community of Health Glossary

ACH	Accountable Community of Health
AI/AN	American Indian/Alaska Native
AIM	Analytics, Interoperability, and Measurement, part of HCA
AIMS	Advancing Integrated Mental Health Solutions, part of University of Washington
AMDG	Agency Medical Directors' Group
BHO	Behavioral Health Organization
BMI	body mass index
BRFSS	Behavioral Risk Factor Surveillance System
CMS	Centers for Medicare & Medicaid Services
CBO	community-based organizations
CCM	chronic care model
CCV	Community/Consumer Voice Committee
CDP	Chronic Disease Prevention and Control Project
CDR	Clinical Data Repository
CEO	chief executive officer
CHARS	Comprehensive Hospital Abstract Reporting System
CHW	Community health worker(s)
CLS	Community Learning Sessions
CMCH	Center for MultiCultural Health
CMS	Centers for Medicare & Medicaid Services
DCHS	Department of Community and Human Services
DPC	Demonstration Project Committee
DPP	Diabetes Prevention Program
DSHS	Department of Social and Health Services
DSRIP	Delivery System Reform Incentive Payment
DT	Design Team
DY1	DSRIP Year 1
ED	emergency department
EHR	electronic health record
FIMC	fully integrated managed care
FFS	fee-for-service
FPL	federal poverty level
FQHC	Federally Qualified Health Centers
G2P	Guidelines to Practice
HCA	Health Care Authority
HCP LAN	Health Care Payment Learning & Action Network
HHSTP	Health and Human Services Transformation Plan
HIE	health information exchange
HIT	health information technology
HKCC	Healthy King County Coalition
HUD	U.S. Department of Housing and Urban Development
IDC	Integration Design Committee
IHCP	Indian Health Care Provider
ILC	Interim Leadership Council
IOM	Institute of Medicine

IT	information technology
ITU	Indian Health Service, tribally operated, or urban Indian health program
JAMA	Journal of the American Medical Association
KCACH	King County Accountable Community of Health
LEAD	Law Enforcement Assisted Diversion
LGBT	Lesbian, Gay, Bisexual, and/or Transgender
LOI	letter of intent
MAT	Medication Assisted Treatment
MCO	managed care organization
MeHAF	Maine Health Access Foundation
MHIP	Mental Health Integration Program
MIDD	Mental Illness and Drug Dependency
MOU	memorandum of understanding
MTP	Medicaid Transformation Project(s)
MVP	Medicaid value-based purchasing
ODD	opioid use disorder
P4P	Pay-for-performance
P4R	Pay-for-reporting
PAL	Partnership Access Line
PCORI	Patient-Centered Outcomes Research Institute
PCP	primary care provider
PHSKC	Public Health – Seattle & King County
PIMH	Partnership for Innovation in Mental Health
PMD	Performance Measurement and Data
PMP	Prescription Monitoring Program
PRISM	Predictive Risk Intelligence System
PSH	Permanent Supportive Housing
QBS	Quality Benchmarking System
RHIP	Regional Health Improvement Plan
RHNI	Regional Health Needs Inventory
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCORE	South Correctional Entity
SIHB	Seattle Indian Health Board
SIM	State Innovation Model(s)
SUD	substance use disorder
TA	technical assistance
TSP	Transition Support Program
UIHI	Urban Indian Health Institute
US	United States
VBP	value-based payment
VOCAL-WA	Voices of Community Activists and Leaders, Washington state chapter
WSHA	Washington State Hospital Association
WSMA	Washington State Medical Association