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CERTIFIED PUBLIC ACCOUNTANTS

Produced by Myers and Stauffer on behalf of the Washington Health Care Authority

Healthier Washington Medicaid Transformation Accountable Communities of Health Semi-annual Reporting Guidance

SAR 4.0

Reporting Period:

July 1, 2019 – December 31, 2019

Template Release Date: August 7, 2019

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Semi-annual report information and submission instructions

Purpose and objectives of ACH semi-annual reporting

As required by the Healthier Washington Medicaid Transformation’s Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit semi-annual reports on project implementation and progress milestones. ACHs submit documentation per the requirements of the reporting guidance. The guidance will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each year of the Medicaid Transformation:

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

The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved project plans and corresponding implementation plans. The Washington State Health Care Authority (HCA) and the state’s contracted Independent Assessor (IA) will review semi-annual report submissions.

The ACH may be called upon to share additional information that supports the responses submitted for the purposes of monitoring and auditing, or for general follow-up and learning discussions with HCA, the IA and/or the Independent External Evaluator (IEE).

Reporting requirements

The semi-annual report for this period (July 1, 2019 to December 31, 2019) includes four sections as outlined in the table below.

Semi-annual reporting requirements (July 1, 2019 – December 31, 2019)		
Section	Item num	Sub-section components
Section 1. ACH organizational updates	1-8	Attestations
	9-13	Attachments/documentation <ul style="list-style-type: none"> - Key staff position changes - Budget/funds flow update
Section 2. Project implementation status update	14-16	Attachments/documentation <ul style="list-style-type: none"> - Implementation work plan - Partnering provider roster - Quality improvement strategy update
	17-19	Narrative responses <ul style="list-style-type: none"> - General implementation update - Regional integrated managed care implementation update
	20	Attestations
Section 3. Value-based payment	21-23	Narrative responses
Section 4. Pay-for-Reporting (P4R) metrics	24	Documentation

There is no set template for the semi annual report. ACHs have flexibility in how to put together the report, as long as all required elements are clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

Achievement values

Throughout the transformation, each ACH can earn achievement values (AVs), which are point values assigned to the following:

1. Reporting on project implementation progress (Pay-for-Reporting, or P4R).
2. Performance on outcome metrics for an associated payment period (Pay-for-Performance, or P4P).
3. Reporting on Value Based Payment (VBP) milestones (Pay-for-Reporting, or P4R).

ACHs can earn AVs by providing evidence they completed reporting requirements and demonstrated performance on outcome metrics. The amount of incentives paid to an ACH region will be based on the number of earned AVs out of total possible AVs for a given payment period.

For DY 3, 75% of Project Incentives are earned through P4R, while 25% are earned through performance on P4P. This semi-annual report covering the period of July 1 through December 31, 2019 determines achievement for half of the available P4R-associated Project Incentives.

AVs associated with Project Incentives for this reporting period are identified in the table below.

Table 1. Potential P4R Achievement Values (AVs) by ACH by Project for Project Incentives, Period July 1, 2019 – December 31, 2019

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	6	6	-	-	7	-	-	5	24
Cascade Pacific Action Alliance	6	6	5	-	7	5	-	5	34
Greater Columbia ACH	6	-	5	-	7	-	-	5	23
HealthierHere	6	-	5	-	7	-	-	5	23
North Central ACH	6	6	5	5	7	-	-	5	34
North Sound ACH	6	6	5	5	7	5	5	5	44
Olympic Community of Health	6	-	-	5	7	5	5	5	33
Pierce County ACH	6	6	-	-	7	-	-	5	24
SWACH	6	6	-	-	7	-	-	5	24

For DY 3, up to 75% of VBP Incentives can be earned through achievement of P4R VBP milestones. Reporting is for the period of January 1 through December 31, 2019 and is reviewed to determine achievement for all available P4R-associated VBP Incentives.

Table 2 provides the AVs associated with VBP Incentives for this annual reporting period.

Table 2. Potential P4R VBP Achievement Values (AVs) by Milestone by ACH, Period January 1, 2019 – December 31, 2019

Milestone	BHT	CPAA	GCACH	HH	NC	NS	OCH	Pierce	SWACH
Identification of providers struggling to implement practice transformation and move toward value-based care	1	1	1	1	1	1	1	1	1
Support providers to implement strategies to move toward value-based care	1	1	1	1	1	1	1	1	1
Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of state-issued Paying for Value Provider Survey	1	1	1	1	1	1	1	1	1
Potential AVs	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3

Semi-annual report submission instructions

ACHs must submit their completed semi-annual reports to the IA **no later than January 31, 2020 at 3:00p.m. PST.**

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

ACHs must submit their semi-annual reports through the WA CPAS: <https://cpaswa.mslc.com/>.

ACHs must upload their semi-annual report and associated attachments to the sub-folder titled “Semi-Annual Report 4 – January 31, 2020.”

The folder path in the ACH’s directory is:

Semi-Annual Reports → *Semi-Annual Report 4 – January 31, 2020.*

See WA CPAS User Guide available in each ACH’s directory on the CPAS website for further detail on document submission.

File format

ACHs must include all required attachments. ACHs must label and refer to the attachments in their responses, where applicable. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

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

- *Main Report or Full PDF:* ACH Name.SAR4 Report. 1.31.20
- *Attachments:* ACH Name.SAR4 Attachment X. 1.31.20

Upon submission, all submitted materials (except for the P4R metrics reporting workbook) will be posted publicly to HCA’s [Medicaid Transformation resources webpage](#).¹

Semi-annual report submission and assessment timeline

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1, 2019 – December 31, 2019.

ACH semi-annual report 4 – submission and assessment timeline			
No.	Activity	Responsible party	Anticipated timeframe
1.	Distribute semi-annual report instructions for reporting period July 1 – December 31, 2019 to ACHs	IA	August 2019
2.	Submit semi-annual report	ACHs	January 31, 2020
3.	Conduct assessment of reports	IA	Feb 1-25, 2020
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2020
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2020
6.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2020
7.	Issue findings to HCA for approval	IA	April 2020

Contact information

Questions about the semi-annual report template, submission, and assessment process should be directed to WADSRIP@mslc.com.

¹ <https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents>
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ACH contact information

Include in the semi-annual report the contact information for the primary ACH representative. The primary contact will be used for all correspondence relating to the ACH's semi-annual report. If secondary contacts should be included in communications, also include their information.

ACH name:	Elevate Health of Washington
Primary contact name Phone number E-mail address	Alisha Fehrenbacher Alisha@elevatehealth.org
Secondary contact name Phone number E-mail address	Angie Treptow Angie@elevatehealth.org

Section 1. ACH organizational updates

The following sub-sections are required components of the ACH’s semi-annual report. ACHs may submit reports in the formats of their choosing, as long as all required elements are clearly addressed.

Attestations

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

Foundational ACH requirements	Yes	No
1. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
2. The ACH has an Executive Director.	X	
3. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: <ul style="list-style-type: none"> • Primary care providers • Behavioral health providers • Health plans, hospitals or health systems • Local public health jurisdictions • Tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region • Multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region. 	X	
4. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.	X	
5. Meetings of the ACH’s decision-making body are open to the public.	X	
6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this template or a similar format) that addresses internal controls, including financial audits. ²	X	
7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.	X	
8. The ACH conducted communication, outreach and engagement activities to provide opportunities for community members to inform transformation activities and to receive updates on progress.	X	

² <https://wahca.box.com/s/nfesjalde5m1ye6aobhiouu5xemeoh26>

If unable to attest to one or more of the above items, provide a brief explanation of how and when the ACH will come into compliance with the requirements. Identify the specific attestation number when providing the response.

Attachments

The ACH should provide applicable attachments or additional context for clarity that addresses the following:

9. **Key staff position changes.** If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes to key staff positions during the reporting period.

Org chart imbedded below



Org Chart for SAR
4.pdf

10. Budget/funds flow.

- a) Financial Executor Portal activity for the reporting period. The Financial Executor will provide to the Independent Assessor an ACH-specific report from the Financial Executor Portal, representing activity in the Portal during the reporting period. The Independent Assessor will append this document to the semi-annual report. No action is required by the ACH for this item.
 - Optional: The ACH may provide any context that may add clarity regarding the portal activity reports (e.g., inaccurate provider type designations, payments made outside the portal).

Documentation

The ACH should provide documentation that addresses the following:

11. **Tribal Collaboration and Communication.** Provide two examples that demonstrate how the ACH furthered the relationships with Tribes and Indian Health Care Providers (IHCPs) with whom the ACH shares the region.

In June of 2019, Elevate Health dedicated a staff member to work with the Puyallup Tribe of Nations. This staff member's goal was to facilitate the Tribal collaboration. Though correspondence was not immediately achieved, by the end of 2019 Elevate Health successfully connected with the Puyallup tribe and established a cadence for meetings in 2020.

Elevate Health and the Puyallup Tribe of Nations will host their first annual meeting on January 16th. At this meeting, Elevate Health will learn how to best support the Puyallup Tribe of Nations with the Nurse Family Practice program.

The agreement between Elevate Health and the Puyallup Tribe of Nations outlines several deliverables and milestones to be achieved throughout the agreement. The first deliverable and milestone were to be completed by December 31, 2019. The Tribe is dedicated to accomplishing its milestones, commencing with 16 families who are now enrolled in the

Nurse Family Practice program. Elevate Health is dedicated to assisting in the success of this goal by providing workflow, implementation, and rapid cycle testing support through the clinical improvement advisor team.

12. Design Funds.

Earned Design Funds	Expenditures to Date	Remaining Design Funds	% Remaining
\$ 6,000,000	\$ 1,645,800	\$ 4,354,200	73%

Use Category	Expenditures to Date	Expenditure Details
Administration	\$ 272,400	Operational costs to build infrastructure of the ACH and manage start-up activities.
Health Systems and Community Capacity Building	\$ 828,500	Costs incurred to build the community engagement strategy and project plan for the ACH. Includes investments in systems and processes to support community care coordination and integration projects.
Project Management	\$ 376,200	Outside consulting expertise for strategic planning and organizational development and support while the internal team was being recruited.
Provider Engagement, Participation and Implementation	\$ 168,700	Funds used to engage partners and the community at large in the new of the ACH as it launched in 2017.
Total	\$ 1,645,800	

- Provide the ACH's total Design Fund expenditures to date and an outline of how those funds have been used, by Use Category or other ACH-specific identifiers.
- If the ACH has not expended the full amount of earned Design Funds, describe the planned use for these funds. ACHs may identify future expenditures by Use Category, or other ACH-specific identifiers.

Remaining design funds will be kept in reserve and used over the course of the transformation project for gaps that are identified and are not specific to incentives and support in the binding agreements with partners. Examples include community and consumer engagement activities, sponsorship of regional stakeholder forums, development of population health and care management tools and processes, and administration of the Community Resiliency Fund.

13. Incentives to support integrated managed care.

Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support behavioral health providers transitioning to integrated managed care.

- Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.

- b) ACHs may use the table below or an alternative format as long as the required information is captured.
- c) Description of use should be specific but concise.
- d) List of use and expenditures should reflect a cumulative accounting of all incentives distributed or projected to support behavioral health providers transitioning to integrated managed care. It is not limited to the reporting period.

Use of incentives to assist Medicaid behavioral health providers		
Description of Use	Expenditures (\$)	
	Actual	Projected
Allocation of integration incentive funds to Pierce County to be used to support projects around integration, transitions of care and crisis/diversion	\$3,700,000	\$120,000
Transition support incentives to behavioral health providers	\$1,000,000	
Regional investments in IMC Learning Network	\$500,000	\$200,000
Direct technical assistance from Strategic Improvement Team	\$2,000,000	\$600,000
Sponsorship and management of the Whole-Person Care Collaborative for primary care and BH clinic teams	\$500,000	
Investments in centralized technical assistance and data tools for behavioral health	\$700,000	
TOTAL	\$8,400,000	\$920,000

Section 2. Project implementation status update

The following sub-sections are required components of the ACH's semi-annual report. ACHs may report in the format of their choosing, as long as all required elements are addressed.

Attachments

The ACH should provide applicable attachments or additional context that addresses the following:

14. Implementation work plan

Implementation plans are “living documents” that outline key work steps and plans to be conducted within the time frame of the Medicaid Transformation. The ACH's implementation plan (work plan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress. These plans provide HCA with the information required to monitor the ACH activities and project implementation timelines.

The ACH must submit an **updated implementation plan** reflecting *progress made during the reporting period*.³

- a) The updated implementation plan must clearly indicate progress made during the reporting period. The ACH may decide how to indicate progress, so long as it allows for the IA to review and understand implementation progress, specifically:
 - i. Work steps and their status.
 1. At minimum, work steps should be updated as either in progress, completed, or not started. The ACH may provide a work step status legend that defines and indicates the different work step statuses defined by the ACH. Recommended work step status options include:
 - Completed, Deliverable Met: The work step deliverable has been completed. The ACH is able to provide supporting documentation regarding the completion of the deliverable upon request.
 - Fulfilled for Quarter, Remains in Progress: Actions were taken toward achieving the work step deliverable, but the deliverable has a target end date in the future. The ACH is able to provide supporting documentation regarding activities fulfilled in the quarter upon request.
 - Delayed, Remains in Progress: Work step deliverable is past due. Work step was scheduled to be complete, but the ACH is still working towards completion.
 - Not Started: Work step has not been started.
 2. The ACH is to assign a status for each work step provided in the implementation plan work plan. This applies to work steps that have yet to be started.
 - b) If the ACH has made minor changes for any work step from their originally submitted

³ Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan. Semi-annual reporting guidance
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work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.

- c) If the ACH has made substantial changes to the work plan format since the last submission, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes. All required elements of the work plan must be preserved.

Submit updated implementation work plan that reflects progress made during reporting period.

See attached Implementation workplan document.

15. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.⁴ To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

Instructions:

- a) HCA will process the partnering provider roster submissions for SAR 3 during August-September. The processing step is to update the state database, and apply consistent formatting for ease of maintenance for future reporting periods.
- b) By **October 15**, HCA will provide ACHs a clean version of the ACH's partnering provider roster (based on SAR 3 submissions) to update for the SAR 4 reporting period.
 - i. This will be the version that ACHs maintain for the remaining semi-annual reporting periods.
- c) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
 - i. Whether the partnering provider site is pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Place an "X" in the appropriate project column(s).
 - ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.
- d) Update partnering provider site information as needed over each reporting period.

Submit updated partnering provider roster.

See attached Partnering Provider roster.

⁴ Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH's projects. Traditional Medicaid providers are those that bill for services, either to a managed care organization or to the state directly (e.g., hospitals, primary care providers). Non-traditional Medicaid partners may receive some Medicaid funding through programs that provide grant dollars, etc., but they do not provide billable healthcare services to Medicaid members (e.g., behavioral health organizations, community based organizations, fire districts).

Documentation

The ACH should provide documentation that addresses the following:

16. Quality improvement strategy update

The ACH must submit quality improvement strategy updates on a semi-annual basis to keep HCA and the IA apprised of quality improvement activities and findings. ACHs may determine the format to convey this information.

Semi-annual updates should demonstrate that the ACH has insights into the current implementation of transformation approaches, barriers identified by partnering providers, and the resources and technical assistance provided by the ACH to partnering providers to promote achievement of transformation outcomes and objectives.

Through these updates, ACHs are expected to report developments over the reporting period, such as:

- Modifications to the ACH's quality improvement strategy.
- Summary of findings, adjustments, and lessons learned.
- Support provided to partnering providers to make adjustments to transformation approaches.
- Identified best practices on transformation approaches.

For this recurrent reporting requirement, HCA does not require that ACHs report site/provider organization-level quality improvement data. HCA will rely on these updates for evidence of forward momentum, including evidence that partnering providers have the resources and support required for success.

Attach or insert quality improvement strategy update.

See Attached Quality Improvement Plan

Narrative responses

ACHs must provide **concise** responses to the following prompts:

17. General implementation update

- a) *Description of training and implementation activities:* Implementation of transformation approaches requires specific training and activities.
 - i. Across the project portfolio, provide three examples of *each* of the following:
 1. Trainings and technical assistance resources provided to or secured by partnering providers or members of care teams necessary to follow required guidelines and to perform their roles in an approach in a culturally competent manner. Be specific when describing the project(s), partnering provider(s), the guidelines or evidence-based approaches, specific needs that the training and/or technical assistance addresses and describe how the training and/or technical assistance promoted successful performance of roles in a culturally competent manner.

Detail the gaps that remain for partnering providers to follow required evidence-based guidelines and the types of training and/or technical assistance that are anticipated to be addressed in the future.

The Elevate Health Care Continuum Network provides trainings and workshops to enhance services, increase workforce capacity, and facilitate community-based care coordination programming for population-specific cohorts. Training provided is evidence-based and facilitates culturally and linguistically appropriate care in compliance with implemented models - the Pathways Community HUB, Care Transitions (component of the Community Health Action Teams (CHAT) and Health Homes.

Training is offered on a monthly basis and are open to the community to increase knowledge and culturally appropriate care. Trainings from July 2019- Dec 2019 includes:

- *Pathways HUB Model Refresher training 7.2.19; 20 attendees*
- *Certification Review with Supervisors and CHW 7.17.19; 17 attendees*
- *Pathways & CCS Training 7.18.19; 3 attendees*
- *Naloxone Training 10.24.19; 21 attendees*
- *Coping with Holiday Stress Training 12.05.19; 10 attendees*

In addition, as a Health Homes lead, Elevate Health is a care coordinator trainer for this program. Health Homes trainings are provided on a quarterly basis. The list of trainings offered in 2019 include:

- *Health Homes Care Coordinator training, 12.12.19/12.13/19; 28 attendees*

The Care Continuum Network leverages the Washington State Department of Health Community Health Worker (CHW) training program and provides supplemental, disease-specific training in compliance with the Pathways program CHW competencies.

Elevate Health also discussed opportunities in leveraging the PCORI Asthma training offered through the Public Health King County and the Stanford Chronic Disease Self-Management program training for the community – both evidence-based programs to improve health outcomes for defined populations.

The Whole Person Care Collaborative 1.1.2019-12.10.2019, targeting bi-directional behavioral health integration is an example of a training provided to behavioral and primary care providers. This training was founded on the evidence-based best practice of the Collaborative Care Model. There were 10 organizations and 13 total care teams who participated in the Whole Person Care Collaborative in 2019. A remaining gap in training to the Collaborative Care Model in 2020 is ensuring patient access is bi-directional. In addition, just as behavioral health access expands within primary care, there is also an effort to expand primary care access in behavioral health settings.

2. Implementation of bi-directional communication strategies/interoperable HIE tools to support project priorities. Be specific when describing the project(s), partnering provider(s), strategies and/or tools, and how these activities support project priorities.

In the roll-out of bi-directional behavioral health integration, there was a focus on finding a solution for how to co-manage registries of shared patients across organizations. Some organizations opted to share access to their Electronic Health Records or build specific templates within their EHRs to improve co-documentation (Sea Mar and Multicare Health Systems; Comprehensive Life Resources and Planned Parenthood, respectively). Other organizations chose to test out a registry tool provided by the University of Washington AIMS Center called the 'Caseload tracker' which allowed teams to track intake screening scores and other vital signs across organizations. There were barriers to both approaches, such as the speed to development within the Electronic Health Record approach and capacity issues within the caseload tracker. Elevate Health participates in regional workgroups and sub workgroups to support the implementation and standardization of Collective Medical Technology (CMT) in the region. Current activities pertain to the assessment of regional tool use via the PreManage sub workgroup, under the Potentially Preventable Hospitalizations work with the health department. Additional focus in 2020 will include participation in workgroups to support regional and statewide accountability of CMT applications.

Additional assessment of community health information exchange/social determinants of health technology solutions were scoped in 2019 and include:

- *Unite Us*
- *Healthify*
- *Julota*
- *Innovaccer -2-1-1/Aunt Bertha application*

Elevate Health 2020 plans include assessment of CBO, BH/SUD, primary care and hospital system's 1) interest, 2) commitment, and 3) regional investments to secure use of a shared platform for bi-directional exchange of information between sectors.

3. Mechanisms that have been established for coordinating care management and/or transitional care plans with related community-based services and supports such as those provided through supported housing programs. Be specific when describing the project(s), partnering provider(s), care management and/or transitional care approaches/supports, and how these activities support project activities.

Elevate Health partners with the Tacoma-Pierce County Health Department (TPCHD) on the Potentially Preventable Hospitalizations steering committee, CHW, and PreManage sub-workgroups. The PreManage sub-workgroup is focused on reducing service utilization and hospitalizations. Community stakeholders represented in this workgroup include BH/SUD

case managers, EMS paramedics/community nurses, residential treatment providers, hospital care management, and primary care providers. The sub-workgroup has evolved in our community to take on case review for medically complex clients across systems, including hospitals, EMS, BH/SUD, and community care coordination programs. This information is being collected and assessed by a community partner, Northwest Physicians Network, and TPCHD to facilitate systems-wide improvement in coordination and client hand-off of care between systems. Elevate Health attends these forums and brings issues/challenges back to the Provider Integration Panel (PIP) to identify regional accountability and facilitate P4P outcomes improvement.

Elevate Health also works closely with Pierce County. In 2019, the Pierce County housing crisis response created a funding opportunity in the region to implement the Critical Time Intervention (CTI) model. The CTI is an evidence-based model using therapeutic communication and motivational interviewing to facilitate client-driven solutions to housing. Pierce County and Elevate Health are in preliminary conversations to integrate the CTI training within community-based care coordination programming including Pathways, Health Homes, and CHAT.

Additional tracking of care plans and care coordination services is done on technology platforms and monitored by the Care Continuum Network for the Pathways, CHAT, and Health Homes programs. For Pathways, all contracted agencies are required to input their data into a common data system developed for the HUB Pathways model. System training, coordinated through the CCN, is required prior to providing services. Care Continuum Network documentation platform (CCS) is the data system utilized by the Elevate Health Care Continuum Network Pathways Community HUB. Key system functionality includes:

- Tracking the number and type of clients served;
- Risk tracking over time;
- Information by client, care coordinator, agency, and HUB;
- Communication and data sharing among the client care team, agencies, community health workers, and referral source;
- Pre-loaded standard pathways;
- Tracking of initiated, in-process and completed pathways; and
- Outcome/Risk Reduction.

Challenges to service tracking for Pathways is limited in the bi-directionality of the CCS platform to capture a referral receipt and notification of completion. This is currently a manual process of the CHW.

The ACHs collectively developed and agreed upon the following vision for health IT in Washington:

Better engage people, organizations, and community partners in the circumstances, health events, and care-system encounters to enable whole-person care in traditionally-disconnected care settings and services through the use of health IT.

To achieve this vision, the ACHs are working collaboratively to identify a set of initial goals and recommended activities to support each goal.

The ACHs will discuss the goals and recommendations with stakeholders and determine how each fits with the ACHs' priorities, projects, and roadmaps, while adding relevant activities to their plans for 2020 and beyond. The ACHs are also identifying best practices to be shared and potentially scaled among ACHs, and they developing individual action plans for accomplishing priority goals.

4. Systems or rapid-cycle quality improvement processes that have been developed to monitor performance, provide performance feedback, implement changes and track outcomes.
- *In 2019, the Strategic Improvement Team developed the Strategic Improvement Toolkit. The strategic improvement toolkit contains the key components of chartering and tracking any project or program. It provides the tools needed to implement rapid-cycle improvements within the project. There are standard documents for project chartering, workflow development, measurement selection, and tracking tools, as well as plan, do, study, act worksheets. In 2019, Clinical Improvement advisors used this toolkit as a standard framework in how they supported partners in rolling out new work or rapidly testing changes. The strategic improvement toolkit was used in the respite center workflow development, CHAT team development, and all binding letter of agreement partnerships.*
 - *In addition, each partner who receives Medicaid Transformation Funds submits a quarterly workplan. This workplan outlines the measures that are being tracked for each scope of work. The workplan reports performance improvement, targets, and any specific actions taken to address changes. The purpose of this workplan is to ensure partners are aligning tests of change with measurement-driven outcomes.*
 - *Elevate Health's Care Continuum Network utilizes program-specific standards and guidelines to support ongoing process improvement within community care coordination programs. Below is a link to Elevate Health's QI Policy, reviewed and approved through the Pathways Community HUB Institute to support Level-I certification, which was achieved November 29, 2019.*



Quality-Improvement
-Policy_Final.doc

- i. For each project in the ACH Project Plan, provide clear, specific, and concise responses to the below as applicable. For projects the ACH is not implementing, indicate “Not Applicable.”

1. Project 2A: Provide a summary of financial resources provided to participating providers and organizations to offset the costs of infrastructure necessary to support integrated care activities.

Description	Expenditures to Date
Implementation Fees and custom development	280,000
Infrastructure Fees	40,000
Training	30,000
Direct Technical assistance from CCN team	100,000
Administrative support for custom development	200,000
Direct support to partners	25,000
Total	675,000

2. Project 2B: Provide information related the following:
 - a. Schedule of initial implementation for each Pathway.

Pathway	Date of implementation (actual or anticipated)	Notes (optional)
Adult education	Actual – 3/21/2018	
Employment	Actual – 3/21/2018	
Health insurance	Actual – 3/21/2018	
Housing	Actual – 3/21/2018	
Medical home	Actual – 3/21/2018	
Medical referral	Actual – 3/21/2018	
Medication assessment	Actual – 3/21/2018	
Medication management	Actual – 3/21/2018	
Smoking cessation	Actual – 3/21/2018	
Social service referral	Actual – 3/21/2018	
Behavioral referral	Actual – 3/21/2018	
Developmental screening	Actual – 3/21/2018	
Developmental referral	Actual – 3/21/2018	
Education	Actual – 3/21/2018	
Family planning	Actual – 3/21/2018	
Immunization referral	Actual – 3/21/2018	
Lead screening	Actual – 3/21/2018	
Pregnancy	Actual – 3/21/2018	
Postpartum	Actual – 3/21/2018	

- b. Partnering provider roles and responsibilities to support Pathways implementation.

Below is a description of the roles and responsibilities of partnering Care Coordination Agencies and their staff to support Pathways implementation. Source is from Elevate Health Pathways Community HUB policies & procedures as reviewed and approved by the Pathways Community HUB Institute to support Elevate Health’s Level-I certification (received Nov. 29, 2019).

- Hire at least one .5 FTE community health worker with an average of at least 15 clients on their caseload;
- Provide care coordination to clients using community health workers who have trained in the Pathways model;

- *Track client Pathways and accessed services utilizing the Care Continuum Network documentation platform (CCS)*
- *Undertake reasonable efforts to identify at-risk individuals within the identified populations and enroll them as care coordination clients through the HUB;*
- *Maintain human resource policies and procedures that include at a minimum: training requirements, policies regarding hiring, termination, performance, dress code, complaint procedures, background check information, sexual harassment and discrimination policies, disciplinary policy, problem-resolution process, and professional boundaries education;*
- *Maintain client data in compliance with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and all rules promulgated thereunder;*
- *Enter into a HIPAA Business Associate Agreement with the HUB;*
- *Perform mutually agreed upon quality improvement and quality assurance activities;*
- *Participate in training;*
- *Conduct performance reviews, no less than annually, on each community health worker providing services for the HUB. The care coordination agency will provide copies of performance evaluations to the HUB to document compliance. If a community health worker receives a less than satisfactory rating, the care coordination agency should include a plan of corrective action.*
- *ACH Health IT Strategy. All ACH Executive Directors are collaborating to develop an ACH Health IT Strategy comprised of a vision for health IT in Washington, goals, and recommendations, and near-, mid-, and long-term ACH activities.*

recommendations. Later in 2020, the ACHs plan to begin implementing their action plans. The ACHs plan to share the Health IT Strategy with HCA in the first quarter of 2020 and look forward to discussing partnership opportunities in pursuit of the collective ACH vision.

- a. *Inventory of Care Coordination Agencies (CCAs) and the number of referrals initiated to date.*

CCA Name	Total # of Referrals to CCA for any Pathway
Tacoma-Pierce County Health Department	77
Hopesparks	131
Sea Mar	143
Community Health Care	237
Korean Women's Association	163

b. Systems the HUB lead entity is using to track and evaluate performance. Provide a list of the related measures.

- In 2019, Elevate Health formed the Pathways Advisory Workgroup (PAW). The PAW is comprised of key community stakeholders with interest in improving the delivery of health and social services to at-risk populations. It was established to ensure community input into HUB operations. At least one representative whom has received services and one community health worker serves on the committee to share their perspective. The PAW reviews performance and clinical outcomes to support process improvement. Meetings are approximately every quarter, no less than twice a year.*

List of clinical metrics tracked:



Pathways%20Clinical
%20Condition%20Ass

- Performance metrics are monitored for each Care Coordination Agency (CCA) to assess community health worker (CHW) caseload and case mix. The attached document is Elevate Health's policy for CCA caseload and case mix:*



Caseloads-Caseload
%20Monitoring%20Pi

a. Success in hiring staff, a listing of open positions and efforts to fill those. Describe barriers or gaps that exist in retaining staff and mechanisms the ACH uses, if any, to address reasons for those barriers or gaps.

Three of the five Community Care Agencies (CCAs) experienced issues in staff turnover. Issues in community health worker (CHW) turnover in 2019 were largely due to equitable pay and limitations in CCA facilitating a pipeline for CHW growth. Those CCAs offering workforce

development and strategies to retain staff (equitable pay, supervisory support) did not experience this issue.

To address concerns in 2020 an incentive structure will be used to support CHW workforce development and staff retention for each of our CCAs. Staff retention and workforce development is assessed by Elevate Health for each of our contracted CCAs. Elevate Health works with the Pathways Advisory Workgroup (PAW) to assess CCA workforce and staffing concerns. The incentive structure, quarterly assessment, and matrix-structure is approved by the PAW. The Elevate Health Community HUB will review workforce performance quarterly with the PAW and to develop CCA-specific coaching and support plans for ongoing improvement.

The following is an example of reporting criteria to support community health worker (CHW) retention as described in the CCA contracts and approved by the PAW:

- Did your organization experience CHW and/or supervisor turnover from the Pathways Community HUB Program this quarter? If so, please explain (upon exit interview, what reasons were stated?)*
- Do you have a standing procedure in place to retain staff?*
- Does your organization evaluate staff satisfaction? If yes, does your organization have a process to support improvement in staff satisfaction?*

b. Describe the training plan for community health workers, and the number trained. What is the feedback loop for the identification and offering of continuing education training and development? What evaluation and assessment does the ACH conduct, if any, post-training to determine if trained individuals have increased skills, competencies, or performance? How does the ACH use such information or other feedback to determine trainings to provide either to individuals or groups, what trainings to require as mandatory versus individual goals-based, and key partners to include in offering trainings.

- Elevate Health complies with training requirements necessary for community health workers (CHWs) to facilitate Level-I certification with the Pathways Community HUB Institute. Training requirements are tracked and monitored by the Elevate Health Pathways Community HUB program manager and reported to the PCHI for auditing and compliance purposes. If a CHW is out of training compliance, the Elevate Health program manager works with the CHW and CHW supervisor to facilitate next steps. Elevate Health leverages the Washington State Department of Health's CHW training program to meet PCHI compliance, and Elevate Health has developed an 8-hour, in-person chronic disease and basic anatomy & physiology training for newly hired Pathways CHWs. The program was developed and is led by Elevate Health's Clinical Director of the Care Continuum Network (MSN, RN).*

- The Elevate Health Pathways Community HUB program manager manages a monthly*

training and case review schedule with CHWs and their supervisors. These monthly forums include additional training opportunities to support identified knowledge gaps or highlight community resources to facilitate client-navigation. Case reviews serve as an opportunity for CHWs to meet and collaborate on both successful and complex client cases. This is another mechanism to provide ongoing process improvement and support.

- a. Describe technology enabled care coordination tools being used, and how information being captured by care coordinators is integrated with clinical information captured through the statewide health information exchange.
- *At the start of the Pathways-Community HUB program in 2018, Elevate Health contracted with Care Coordination Systems (CCS) as the selected vendor to support documentation and reporting for the Pathways Community HUB. There was hope the platform would also support bi-directional information exchange and closed-loop referrals with community-based organizations and health systems; however, the system’s functionality did not meet this need.*
- *Beginning in 2020, Elevate Health will utilize the Population Health Management system Innovaccer to facilitate our care coordination documentation (i.e. Health Homes, Pathways-Community HUB and our innovations project, Community Health Action Teams). The decision to move to Innovaccer ensures HITRUST and opportunity for bi-directional connectivity to EHRs such as Collective Medical Technology’s EDIE and PreManage applications*

e. Include two examples of checklists or related documents developed for care coordinators

- *The following are checklists Elevate Health created and uses to ensure Community Health Workers meet the programmatic expectations of the Pathways-Community HUB model:*



Passage 2
Motherhood to Welln



Onboarding CHW
Checklist.pdf

1. Project 2C: Provide a summary of activities that increase the availability of POLST forms across communities/agencies, where appropriate and when applicable based on the strategies the ACH has promoted. Describe activities that have been most successful as well as any continued challenges in increasing the availability of POLST forms, as applicable.
2. Project 3A: Provide two examples of the following:
 - a. Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recover supports.

- *In 2019 as part of the Access to Treatment workgroup, the MedsFirst program conducted by the Needle Exchange in Pierce County reported great success in their first year of implementation. During this implementation it was realized that one of the main barriers in this program was prescribing; Needle Exchange ran the risk of reaching their prescriber limit. This barrier is one of the main focuses in 2020 of the Access to Treatment workgroup; to ensure that there are strategies that address how to best prescribe and to be in compliance with prescribing limits. Additionally, in 2020 this workgroup hopes to strategize initiatives advocating for policy change for Naloxone availability in the county. There have been several barriers faced by providers and the community at large, in reference to Naloxone being readily available. Finally, the Access to Treatment workgroup hopes to understand how to best support the county's MAT access for Medicare patients as it is for Medicaid.*

 - a. Methods the ACH is using to monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan.
 - b. A description of existing local partnerships the ACH has convened or leveraged to implement strategies under this project, including a summary of the structure, frequency of meeting, and confirmation that the partnership includes all required individuals and entities (e.g., consumer representatives, community-based service providers, and law enforcement). Describe any successes and challenges with identification of partnership leaders and champions.
- *Elevate Health continues to participate in the Pierce County Opioid Taskforce. The taskforce is a multi-disciplinary team of organizations and leaders across the region that are focused on addressing the up-stream drivers of the opioid crisis in Pierce County. The Opioid Taskforce Steering Committee, which Elevate Health sits on, meets once per month to review the findings and needs of the smaller workgroups comprising the taskforce. The individual workgroups (prevention, access to treatment, and right services right time) meet monthly as well.*

 - a. Describe gaps in access and availability of providers offering recovery support services, and provide an overview of the ACH's planned approach to address gaps. Describe whether the approach will impact the number, or location of current providers.
- *Elevate Health has identified a large gap of availability of providers offering recovery support services and a gap in access. We have many clinical sites across the county that do not have any providers that are licensed to provide MAT therapy. Of 35 sites identified, only six sites have any MAT providers. The second gap we identified is around access. Of the 33 identified MAT licensed providers, only 17 are actively prescribing MAT. Many providers with MAT licensing who were not currently prescribing cited the complexity of managing MAT patients along with a lack of time*

and knowledge about how to best approach managing multiple MAT patients. The ACH is currently in an information gathering stage around barriers to recovery support services. As we continue to better understand gaps and barriers, we will put in place a plan into place to address the identified gaps and barriers.

1. Project 3C: Provide the following:

- a. A summary of mechanisms established for coordinating care with related community-based services and supports, as well as referral relationships that have been established with dentists and other specialists, such as ENTs and periodontists.
- b. Two examples of workflows developed to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed.
- c. A summary of methods used to engage with payers in discussion of payment approaches to support access to oral health services. If applicable, indicate payment approaches that have been agreed upon.

2. Project 3D: Provide the following:

- a. Description of status of activities that have been conducted based on the Chronic Care Implementation Plan, including a summary of how the ACH is ensuring integration of clinical and community-based strategies through communication, referral, and data sharing strategies.

- *Elevate Health is implementing a portfolio approach fusing all project areas using two primary tactics:*

- 1) *Strategic improvement to facilitate transformation and outcomes improvement, and*
- 2) *Care coordination.*

Both of these efforts aim to assess the needs of the population to target interventions that drive outcomes improvement for chronic disease.

- *Strategic improvement and care coordination activities that support the Chronic Care Implementation Plan include participation in regional learning communities and collaborations to facilitate accountability and bi-directional exchange of information to facilitate coordination of care. In addition, both the Provider Integration Panel and the Pathways Advisory Workgroup are the two forums Elevate Health facilitates for guidance on transformation efforts in alignment with Medicaid waiver priorities.*

- *Further description of Elevate Health's role in ensuring integration and community-based strategies for bi-directional communication are defined below.*

- a. Description and two examples for how the Chronic Condition/Transition Management plans align with and partner with Pathways or other community-based care coordination strategies or programs to address social needs interventions (e.g., referrals to program/communication and data

sharing for shared care planning).

- *In 2019, Elevate Health funded five fire districts to facilitate a sustainability plan for a Community Paramedicine collaboration started in 2014. Northwest Physicians Network (NPN) was key in this collaborative partnership to assist in a community-care coordination design linking Emergency Medical Service (EMS) providers to reduce over-utilization of emergency services. The project focus included three core strategies: (1) referrals to appropriate care management or community-care coordination services; (2) wellness meetings; and (3) partner coordination.*
- *Cross-sector collaboration with the Community Paramedicine Collaborative includes the Mobile Crisis Intervention & Response Team (MCIRT), a mobile community-care coordination team with licensed medical and behavioral health (BH) professionals to facilitate chronic condition and BH/substance use disorder (SUD) support for identified clients. Additional referral connections for clients utilized by Community Paramedicine are facilitated through the region's Care Management Collaboration. Workgroup attendees include care managers from managed care organizations; hospital case managers, BH/SUD providers, aging & disability, and other relevant organizations in Pierce County.*
- *Below is a guide developed by NPN for the Care Management Collaboration to support referrals, communication and data-sharing for care planning:*



Community%20Collaboration%20Spreadsheet

- *The collaboration between care management partners hosted/managed by NPN is focusing more deeply in designing accountability for care plan documentation between hospitals, BH/SUD, primary care, and MCO care management. Collaborative Medical Technologies are present to provide support and resources for PreManage utilization across sectors. Elevate Health participates in this monthly collaboration to 1) assess opportunities for standardization with the statewide Collective Medical workgroup, and 2) assess need for accountability metrics to support standardized documentation and information sharing.*
- *Another example in how Chronic Condition/Transition Management plans align with our Pathways and regional collaboration in the community is with the Potentially Preventable Hospitalizations work. Elevate Health is collaborating with the Tacoma Pierce County Health Department (TPCHD) to support the launch of a community health worker (CHW) Exchange pilot project. The goal of this pilot is to ensure community providers have a way of knowing if a client/patient got the support and resources needed to address social needs. This work will extend beyond the Pathways Community HUB to develop a coordinated system for communication and notification of CHW engagement.*
 - *The pilot project will focus on a defined target population, individuals with heart failure, and will be tested with one primary care organization. Elevate Health's role with the CHW Exchange to date includes workflow, workforce,*

and CHW registry development to support a use case for the pilot. Elevate Health will leverage insights from the Pathways Community HUB and work occurring statewide to support outreach and engagement activities for care coordination. Elevate Health will also report out on activities to date with our statewide and regional partners on the development of the CHW Exchange.

- *Elevate Health may also provide existing tools to support client referral as decided by the CHW Exchange and in compliance with the State’s Medicaid program. Should the CHW Exchange decide and agree to the mechanism for funding the test pilot, Elevate Health may oversee the registry, staff, and core functions of the pilot for appropriate routing of clients to CHW’s and the associated programs.*

- b) Describe the key challenges or risks identified in implementing selected transformation strategies, including potential impacts and mitigation strategies for specific transformation project areas or Domain I strategies. Include impacts across projects, as well as within a specific project area.

Health system capacity building includes the following dependencies: workforce development; system infrastructure technology and tools; and system supports to assist providers in adopting value-based purchasing and payment.

- *Workforce Challenges include:*
 - *Limited number of substance use providers particularly for Medicare and older adult population.*
 - *Ensuring a living wage and sustainable payment for community health workers.*
 - *Provider burn-out particularly with behavioral health and SUD providers.*
- *Mitigation*
 - *CEO participates in State Wide Workforce Council, supporting learnings from State Wide Workforce Council, and bringing learnings back to the community*
 - *Working with Providers on High School to Career for workforce development opportunities*
 - *Supporting Graduate Medical Education (GME) opportunities in the community, in conjunction with Pacific Northwest University*
 - *Supporting workforce stability around hiring practices and employee retention with local FQHC’s*
- *Technology and Tools/Infrastructure challenges:*
 - *Bi-directional communication and standardization of care management processes across sectors remains a challenge due to limited accountability in*

MCO contracts or standardized systems.

- *Integration of EHR platforms with standard tools including Collective Medical is varied across primary care and hospital systems. Currently, no Pierce County behavioral health and SUD providers have access to Collective Medical applications.*
- *Gaps in real-time access to information, particularly with regional Pay for Performance (P4P metrics).*
- *Mitigation*
 - *Supporting EPIC implementation and expansion between HealthSystem and 90+ sites in SeaMar-FQHC Statewide*
 - *Working with our community and community partners on a data structure to support communication between community and providers*
- *Value-based payment adoption challenges:*
 - *Realtime exchange of information and outcomes based reporting for behavioral health providers.*
 - *Reimbursement rates, particularly for our behavioral health and substance use providers.*
- *Mitigation*
 - *One on one support offered to individual organizations*
 - *CEO is part of the Pierce County Oversight Board, with additional staff acting as subject matter expert when needs arise on aligning the County, Providers and Payors*

18. Pre- and post-project implementation example

- a) Highlight a success story during the reporting period that was made possible due to DSRIP investments, including how DSRIP removed the barrier to implementation and lessons learned that the ACH has used to make modifications moving forward.

In January 2019, Northwest Physicians Network enrolled a care team at their Key Peninsula Clinic in the Whole Person Care Collaborative. The care team participated in the coaching calls hosted by Elevate Health which prepared the Key Peninsula Clinic for developing their shared care team, how to hire behavioral health therapists who are geared toward collaborative care and how to manage warm handoffs.

The Key Peninsula Clinic staffed up appropriately and quickly, hiring a behavioral health therapist and a psychiatric nurse practitioner was identified to managed prescribing and medication management for behavioral health patients. A workflow was designed which

would allow the primary care physician to screen the patient for their medical and behavioral health needs. Based on screening results, the patient is referred to the appropriate staff member for management.

The target population was patients with more complex behavioral health and diabetic conditions. Upon launching the program, the patient engagement was not meeting the goals set out by the clinic. For this reason, they decided to expand the patient population to support patients on suboxone. After expanding the clinical criteria, the team began using a shared tracking tool to treat patients to target over time. This allowed the team to complete regular follow ups with patients and monitor their PHQ-9 scores over time. Additionally, this tool provided an added benefit of seeing at-a-glance how patients interacted with multiple care team members over time, and the track the amount of time that care team members were spending with patients. This allowed the team to begin successfully billing collaborative care codes for Medicare and Medicaid patients beginning in July of 2019. There are currently nine patients enrolled in the program, but the team would like to expand in 2020 with the addition of a Behavioral Health Manager position.

“Northwest Physicians Network has had the opportunity to participate in Elevate Health’s year-long, intensive training with the University of Washington’s AIM Center, learning how to implement the Collaborative Care model. Many of our primary care providers have spoken to us over the years about the difficulty in finding both mental health providers to refer their patients to, and communicating with them when care is established. One of the providers who had the greatest difficulty was Bret Price ARNP who has a private primary care practice in the rural area of Key Center, WA. Bret serves patients with a very wide range of ages, socioeconomic status and challenges in both mental health and substance use. He has been very enthusiastic about having the opportunity to participate in this training. One of the challenges in the beginning of the training was the time commitment for the online and in person trainings. Although it felt like we were spending many hours learning how to employ this model in the clinic, we learned that the number of hours spent planning and understanding each of our roles was very much needed as we began to implement it in the clinic. From the beginning we have received very positive feedback from all of the patients who have participated. One of those patients sat in front of us and cried when I talked to him about the behavioral health services he would receive as a result of participating. Since the patient had become a Medicare patient three years ago after receiving SSDI, he has had no access to mental health services for managing his bipolar I diagnosis, which has been so severe at times that he has been a resident at Western State Hospital. When I first began working with him he was being seen in the hospital for suicidal ideation. His last depression screener score two weeks ago was a 2. Many of the patients we serve have both behavioral health and medical challenges. In addition to a behavioral health care manager, we also have a RN care manager to assist patients in setting goals to understand and manage their chronic disease states. Each person who is part of our team has expressed a great deal of satisfaction in working together to provide high quality integrated care. We have gotten to see the positive effects it has on our patients as we watch their depression and anxiety screen scores continually decrease and their ability to effectively manage the medical diagnoses increase.

As we move into 2020, NPN plans to roll out the Collaborative Care model into some of our other clinics in Pierce County. Through learning about our successes our partner, The Everett Clinic, plans to do the same in Snohomish County. We would like to offer our thanks to Elevate Health, as well as commend them on their choice of bringing UW AIMS Center to Pierce County and giving us the opportunity to participate.”

- Melissa Haney LMFT, CCM Behavioral Health Integration Manager, NPN

19. Regional integrated managed care implementation update

- a) For **2019 adopters**, briefly describe the primary integrated managed care-related challenges in the region after the transition to integrated managed care. Challenges may include issues with client enrollment/eligibility, provider payment, data/HIT, etc. What steps has the ACH taken, in partnership with providers and MCOs, to address these challenges?

- *Integrated Managed Care Implementation Challenges*
 - *Transfer of billing codes mid-adoption due to SERI updates, not all MCOs were prepared for the 7/1/2019 SERI change, some had to do contract addendums, which led to delays in payments, or wrongful denials.*
 - *Pre-Authorization requirements for Residential Treatment Facilities and differing requirements from BHOs in other regions.*
 - *Non-Local contacts for authorization requests (MCOs) led to denials due to not understanding WAC requirements, or availability of services.*
- *For all of the above, we continued to host monthly meetings to bring providers, payors, the HCA, and County government members together to discuss and resolve issues in a timely manner. This information was also shared thru email, and our collaboration site, to ensure the network of Pierce County providers was provided the information to improve process, and correct issues. Elevate Health also offered classes in conjunction with the payors to help education Pierce providers, and other regions, on payor requirements, related to authorization/reviews.*

For issues, that were single provider specific, Elevate Health would provide one on one consultation with the provider, and assist them in correcting issues, and also ensure that the provider was working with the appropriate contacts at each MCO/ASO to ensure a timely resolution.

- b) For **2020 adopters**, briefly describe progress made during the reporting period on the development and participation in the region’s early warning system, communications workgroup, and provider readiness/technical assistance workgroup.
- c) For **2020 adopters**, briefly describe behavioral health provider readiness and/or technical assistance needs (financial and/or non-financial) the region has identified as it

pertains to integrated managed care. What steps has the ACH taken, in partnership with providers and MCOs, to address these needs?

Attestations

The ACH attests to complying with the items listed below during the reporting period. Upon request, the ACH shall have available for review by the IA and HCA all supporting data and/or back-up documentation related to the attestations provided.

	Yes	No
<p>20. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:</p> <ul style="list-style-type: none"> • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. • Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities. 	X	

If the ACH checked “No” in item above, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.

Section 3. Value-based Payment

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 3, Q4.

*Note: The reporting period for VBP milestones cover the **full calendar year** (January 1 through December 31, 2019).*

Narrative responses

21. Identification of providers struggling to implement practice transformation and move toward value-based care

- a) Describe methods the ACH uses to identify providers struggling to implement practice transformation and move toward value-based care and a general overview of activities the ACH conducted to support those providers. **Include one detailed example** of the ACH's efforts to support a provider to address the identified struggles, progress that was made, and lessons learned.

For sites receiving waiver funds, Elevate Health requires that a quarterly workplan be submitted along with monthly meetings with one of our clinical improvement advisors. With the completion of the quarterly workplan, the team and the clinical improvement advisor are able to identify barriers and successes in tracking outcomes and tweaking programs.

Value-based contracting is predicated on the ability of organizations to empanel, manage and risk stratify and provide appropriate treatment to their patient population with the goal of managing cost and utilization. The example below touches on Elevate Health's support of a partner empaneling and risk stratifying their patients.

One example of supporting an organization to work toward value-based contracting has been with the HopeSparks and Pediatrics Northwest Partnership. Pediatrics Northwest and HopeSparks joined in the mission of increasing access for pediatric patients in early 2018. At this time, both of these organizations were committed to partnership yet had not yet tackled their shared patient population and understood the total number of lives they were seeking to 'co-manage'. Through a number of meetings with our clinical improvement advisor team and understanding how to identify shared patients and developing shared definitions of an open and closed referral, Pediatrics and HopeSparks were able to successfully identify the total number of patients they were currently managing and had the capacity to manage should their program take root.

The ability to know their shared patients allowed for them to dive a layer deeper and begin risk stratifying their shared patient population. Now, Pediatrics Northwest and HopeSparks have a model by which they are able to identify the services a patient should receive based on their normal to acute behavioral health or medical needs. The ability to identify, risk stratify and ensure patients are properly accessing services based on their acuity situates them well for cost savings and value based payment contracting with MCOs.

22. Support providers to implement strategies to move toward value-based care

- a) **Provide three examples** of how the ACH has supported providers to implement strategies to move toward value-based care, including provider type, provider needs, supportive activities, description of action plan, and key milestones that have been achieved. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

We have provided training in the various value-based payment methods to different councils and to our Board with the goal of socializing the various VBP contract types.

In 2020, we have an opportunity to better support provider groups seeking to work toward value-based contracting. We have an assessment of needs in the community and need to begin deploying resources in the contracting and coaching process for our partners working toward VBP contracts with their MCOs.

Examples of providers working toward VBP contracting:

VBP Category 2A: Foundational Payments for Infrastructure and Operations: partners engaged in the Whole Person Care Collaborative are working toward standing up collaborative, co located and integrated care teams. Organizations participating range from large provider organizations such as Multicare and CHI to smaller community-based providers such as Comprehensive Life Services and Consejo. The ability to bill for the Collaborative Care Model and Behavioral Health Integration CPT codes is an example of a 2A contract.

VBP Category 2B: Pay for Reporting: A requirement of receiving Medicaid Transformation Waiver dollars has been that partners report performance in clinical measures related to their funded scopes of work. Partners are currently reporting performance to the ACH for a host of clinical measures ranging from diabetes management to PHq9 scores. Partners who are reporting clinical measures directly to the ACH for waiver dollars are Multicare Health System, Sea Mar Community Health Centers, Pediatrics Northwest, HopeSparks, CHI Franciscan, Comprehensive Life Services, Consejo Counseling and Referral Service, Community Health Care, and beginning in 2020 all Fire Districts will begin reporting performance measures. The intent here is to familiarize our partners with the required reporting mechanism of VBP Contracts.

VBP Category 4A: Condition-Specific Population Based Payment: focusing on population-based payment to encourage providers to deliver coordinated and high quality care within a defined budget is an intent of the Pathways per member per month payment that partners engaged in the Community HUB are receiving. An example of a partner receiving Pathways PMPM is Community Health Centers.

23. Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of the state-issued Paying for Value Provider Survey

- a) **Provide three examples** of the ACH’s efforts to support completion of the state’s 2019 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.

Elevate Health did not incentivize providers to complete the VBP survey. Elevate Health sent bi-weekly reminders to all of our providers thru our IMC Learning Network distribution list, and brought it up during our community meetings as a reminder item.

- b) Describe how the ACH utilized individual responses and/or aggregate data, provided by HCA to the ACH from previous state-issued provider Paying for Value Surveys, to inform communications and/or identify providers in need of technical support.

Elevate Health did not use the results of the VBP survey to deploy technical support in 2019 yet we intend to take a greater focus in 2020 in supporting providers who would like support in VBP contracting.

Section 4. Pay-for-Reporting (P4R) metrics

Documentation

24.P4R Metrics

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level.⁵ Twice per year, ACHs will request partnering providers participating in Project 2A and 3A to respond to a set of questions. Potential respondents should be consistent with the list of partnering provider sites identified in the ACH’s Partnering Provider Roster affiliated with Project 2A and 3A. ACHs will gather the responses and report an aggregate summary to the state. ACHs will receive credit for timely reporting on these indicators of project implementation progress.

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: [How to read metric specification sheets.](#)
- Full P4R metric specifications are available on the [Medicaid Transformation metrics](#) webpage, under “ACH pay for reporting metrics.”
- The value of the P4R metric information to HCA is to track progress by primary care, behavioral health and community based organizations in implementing changes that advance clinical integration and strengthen statewide opioid response. Reporting may evolve over time to ask ACHs to generate reports or increase the participation among providers as needed to track progress on Projects 2a and 3a.

⁵ For more information about ACH pay for reporting (P4R) metrics, see Measurement Guide Chapter 6 and Appendix K. Link: <https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf>

Instructions:

- a) Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g., count of sites that selected each response option).
- b) Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the [reporting template](#).

Format:

- a) ACHs submit P4R metric information using the [reporting template](#) provided by the state.

Submit P4R metric information.

See Attached document for P4R

Elevate Health (Pierce County ACH)

July 1, 2019- December 31, 2019

Source: Financial Executor Portal

Prepared by: Washington State Health Care Authority

Table 1: Incentives earned

	Q3	Q4	Total
Project 2A	\$ -	\$ 1,361,169.00	\$ 1,361,169.00
Project 2B	\$ -	\$ 935,804.00	\$ 935,804.00
Project 3A	\$ -	\$ 170,146.00	\$ 170,146.00
Project 3D	\$ -	\$ 340,293.00	\$ 340,293.00
Integration	\$ -	\$ -	\$ -
VBP	\$ -	\$ -	\$ -
Total	\$ -	\$ 2,807,412.00	\$ 2,807,412.00

Table 2: Interest accrued for funds in FE portal

	Q3	Q4	Total
Interest accrued	\$ 27,282.32	\$ 33,566.31	\$ 60,848.63

Table 3: distribution of funds for shared domain 1 partners

	Q3	Q4	Total
Shared domain 1	\$ -	\$ -	\$ -

Table 4: incentive funds distributed, by use category

	Q3	Q4	Total
Administration	\$ -	\$ 2,500,000.00	\$ 2,500,000.00
Community health fund	\$ -	\$ 2,500,000.00	\$ 2,500,000.00
Health systems and community capacity building	\$ 41,350.00	\$ 1,537,380.00	\$ 1,578,730.00
Integration incentives	\$ -	\$ -	\$ -
Project management	\$ -	\$ -	\$ -

Provider engagement, participation, and implementation	\$ -	\$ 139,200.00	\$ 139,200.00
Provider performance and quality incentives	\$ -	\$ 5,188,000.00	\$ 5,188,000.00
reserve/contingency fund	\$ -	\$ -	\$ -
Total	\$ 41,350.00	\$ 11,864,580.00	\$ 11,905,930.00