



**Healthier Washington Medicaid Transformation**  
**Accountable Communities of Health**  
**Semi-annual reporting guidance**  
***Reporting period: January 1, 2019 – June 30, 2019***  
**SAR 3.0**

**July 31, 2019**  
***Prepared by HealthierHere***

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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 (January 1, 2019 to June 30, 2019) includes three sections as outlined in the table below.

Semi-annual reporting requirements (January 1, 2019 – June 30, 2019)		
Section	Item num	Sub-section components
<b>Section 1. ACH organizational updates</b>	1-8	Attestations
	9-14	Attachments/documentation <ul style="list-style-type: none"> <li>- Key staff position changes</li> <li>- Budget/funds flow update</li> </ul>
<b>Section 2. Project implementation status update</b>	15-17	Attachments/documentation <ul style="list-style-type: none"> <li>- Implementation work plan</li> <li>- Partnering provider roster</li> <li>- Quality improvement strategy update</li> </ul>
	18-19	Narrative responses <ul style="list-style-type: none"> <li>- General implementation update</li> <li>- Regional integrated managed care implementation update</li> </ul>
	20	Attestations

<b>Section 3. Pay-for-Reporting (P4R) metrics</b>	21	Documentation
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**There is no set template for this 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).

ACHs can earn AVs by providing evidence they completed reporting requirements and demonstrated performance on outcome metrics. The amount of Project 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 all Project Incentives are earned through P4R, while 25% are earned through performance on P4P. This semi-annual report covering the period of January 1 through June 30, 2019, determines achievement for half of the available P4R-associated Project Incentives. The remaining half of the P4R Project Incentives will be earned through the semi-annual report covering the period from July 1 to December 31, 2019.

ACHs will earn AVs and associated incentive payments for demonstrating fulfillment of expectations and content requirements. AVs associated with this reporting period are identified in the table below.

*Table 1. Potential Achievement Values by ACH by Project for Semi-annual Reporting Period Jan. 1- June 30, 2019*

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	8	6	-	-	7	-	-	6	27
Cascade Pacific Action Alliance	7	6	6	-	7	6	-	6	38
Greater Columbia ACH	8	-	6	-	7	-	-	6	27
HealthierHere	8	-	6	-	7	-	-	6	27
North Central ACH	8	6	6	6	7	-	-	6	39
North Sound ACH	8	6	6	6	7	6	6	6	51
Olympic Community of Health	7	-	-	6	7	6	6	6	38
Pierce County ACH	8	6	-	-	7	-	-	6	27

### ***Semi-annual report submission instructions***

ACHs must submit their completed semi-annual reports to the IA **no later than July 31, 2019 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 3 – July 31, 2019.”**

The folder path in the ACH’s directory is:

*Semi-Annual Reports* → *Semi-Annual Report 3 – July 31, 2019.*

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 submit semi-annual reports that provide HCA and the IA an update on regional project implementation progress during the reporting period. Reports should respond to all required items in this guidance document. ACHs are encouraged to be concise in narrative responses.

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.SAR3 Report. 7.31.19
- *Attachments:* ACH Name.SAR3 Attachment X. 7.31.19

***Upon submission, all submitted materials will be posted publicly to HCA’s [Medicaid Transformation resources webpage](#).<sup>1</sup>***

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

### ***Semi-annual report submission and assessment timeline***

Below is a high-level timeline for assessment of the semi-annual reports for reporting period January 1, 2019 – June 30, 2019.

<b>ACH semi-annual report 3 – submission and assessment timeline</b>			
<b>No.</b>	<b>Activity</b>	<b>Responsible party</b>	<b>Anticipated timeframe</b>
1.	Distribute semi-annual report template and workbook for reporting period January 1 – June 30, 2019 to ACHs	HCA	February 2019
2.	Submit semi-annual report	ACHs	July 31, 2019
3.	Conduct assessment of reports	IA	Aug 1-25, 2019
4.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Aug 26-31, 2019
5.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Aug 27- Sept 15, 2019
6.	If needed, review additional information within 15 calendar days of receipt	IA	Aug 28-Sept 30, 2019
7.	Issue findings to HCA for approval	IA	September 2019

### ***Contact information***

Questions about the semi-annual report template, submission, and assessment process should be directed to [WADSRIP@mslc.com](mailto:WADSRIP@mslc.com).

## 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, please also include their information.

<b>ACH name:</b>	HealthierHere
<b>Primary contact name</b>	Gena Morgan, Chief Operating Officer
<b>Phone number</b>	206.849.6262
<b>E-mail address</b>	gmorgan@healthierhere.org
<b>Secondary contact name</b>	Susan McLaughlin, Executive Director
<b>Phone number</b>	206.790.3709
<b>E-mail address</b>	smclaughlin@healthierhere.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"> <li>• Primary care providers</li> <li>• Behavioral health providers</li> <li>• Health plans, hospitals or health systems</li> <li>• Local public health jurisdictions</li> <li>• Tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region</li> <li>• 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.</li> </ul>	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 <a href="#">template</a> or a similar format) that addresses internal controls, including financial audits. <sup>2</sup>	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	

<sup>2</sup> <https://wahca.box.com/s/nfesjaldc5m1ye6a0bhiouu5xeme0h26>

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:

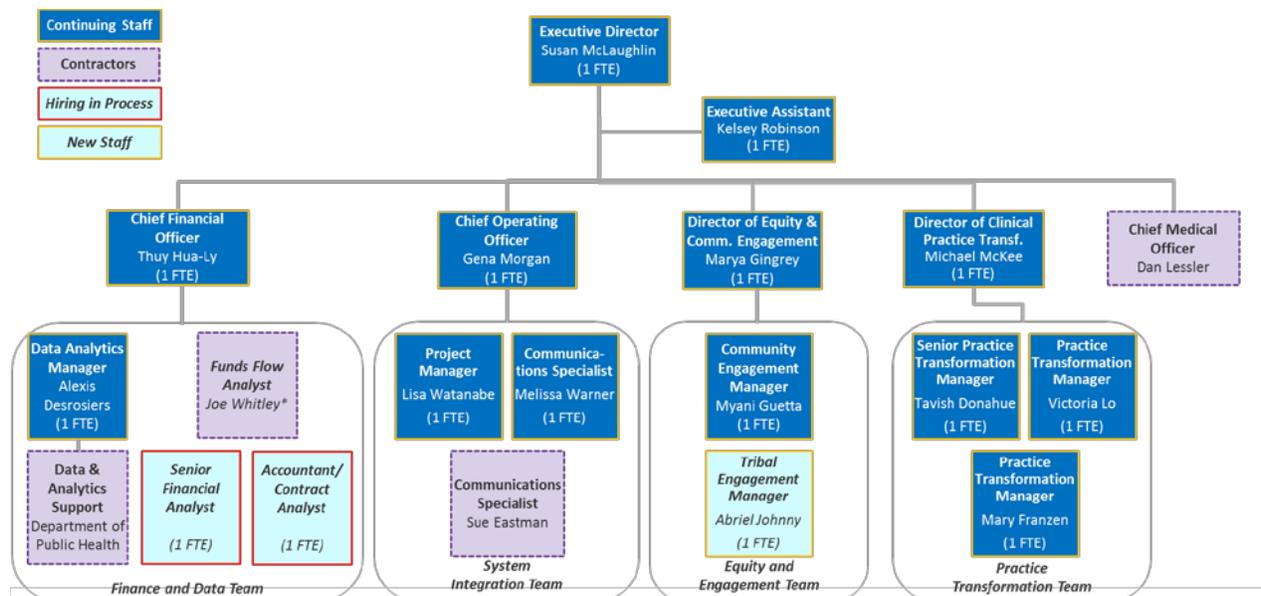
**9. Key staff position changes.** If key staff changes occurred during the reporting period, include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes to key staff positions during the reporting period.

***If applicable, attach or insert current organizational chart.***

## HealthierHere Response

HealthierHere's functional organizational chart as of June 2019 is below.

Figure 1. HealthierHere Organizational Chart as of June 2019



\*Joe Whitley is augmenting a HealthierHere staff position through a contract with Milliman.

## 10. Budget/funds flow.

- 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. Use Category reconciliation documentation will be included, if applicable. 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, etc.).

**HealthierHere Response**

During the first half of 2019, HealthierHere made payments not captured in the Financial Executor (FE) Portal for reasons described below.

Figure 2. **Payment Activity Not Captured in FE Portal**

<b>Payment to:</b>	<b>Amount</b>	<b>Expenditure Detail (Narrative)</b>	<b>Notes/ Why Payment Is Outside FE Portal</b>
<b>Comagine (previously Qualis Health)</b>	\$10,647 (DY1 Integrated Managed Care (IMC) Training and TA revenue) was drawn down by HealthierHere from the FE on May 13, 2019.	Payment is for HealthierHere’s contract with Comagine for implementing the ten-month Value-Based Payment (VBP) Academy curriculum, which is an integral component of HealthierHere’s 2019 investment strategy.	Comagine was unable to register in the FE due to a conflict between the language in the data-sharing portion of the Master Service Agreement (MSA) and the vendor’s contract with HealthierHere. This issue has since been resolved at a statewide level. Comagine has agreed to the language in the MSA and has amended the language in the vendor contract with HealthierHere in alignment with the MSA. Comagine will register in the FE Portal, which will allow HealthierHere to issue payments to Comagine directly from the FE portal.
<b>Various</b>	\$5,000 (DY1 IMC	Payment is for venue	The venue and catering

Payment to:	Amount	Expenditure Detail (Narrative)	Notes/ Why Payment Is Outside FE Portal
<b>Venue and Catering Vendors</b>	<p>Training and TA revenue) was drawn down by HealthierHere from the FE on 12/28/18.</p> <p>Applicable invoices, once received and approved for payment by the CFO, have been/will be paid directly by HealthierHere. Expenditures will be tracked against the \$5,000 draw down from the FE.</p> <p>As of June 2019 (w/June actuals): \$2,428/\$5,000 has been spent toward venue rental and meeting food/refreshments. The remaining \$2,572 will be carried forward and be used for further Training/TA support for IMC.</p>	space and catering for IMC Training/TA sessions.	vendors do not want to register in the FE 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.

### **HealthierHere Response**

Throughout the reporting period, HealthierHere made strides to strengthen our relationships with tribal nations and governments, Indian Health Services (IHS) facilities, and Indian Health Care Providers (IHCPs). In March 2019, Abriel Johnny joined HealthierHere as a Community and Tribal Engagement Manager. Ms. Johnny was most recently employed by the Cowlitz Indian Tribe, where she worked in government relations and affairs, and her professional and personal network has helped HealthierHere make significant inroads with tribal partners. Two examples of how HealthierHere has furthered relationships with tribal nations and governments as well as their engagement in and collaboration on project planning are described below.

- **Targeted outreach to Native-serving community partners to ensure they are represented in HealthierHere's community partner strategy.** In 2019, HealthierHere completed the initial phase of its community partner engagement strategy, including a request for information (RFI) process to gauge community partners' interest in participating in HealthierHere initiatives, a community partner assessment and an initial distribution of funds to community partners. In summer 2019, a cohort of partners will be invited to complete an Innovation Plan and contract with HealthierHere to implement transformation activities. Because HealthierHere believes Native-serving community partners are critical, HealthierHere ensured they were represented in every step of this process. Native-serving community partners have established relationships with Urban and Rural American Indians and Alaskan Natives in King County, are trusted service providers, and are essential to improving health outcomes, identifying health priorities and developing strategies to reduce health disparities in the tribal community. Specifically, HealthierHere has:
  - Engaged the following Native-serving community partners in active discussions regarding their role in transformation activities:
    - Advocates of the Sacred
    - Chief Seattle Club
    - King County Native American Leadership Council
    - Mother Nation
    - United Indians of All Tribes
    - UNKITAWA
  - Developed and implemented a Tribal Land Acknowledgment Protocol (see

attachment)

- Conducted a Tribal Health Disparity presentation for HealthierHere's Community and Consumer Voice Committee (CCV), an established committee of HealthierHere's Governing Board

HealthierHere plans to issue payments to the Seattle Indian Health Board and Cowlitz for completion of various milestones in HealthierHere's community partner engagement strategy. HealthierHere sent certified letters to Muckleshoot and Snoqualmie Health requesting their engagement in the Medicaid Transformation Project (MTP) and expects their response in August 2019, and will subsequently issue payment for their completion of respective milestones. We will report on the status of our partnerships with these tribal nations and governments in the fourth Semi-Annual Report (SAR).

- **Development of a Tribal Engagement Plan.** Recognizing the need for additional and specialized outreach to tribal communities, HealthierHere is developing a Tribal Engagement Plan to enhance connectivity and communication with American Indians, Alaskan Natives, tribal members, Urban Indians, IHCPs and other tribal stakeholders. The Tribal Engagement Plan will focus on identifying opportunities to inform tribes of HealthierHere's work, learn about the health priorities of the Tribal Nations and Native and Indigenous community members, and align and leverage Medicaid transformation activities to improve health outcomes and address health disparities experienced by American Indians and Alaskan Natives in King County. HealthierHere's goal is to have representation and engagement from all Tribal Nations within the King County region, Native and Indigenous community members, and IHCPs in its projects as well as on its governing body and stakeholder committees. The Tribal Engagement Plan is being developed with input from urban and rural native people to ensure their voice is appropriately represented. Tactics within the plan include:
  - In-person learning sessions to introduce HealthierHere's work and identify opportunities to better integrate with and serve tribal communities
  - An RFI process to identify tribal partners' interests in and abilities to participate in Medicaid transformation activities
  - A tribal partner assessment to help determine individual tribal partners' readiness for projects and active partnerships with HealthierHere
  - Codevelopment of solutions and strategies to provide the tribal community with the supports necessary to achieve project goals
  - Completion of Innovation Plans or other instrument detailing how tribal partners will participate in HealthierHere projects and the resources they need in order to be successful.
  - Contracting with tribal partners to participate in Medicaid transformation activities, and thereby allocating resources to Tribal Nations and Native-serving community partners to improve health outcomes and address health disparities for Native and Indigenous people living in King County

- Centering the voices of Native and Indigenous people in Medicaid transformation activities, including through authentic participation in HealthierHere governance and decision-informing bodies
- Partnering with Native-serving community partners and trusted advisors to identify the health needs and priorities within the Native and Indigenous community as well as the barriers that people face when attempting to access the healthcare system
- Building trusted relationships with tribal leaders, Tribal Elders, important community leaders, and Youth Leadership Councils working with the Native and Indigenous community

**12. Design Funds.**

- 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.

**HealthierHere Response**

**Figure 3. HealthierHere Total Design Fund Expenditures**

Use Categories	Design Fund Expenditures	Expenditure Details (Narrative)
<b>Administration</b>	\$5 million out of \$6 million in Design Funds has been used.	<p>HealthierHere received \$6 million in Design Funds in 2017. These dollars are dedicated to funding direct administrative costs.</p> <p>\$3.3 million in Design Funds were spent from 2017 to 2018 to support HealthierHere’s 2017 and 2018 administrative budget as HealthierHere worked to earn pay-for-reporting incentives. These funds were used to support HealthierHere’s direct administrative functions such as staff salaries/benefits, office space lease, fiscal sponsor fees, consulting contracts for various services, office supplies/equipment, etc.</p> <p>HealthierHere’s administrative budget for 2019 is \$5.6 million. The budget is partially funded by the remainder of the earned Design Funds (\$2.7 million). HealthierHere monitors its administrative budget with a monthly forecast-to-actuals budget model. As of June 30, 2019, HealthierHere had \$1.7 million in actual administrative expenditures—all of which is charged against the remaining Design Fund allocation of \$2.7 million. Administrative</p>

Use Categories	Design Fund Expenditures	Expenditure Details (Narrative)
		expenditures reflect actual spend through June 2019.
<b>Community Health Fund</b>	\$0	
<b>Health Systems and Community Capacity Building</b>		
<b>Integration Incentives</b>	\$0	
<b>Project Management</b>	\$0	
<b>Provider Engagement, Participation and Implementation</b>	\$0	
<b>Provider Performance and Quality Incentives</b>	\$0	
<b>Reserve/Contingency Fund</b>	\$0	
<b>Shared Domain 1 Incentives</b>	\$0	
<b>Other (describe below):</b>	\$0	
<b>Total</b>	<b>\$5 million</b>	

- 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.

### **HealthierHere Response**

HealthierHere has spent \$5 million out of its \$6 million allocation as of June 30, 2019. These figures are based on actuals through June 2019. HealthierHere, based on its administrative budget forecast for June 2019, projects that it will exhaust the remaining \$1 million in Design Funds by the third quarter of 2019. As described above, these funds will continue to support HealthierHere's administrative budget, including direct administrative functions such as staff salaries/benefits, office space lease, fiscal sponsor fees, consulting contracts for various services, office supplies/equipment, etc.

**13. Funds flow.** If the ACH has made any substantive changes to its funds flow methodology and/or decision-making process since project plan submission, attach:

- The ACH's current fund flow methodology and structure, including the decision-making process for the distribution of funds. Please note substantive changes within the attachments or describe within this section.
- Decision-making process for incentives held in reserve (e.g., community funds, wellness funds, reserve funds) if applicable. Please note substantive changes within the attachments or describe within this section.

### **HealthierHere Response**

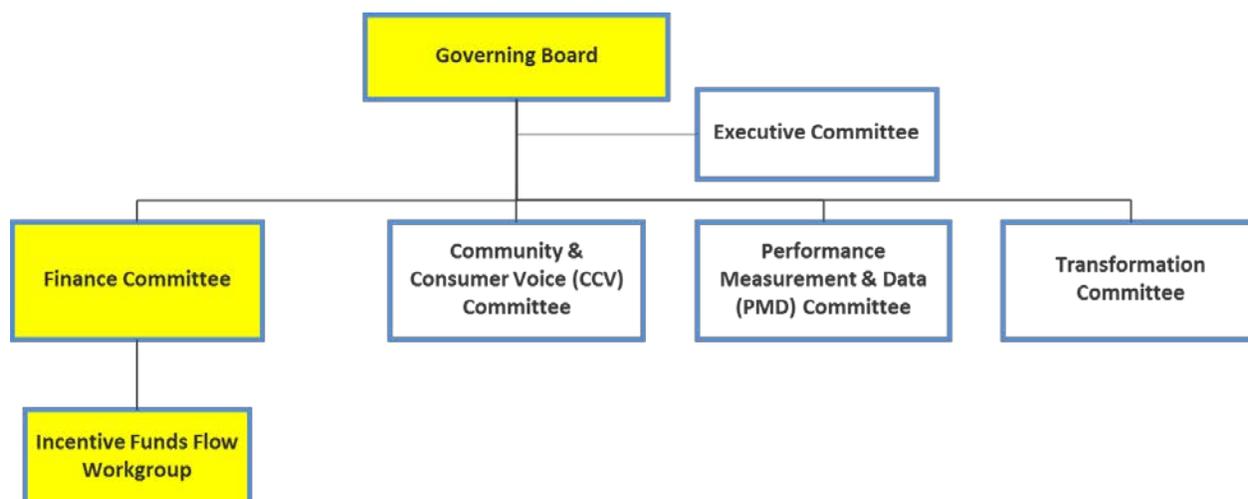
#### ***HealthierHere Funds Flow Governance***

In the [project plan submission](#), HealthierHere described its foundational funds flow methodology and decision-making process. This methodology remains intact and is serving HealthierHere's goals. In the first quarter of 2019, HealthierHere strengthened its governance and management structures to facilitate collaborative decision-making regarding funds flow. Specifically, HealthierHere clarified the roles of the Governing Board and Finance Committee and created an Incentive Funds Flow Workgroup. Their three respective roles are described below:

- The Governing Board assumes full fiduciary responsibility, including approval of the organization's annual budget and MTP fund allocations consistent with its mission.
- The Finance Committee oversees internal functions, including reviewing and recommending HealthierHere's annual budget, overseeing internal control processes and ensuring adequate protection of HealthierHere's assets. It is also responsible for transformation activity fund allocations, specifically, overseeing funds flow to partners and investment priorities, and monitoring contract requirements with state, provider and community partners.
- The Incentive Funds Flow Workgroup of the Finance Committee provides input and expertise for the financial modeling and decision-making process.

HealthierHere's governance structure is depicted below, with the above-mentioned groups highlighted. We note that in June 2019, the Incentive Funds Flow Workgroup merged with the Finance Committee to provide enhanced technical financial expertise required for MTP implementation and reduce the intensity of support provided by HealthierHere's partners.

Figure 4. **HealthierHere Governance Structure**



The eight use categories included in the project plan submission continue to serve as a guide for HealthierHere’s distribution of funds. HealthierHere’s anticipated total allocation of project funds by these use categories is depicted below.

Figure 5: **Allocation of Project Funds by Use Category**

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

HealthierHere’s governing bodies continue to use the following principles when making funds flow decisions:

- 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 HealthierHere and its partnering organizations

In line with the principles described above, HealthierHere has evolved its approach to regional investments and partner incentives through its 2019 investment strategy, Innovation Fund and pay-for-progress strategy. HealthierHere has also advanced contracting with and distribution of funds to community and tribal partners. Each of these components is described briefly below.

### ***2019 Investment Strategy***

***Clinical Partner Investment Strategy.*** In early 2019, HealthierHere continued the investment strategy work that began in fall 2018 by identifying how best to direct investments for the most effective and sustainable impact. With input from partners, HealthierHere's stakeholder committees, and assessments and change plans submitted by clinical partners, HealthierHere identified nearly two dozen potential investments for 2019. We then worked with partners, our committees and the Governing Board to finalize an Investment Prioritization Tool (IPT) to assess each potential investment according to HealthierHere's six investment values:

- *Equitable:* Addresses the areas of greatest need, health disparities and underinvestment as determined by authentic community engagement.
- *Innovative:* Extent to which investments support innovation (e.g., is a novel approach).
- *Viable:* Greater likelihood that the proposed activity will deliver intended results (during waiver).
- *Systemic:* Supports the development of solutions that align with systemwide needs.
- *Leveraging:* Leverages available resources in order to build momentum for scaling.
- *Sustainable:* Extent to which investments are sustainable.

The Finance Committee, Transformation Committee, Performance Measurement and Data Committee, and CCV Committee played a significant role in developing and refining the 2019 investment strategy. HealthierHere staff held meetings with committee members to review potential investments, the IPT, scoring of potential investments and the cost/budget analysis of potential investments. Through focused discussion and iterations with these committees, HealthierHere arrived at the 2019 investment strategy depicted below.

In March 2019, HealthierHere's Governing Board approved the 2019 Clinical Partner Investment Strategy—\$8.7 million to catalyze and incentivize transformation. This was the first stage of an ongoing, consensus-based and iterative process to develop HealthierHere's investment strategy. Over time, as we learn from our efforts, our investment strategy will evolve—and as we improve outcomes and earn more funding, we will have the resources to expand our investments. HealthierHere's 2019 investment strategy falls into three categories, described below, each with several corresponding investment areas.

Figure 6: **HealthierHere’s 2019 Clinical Partner Investment Strategy**

Investment Category	Description	Amount Available	Investment Areas
<b>Strengthen Foundational System Infrastructure</b>	Strengthen foundational system infrastructure and capacities through training, technical assistance (TA) and practice coaching to help providers develop the systems, tools and skills to implement population health and transition to value-based care.	\$4.9 million*	<ul style="list-style-type: none"> <li>Integrating Data Use Into Clinical Workflows</li> <li>Support for Population Health Management</li> <li>Collective Ambulatory Implementation and Optimization</li> <li>Support Quality Improvement</li> <li>Support Clinical Best Practices</li> </ul>
<b>Co-Design System-wide Tools for Integrated Care</b>	Co-design systemwide tools to enable community and clinical care by bringing community and clinical partners together to codevelop blueprints for systems and technologies to enable whole-person integrated care. Both the Regional Community Information Exchange (CIE) and Shared Care Planning investments will be the starting points for incorporating social determinants of health screening.	\$1.1 million	<ul style="list-style-type: none"> <li>Regional CIE</li> <li>Mechanism for Shared Care Planning</li> <li>Standardized Social Determinants of Health Screening</li> <li>System-Level Data Integration and Analytics</li> </ul>
<b>Catalyze and Test Innovations</b>	Catalyze and test cross-sector innovations to improve outcomes through seed funding for quick tests of cross-sector innovations that support transformation and have the potential to improve health outcomes for our region.	\$2.7 million	<ul style="list-style-type: none"> <li>Support Partner-Driven Innovations Through the Establishment of an Innovation Fund</li> <li>Nonlicensed Direct Care Staffing</li> </ul>
<b>Total</b>		<b>\$8.7 million</b>	

*\*In addition to the MTP Incentives, HealthierHere will leverage an additional \$830,300 from the Integrated Managed Care (IMC) Incentive Funds approved by the Governing Board in August 2018 to allow more behavioral health agencies (BHAs) to strengthen foundational system infrastructure and capacities.*

**Community Partner Investment Strategy.** HealthierHere streamlined the process used to develop the clinical partner investment strategy with the goal of distributing funding to

community partners as quickly as possible. Leveraging the same joint committee process that was used to recommend the clinical partner investment strategy, the Transformation Committee, CCV Committee, Performance Measurement & Data (PMD) Committee, and Finance Committee met in June and July 2019 to review and discuss the community partner investment strategy. As a result of the joint committees' work, HealthierHere plans to bring a recommendation to the Governing Board in August 2019 to make the following investments; we note that the investment categories for the clinical and community partner investment strategies (described above) are the same.

- *Strengthen Foundational Infrastructure* – Investments will support community partners in developing the systems, tools and skills necessary to build community and clinical partnerships that positively impact health outcomes. HealthierHere will provide training and TA for general population health management, understanding and navigating the healthcare system, use of data collection/management/analysis/sharing, quality improvement, value-based care, and equity and cultural competency.
- *Co-Design Systemwide Tools to Enable Integrated Care* – Investments will convene community partners to codevelop blueprints for systemwide integrated care through supporting participation in co-design activities (stipends, transportation support, etc.) and by getting the community to participate in co-design efforts. Initial co-design efforts will focus on shared care planning, translation and interpreter services, social determinants of health screening and a regional CIE.
- *Catalyze and Test Community Investments* – Investments will provide seed funding for focused investments that help address priority social determinants of health needs and equip community members with what they need in order to achieve the health outcomes they desire for themselves.

HealthierHere will provide an update on these investments in the next SAR.

### ***Innovation Fund***

In line with the approved investment strategy described above, HealthierHere established an Innovation Fund to support partner-led innovations that aim to establish or expand advanced care models, improve community-clinical linkages, and achieve outcome metrics. To date, HealthierHere has identified four potential projects for 2019 implementation based on partner input, partner and project readiness to launch, and potential impact on patient experience of care. These projects will support HealthierHere and its partners in achieving pay-for-performance metrics across all four Medicaid transformation project areas (bidirectional care, care transitions, opioids and chronic disease). The projects under consideration and the corresponding metrics they will impact are summarized below.

Figure 7. **Potential Innovation Fund Projects**

<b>Innovation Fund Project</b>	<b>Pay-for-Performance Metric Impacted</b>
Enhanced Connections/Handoffs to Community-Based Drop-in, Low-Barrier Medication-Assisted Treatment (MAT)	<ul style="list-style-type: none"> <li>• Opioid treatment penetration</li> <li>• Substance use disorder (SUD) treatment penetration</li> <li>• Follow-up emergency department (ED) visit for SUD</li> </ul>
ED Diversion Through Community Paramedicine/Mobile Integrated Health	<ul style="list-style-type: none"> <li>• All-cause ED visit rate</li> <li>• Hospital readmissions rate</li> <li>• Percent homeless</li> </ul>
Jail Re-entry Liaison to Support Successful Transitions and Linkage Back to Care	<ul style="list-style-type: none"> <li>• Percent homeless</li> <li>• SUD treatment penetration</li> <li>• Opioids treatment penetration</li> <li>• Mental health treatment penetration</li> <li>• All-cause ED visit rate</li> </ul>
Nursing Support in Shelters and/or Permanent Supportive Housing	<ul style="list-style-type: none"> <li>• All-cause ED visit rate</li> <li>• Hospital readmissions</li> <li>• Percent homeless</li> </ul>

Beyond helping make progress on pay-for-performance metrics, HealthierHere has the following long-term goals for the work done through the Innovation Fund:

- Prepare clinical and community partners to contract with each other.
- Enhance community and clinical partner experience in “showing value” to one another and building trusted networks.
- Connect clinical and community partners through a regional CIE to facilitate closed-loop referrals.
- Integrate shared care planning including capture of social determinants of health information.

HealthierHere expects to award up to \$2.7 million to partners for innovation projects by the end of 2019. Projects are expected to run for one to two years, with ongoing monitoring and reporting, enabling HealthierHere and its partners to quickly adjust projects to ensure their success and scale projects with the potential for significant impact within the timeline of the MTP. HealthierHere plans to pursue additional projects in 2020 and beyond.

***Pay for Progress***

Starting with 2019 partner contracts, HealthierHere implemented a Pay-for-Progress incentive payment strategy to reward clinical partners for positive workflow changes and encourage the establishment of foundational infrastructure. The strategy includes five payment bundles, made up of 12 incentives, with reporting obligations at the organization or site level (see details in Figure 8 below). HealthierHere allocated \$4 million for Pay-for-Progress incentives in 2019; the

first clinical partner reports on these bundles are due in early July 2019. HealthierHere anticipates requiring partners to report on their progress (via process metrics or activities) every six months and will award partner incentives based on their progress.

**Figure 8: Pay-for-Progress Incentives by Designated Reporting Level**

Bundles	Incentives	Designated Reporting Level (Clinical Partners)			
		Organization	Primary Care Provider Clinic Sites	BHA Clinic Sites	Hospital ED Sites
Clinical	1) MeHAF Assessment		X	X	
	2) Opioids Survey		X	X	X
	3) Whole-Person Integrated Care Screenings/Assessments		X	X	
	4) Use and Optimization of Collective Ambulatory (formerly PreManage)	X			
Population Health	5) Assignment to a Practice Panel, Care Team or Caseload (Empanelment)		X	X	
	6) Registry Functionality		X	X	
	7) Risk Stratification		X	X	
VBP	8) Health Care Payment Learning & Action Network (HCP-LAN) Status and Goals	X			
	9) VBP Convening/Training	X			
Equity	10) Equity Training	X			
	11) Equity Assessment	X			
	12) Equity Action Plan	X			

***Community Partner Contracting/Funds Flow Update***

As part of HealthierHere’s efforts to advance community partner engagement, HealthierHere has undertaken a robust process to identify community partners aligned with HealthierHere’s values and goals and ready to partner with the healthcare system in different ways. The process began with a “road show” of meetings in fall 2018 to identify as many potential community partners throughout the county as possible. The road shows resulted in approximately 100 organizations expressing interest in partnering with HealthierHere. Of those organizations, HealthierHere identified 58 whose work is aligned with HealthierHere’s project portfolio, and invited them to complete a Community Partner Assessment; the remaining organizations did not meet HealthierHere’s definition of community partner, were a BHA or Federally Qualified

Health Center (FQHC) that refers for community supports but does not directly provide services, or were already contracted with HealthierHere as a clinical partner.<sup>3</sup> The Community Partner Assessment is being used to help evaluate each organization's readiness, capacity and ability to impact Medicaid transformation. HealthierHere is completing a review of the assessments and in summer 2019 will invite a select number of potential partners to submit Innovation Plans. HealthierHere will use the Innovation Plans to finalize the first group of community partners with which it will contract beginning in fall 2019 to implement Medicaid transformation projects.

During this SAR reporting period, HealthierHere distributed \$1.8 million of the Governing Board-approved \$5.2 million in DY1 non-Medicaid dollars to 58 community partners that met the definition and are actively working to promote or provide social determinants of health services within King County. The remaining balance is scheduled to be distributed to eligible community partners during Q3 and Q4 for completion of deliverables. Community partners have also participated in a series of Partner Summits in Q1 and Q2 of this year to develop and design community-identified solutions to achieve the MTP goals. Those solutions have informed HealthierHere's DY2 Non-Medicaid Investment Strategy that will be presented to the Governing Board for approval on August 1, 2019. Once it is approved, HealthierHere will begin the process of allocating \$5.8 million to community partners to support the implementation of strategies to achieve the MTP goals over the next 12 months.

HealthierHere is in the process of transitioning its Learning Collaboratives to Co-Design Collaboratives where community and clinical partners will for the first time collaborate on projects and innovations. HealthierHere is deliberately evolving the Collaboratives to be forums where community and clinical partners will come together to establish and enhance their working relationships and develop partnerships both in pursuit of Medicaid transformation goals and to address critical health needs and challenges in King County. These Co-Design Collaboratives will inform future investment and funding strategies.

### **Tribal Partners Contracting/Funds Flow Update**

During the first half of 2019, HealthierHere developed a funding strategy for its approved DY1 allocation (\$997,000) for tribal partners. HealthierHere received approval for the DY1 tribal allocation methodology from the Governing Board on July 11, 2019. The methodology assumes there are four tribal partners and would pay each tribal partner up to a quarter of the tribal allocation for DY1 based on completion of deliverables (e.g., signing of a project-specific agreement (PSA), registering in the FE Portal, completion of change plan). HealthierHere has agreements with the Cowlitz Tribe and Seattle Indian Health Board, and will issue payment to these organizations in the third quarter of 2019. HealthierHere is waiting for engagement responses from both the Muckleshoot and Snoqualmie Tribes. Should one or both of these tribes express interest in engaging directly with HealthierHere, we will work with them to support

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<sup>3</sup> HealthierHere defines community partners as formally organized groups, organizations and/or institutions with an established and trusted presence and history working within a community in a nonclinical setting that provide and/or promote the community supports and innovation necessary to help HealthierHere meet its goals for improving health and health equity in King County. Community partners may or may not provide direct health services and are "trusted advisors" within a community that reach HealthierHere's focus populations.

planning and engagement through agreed-on deliverables in the third quarter of 2019. Any unallocated funding will be moved forward to the 2019 tribal allocation. Planning will begin in September 2019 with all tribal partners and Native-serving community-based organizations (CBOs) to develop tests of innovation and an investment strategy for tribal funds for 2020 and beyond.

**14. 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.
- ACHs may use the table below or an alternative format as long as the required information is captured.
- Description of use should be a brief line item (not narrative).

**HealthierHere Response**

**Figure 9. Use of Incentives to Assist Medicaid Behavioral Health Providers**

Description	Expenditures (\$)		
	Actual	Projected	Fund Source
Funds directed to contracted Medicaid BHAs to support infrastructure needs required for transition to IMC.	\$ 3,955,078	\$ 4,168,862	DY1: IMC
HealthierHere is overseeing and maintaining training and TA. The ACH will purchase systemwide training and TA for BHAs to help them transition to IMC and to support clinical models that will help make BHAs eligible for further incentives under HealthierHere’s bidirectional care project. Trainings included: <ul style="list-style-type: none"> <li>• VBP Academy for 28 agencies</li> <li>• Managed care contracting TA for BHAs</li> <li>• University of Washington Advancing Integrated Mental Health Solutions (AIMS) training for providers</li> </ul>	\$ 39,791	\$ 1,488,879	DY1: IMC

Description	Expenditures (\$)		
	Actual	Projected	Fund Source
HealthierHere used incentive funding to support the King County Behavioral Health Organization (BHO) during the transition to IMC. Specifically, these funds were used for temporary staffing to support the King County Behavioral Health and Recovery Division in transitioning the BHO to the new Behavioral Health Administrative Services Organization.	\$ 297,776	\$ 297,776	DY1: IMC
<b>Subtotal</b>	<b>\$4,292,645</b>	<b>\$5,955,517</b>	<b>DY1: IMC</b>
UW AIMS-DY2	\$42,582	\$42,582	DY2: Project
<b>Subtotal</b>	<b>\$42,582</b>	<b>\$42,582</b>	<b>DY2: Project</b>
TBD <sup>1</sup>	\$0	\$9,233,275	DY2: IMC
<b>Subtotal</b>	<b>\$0</b>	<b>\$9,233,275</b>	<b>DY2: IMC</b>
<b>Total</b>	<b>\$4,335,227</b>	<b>\$15,231,374</b>	<b>All</b>
<i>Note: (1) In June 2019, HealthierHere received the final IMC payment and is working with the Integration Design Steering Committee (small group of six representing health plans, FQHCs, BHAs and King County Integrated Care Network (ICN)) to develop a shared vision and investment plan for the IMC incentive dollars.</i>			

## Section 2. Project implementation status update

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.

### Attachments

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

#### 15. 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*.<sup>4</sup>

- 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:
  - Work steps and their status.
    - 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.

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<sup>4</sup> Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

- The ACH is to add a “Work Step Status” column to the work plan between the “Work Step” column and the “Timing” column. This column should reflect the status assigned to the work step.
- 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.
- If the ACH has made minor changes for any work step from their originally submitted work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.
- If the ACH has made substantial changes to the work plan format used in the October 2018 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.***

## 16. Partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.<sup>5</sup> ACHs are to indicate partnering providers that are taking action on the ground to implement tactics and/or making substantive changes or enhancements to care processes to further local, regional and state progress towards the following Project Toolkit objectives per the STCs:<sup>6</sup>

- *Health systems and community capacity building*
- *Financial sustainability through participation in value-based payment*
- *Bidirectional integration of physical and behavioral health*
- *Community-based whole person care*
- *Improve health equity and reduce health disparities*

The partnering provider roster is a standard component of semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in Medicaid Transformation activities.

To earn the achievement value associated with this reporting component, ACHs are required to confirm and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

A high-level overview of the process:

- To facilitate the process, the state will generate an initial list of potential sites (“potential site list”), based on ACH SAR 2.0 partnering provider roster submission.
- HCA will provide the expanded list of potential partnering provider sites (“potential site list”) to ACHs no later than **April 15, 2019**.
- ACHs will review the ACH-specific “potential site list” to identify the sites that are participating, and add identifying information as available (e.g., addresses for partners that are not successfully matched with state administrative data systems).
- For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
  - 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).
  - When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

### ***Submit partnering provider roster.***

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<sup>5</sup> 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 traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

<sup>6</sup> <https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf>

## Documentation

The ACH should provide documentation that addresses the following:

### **17. 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 TA 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.***

### **HealthierHere Response**

#### **Quality Improvement Strategy Development Process**

HealthierHere sees effective Quality Improvement (QI) as a key building block for population health and quality care. During this reporting period, HealthierHere developed its QI Strategy, with input from partners via the Learning Collaboratives, the Transformation Committee, the Consumer and Community Voice Committee, and other stakeholders.

As an initial step in developing the plan, HealthierHere reviewed findings from the Current State Assessments, Organizational Change Plans and partner site visits conducted in fall 2018. It became evident through this review that within the King County region, QI infrastructure varies significantly within and across providers in various healthcare sectors, including hospital systems, FQHCs and BHAs. The QI Strategy was developed with a commitment by HealthierHere to making targeted investments to support partners who have traditionally been under-resourced. Through these investments, HealthierHere's goal is to build a more robust QI

infrastructure for the King County healthcare system and establish a strong foundation for population health activities in service to improved outcomes on Pay for Performance (P4P) metrics.

HealthierHere has adopted the Plan Do Study Act (PDSA) framework for QI activities. PDSA is an established and proven protocol that has been adapted for healthcare delivery and promoted by the Institute for Healthcare Improvement, among other organizations. PDSA fosters rapid-cycle improvement strategies. Organizations will report progress every six months, giving HealthierHere the opportunity to monitor clinical partners' progress and identify opportunities for intervention. In addition, HealthierHere will continue to provide and expand other avenues for monitoring and open communication, including but not limited to dashboards derived from regional- and clinical partner-level performance data, Learning Collaboratives, planned tests of innovation, partner learning webinars, TA, practice coaching, and in-person seminars and summits. Ideally, the mechanisms described above will enable HealthierHere to identify the need for intervention before a clinical partner's scores drop below the established benchmark(s).

HealthierHere's QI Strategy can be found in the attachment *HealthierHere. QI Strategy. 7.31.19*. Moving forward, updates to the plan will be made as QI strategies evolve and best practices and lessons learned are identified. The first update to the plan will occur in Q4 2019, after HealthierHere completes its assessment of community partners and has a better understanding of community partners' QI capabilities.

### **Examples of Findings, Adjustments and Lessons Learned**

HealthierHere has observed clinical partners' use of the PDSA framework for their QI activities and has facilitated partner sharing of such activities through Learning Collaboratives. For example, at the May 2019 meeting of the Transitional Care Learning Collaborative, clinical partners shared some of their QI projects, including:

- Capturing and sharing data on various metrics
- Staffing changes in the ED to support care transitions and work with patients and their families
- Creating new positions such as a "discharge RN" to enhance support and warm handoffs for care transitions
- Adding pharmacy support to assist with medication reconciliation for medium- and high-risk patients
- Placing follow-up calls to discharged patients
- Establishing new and enhanced partnerships with other HealthierHere clinical partners to improve transitions of care among high-utilizer populations
- Sharing best practices among care management teams through a standing phone call

- Improving timeliness of documentation
- Staffing an after-hours and weekend urgent care
- Creating a post-acute care network engaged in QI activities such as root cause analyses and event reviews

HealthierHere is excited by our partners' application of QI processes and the PDSA framework to their Medicaid transformation efforts, and is especially encouraged by the enhanced collaboration and information sharing among partners.

At this time, HealthierHere has not made any adjustments to its QI Strategy. As described above, the QI Strategy will be updated in Q4 2019 based on clinical partner experience and feedback and the onboarding of community partners.

### **Support Given to Partnering Providers to Make Adjustments to Transformation Approaches**

Clinical partners identified training needs and participated in a prioritization process with HealthierHere to guide initial support investments. Based on clinical partner input, HealthierHere has invested in trainings that directly address their needs. Initial investments are supporting a VBP Academy for BHAs, whole-person integrated care training for clinical partners, implementation and optimization of Collective Ambulatory, and a summit of community and clinical partners to develop partnerships.

HealthierHere is contracting with Comagine Health (formerly Qualis Health) to provide BHAs with training, TA and practice coaching to support ongoing QI. Specifically designed for BHAs, the VBP Academy is an intensive ten-month curriculum that guides BHAs through practice transformation. The curriculum includes population health, risk stratification, QI and PDSA cycles. Throughout the ten months, practices are supported in the development and implementation of a QI transformation project that will focus on one of the P4P metrics within HealthierHere's Medicaid Transformation Portfolio. Examples of adjustments being made in support of transformation include:

- One BHA that is focused on improving behavioral and physical health integration developed new workflows to ensure primary care access for its 18-to-24-year-old population enrolled in the Foundational Community Support services.
- Another BHA is working specifically on collecting better health data for its clients and will initially focus on asthma so they can better serve their clients who use the ED.

Comagine Health is also supporting the implementation and optimization of Collective Ambulatory (formerly PreManage) as HealthierHere and King County ensure broad implementation to BHAs and FQHCs. The Collective Ambulatory platform gives organizations a key tool for tracking patient ED utilization and hospital transitions. With access to ED/hospital utilization data, providers can improve and refine follow-up processes relevant to the P4P

metrics. Comagine Health practice coaches are emphasizing the use of PDSA cycles in the development of clinical workflows to improve ED follow-up. As of June 2019, 13 BHAs that had previously not used Collective Ambulatory were implementing the platform and were in the process of developing and adapting clinical workflows to serve an identified subpopulation. Some examples of how partners are modifying practice as a result of this work include:

- Downtown Emergency Service Center (DESC) and Pioneer Human Services have developed and/or refined workflows to ensure that individuals enrolled in the Program for Assertive Community Treatment (PACT) receive follow-up if they have been in the ED.
- Harborview Mental Health staff are developing workflows related to developing care guidelines in Collective Ambulatory for patients who meet high-utilization criteria and are likely to be seen in the ED in the future.
- Many BHAs plan to scale these processes and improvements over time.

HealthierHere is also contracting with the UW AIMS Center to provide whole-person integrated care training, TA and practice coaching tailored to organizational needs and capacity. Under this contract, the AIMS Center is offering both individualized and small group training and TA to clinical partners to help them develop sustainable models of whole-person integrated care. AIMS Center practice coaches also emphasize the use of PDSA cycles in the development of clinical workflows that support whole-person integrated care. Some examples of how partners are modifying practice as a result of this work include:

- Consejo Counseling and Referral Service recently hosted a half-day training with AIMS Center staff. One participant shared, “This is a great training and I wish our whole staff could receive it. I learned so much from this training, it was so beneficial to our mission of successful integration.” As part of its ongoing integration efforts, Consejo Counseling and Referral Service would like to strengthen existing partnerships with Swedish Hospital and Bastyr and plans to hire a medical assistant as a new member of the healthcare team.
- Country Doctor Community Health Center has expressed interest in the Collaborative Care Management model and requested initial TA regarding risk stratification.

In Q2 2019, in collaboration with [Bridging Health & Community](#), HealthierHere convened community and clinical partners for a full day to build and deepen partnerships to better address social determinants needs, work toward a shared vision for how community and clinical partnerships will improve health outcomes, and begin a conversation about focusing on collaborative innovations designed to impact P4P metrics. The convening was attended by over 200 people representing 90 of HealthierHere’s partnering organizations.

## **Narrative responses.**

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

### 18. General implementation update

- *Description of partnering provider progress in adoption of policies, procedures and/or protocols:* Implementation of transformation approaches require the development or adoption of new policies, procedures and/or protocols to define and document the steps required. Partnering providers may be in varying stages of completing this process, depending on selected transformation approach and the organization.
  - Provide a summary of partnering provider progress in the adoption or adaptation of policies, procedures and/or protocols to date. How do ACHs know that successful adoption occurred?

### **HealthierHere Response**

Partnering providers have taken a diversity of approaches to advancing transformation in their organizations. Some have focused on policies to adopt new information technology (IT) systems and data tools, others have focused on developing new workflows, and others have focused on deploying new clinical protocols and building capacity. Below are a few representative examples<sup>7</sup>:

- **IT Policies:** With TA from HealthierHere, clinical partners are implementing and optimizing their use of Collective Ambulatory (formerly PreManage) software. The software provides notifications to enrolled providers when their assigned/empaneled patients experience an ED visit, to promote follow-up visits. Specifically:
  - Valley Cities is using the tool and developing the ability to report on follow up within seven days.
  - DESC has been piloting Collective Ambulatory with their PACT team since April, and plans to expand it to other teams over the summer. They noted that the pilot helped them learn how to use the Collective Ambulatory platform and to develop notification and follow-up workflows.
- **Population Health Analytics Procedures:** Clinical partners are using registries and analytics to support population health management as recommended in HealthierHere's clinical summaries. Specifically:
  - Harborview Medical Center uses registries for care management and care coordination, proactive outreach, and closure of risk gaps.
  - HealthPoint tracks chronic pain patients and opioid prescribing and performs a quarterly review of the opioid use disorder (OUD) patient population with prescribing providers.

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<sup>7</sup> Partner responses to HealthierHere's clinical practice transformation workbook are still pending at the time of SAR 3 submission and have not yet been synthesized into summary statistics.

- University of Washington Medical Center hired population health registered nurses (RNs) in some clinics, and they are informally beginning to use diabetes and hypertension registries to search for patients.
- **New Workflows and Clinical Protocols:** Clinical partners are developing and refining workflows and protocols to support their Medicaid transformation activities. Specifically:
  - DESC is developing a policy regarding opioid prescribing to ensure safe prescribing and appropriate screening for OUD, as well as appropriate management of chronic opioid analgesic treatment.
  - Swedish Cherry Hill Family Medicine uses the best practice alerts in its electronic medical record (EMR) to alert providers to care gaps. Providers are expected to review these as part of their pre-clinic preparation.
- **Training and Capacity Expansion:** Clinical partners are conducting training and hiring additional staff to enhance capacity to serve the Medicaid population. Specifically:
  - Sea-Mar Community Health Centers is expanding SUD outpatient services and has held a number of trainings on best practices related to pain management, opioid prescribing and MAT.
  - Consejo Counseling is hiring a medical assistant for their Columbia City clinic to work on population health workflows, specifically ensuring physical health screenings are completed and documented in registries and flagged for providers.
  - Swedish Family Medicine – Ballard completed a primary care-behavioral health integration project with Community Psychiatric Clinic, which included a coordinated referral process, and the colocation of Ph.D. psychology students in the clinic three and a half days a week.

HealthierHere knows that adoption of policies and protocols is occurring through formal and informal communication with clinical partners. During the first half of 2019, partners participated actively in Learning Collaboratives where they shared insights into their activities and learned from others about workflows, policies, procedures and protocols to address the four areas of focus for HealthierHere (integration of physical and behavioral health, transitional care, addressing the opioid use public health crisis, and chronic disease prevention and control). These Learning Collaboratives were instrumental in developing [Clinical Summaries](#), which lay out transformation expectations and recommended policies, procedures, and protocols for clinical partners.

Second, in spring 2019, HealthierHere invited clinical partners to complete a *Clinical Practice Transformation Reporting Workbook (Reporting Workbook)*, which requested information on partners' progress in implementing new policies and procedures that support each of the four projects selected by HealthierHere. For instance, for physical and behavioral health integration, partners are required to complete the Maine Health Access Foundation (MeHAF) Site Self-Assessment Survey and answer questions about patient screening activities; the answers to these questions provide insights on partners' status with implementing new protocols to achieve integrated care. Similarly, for the OUD project, the *Reporting Workbook* asks partners about

their progress in implementing policies to connect patients with treatment. For example, it asks partners with EDs about their success in instituting protocols to initiate patients on MAT when they present because of an overdose. Preliminary responses from partners indicate that adoption of new policies, procedures and protocols is well underway and showing positive results.

Lastly, HealthierHere is planning a series of site visits to clinical partners to engage directly with their transformation teams and observe how new policies, procedures and protocols are being implemented on the front lines. The HealthierHere team is currently developing a structured interview guide and data collection tool to assess progress with implementation and identify opportunities for partners to enhance their workflows, policies and procedures in support of their transformation objectives.

Through these formal and informal, face-to-face and written reporting mechanisms, HealthierHere has visibility into the successes and challenges of clinical partners in implementing new policies, procedures and protocols, and has been tailoring its support and training activities accordingly.

- Are there examples of partnering providers sharing policies, procedures and/or protocols? If so, describe.

### **HealthierHere Response**

Through the Learning Collaboratives—which ran from November 2018 to June 2019—partners were encouraged to share their approaches to transformation in their organization and learn from others. Learning Collaboratives were partner driven and a place where clinical partners and other stakeholders discussed workflows and could collaboratively troubleshoot challenges.

For example, in April 2019, following discussions about integrating Collective Ambulatory into clinical workflows, a Learning Collaborative member shared her agency's process for receiving, evaluating and assigning alerts. That same collaborative has held ongoing discussions about coordinating responses among multiple organizations that may receive alerts about the same patient's visit to the ED.

- Describe any challenges faced by partnering providers in the adoption of policies, procedures and or protocols for selected transformation approaches. How did the ACH support partnering providers to overcome challenges to adoption?

### **HealthierHere Response**

Clinical partners have noted the following challenges regarding the adoption of new policies, procedures or protocols for their transformation priorities:

- **Challenges with setting up population health tools** (e.g., patient registries and risk stratification tools): Several partners expressed a desire for support developing patient registries—for instance, to identify patients who are at risk of OUD relapse, or for patients with chronic conditions—to allow for more proactive outreach and intervention.

HealthierHere has provided partners with coaching through Comagine Health and other resources to overcome this challenge. HealthierHere will continue to identify and evaluate opportunities to support partners’ application of population health tools.

- **Challenges with interoperability across IT platforms:** Several clinical partners noted challenges with integrating the Collective Ambulatory platform with their EMR so that it does not require a separate log-in or duplicative data entry. Others noted the challenge of sharing patient information with organizations with which they do not have established relationships.

HealthierHere is funding practice coaching and optimization support for the Collective Ambulatory platform, as well as exploring the establishment of a regional CIE and Shared Care Plan to facilitate information sharing among and across clinical and community partners. HealthierHere will use clinical partners’ feedback and experiences to inform additional investments in Collective Ambulatory coaching and optimization as well as involve them in the potential development of a CIE.

- 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.

### **HealthierHere Response**

Key risks, their potential impacts and respective mitigation strategies are summarized in the table below.

Figure 10. **Key Risks, Potential Impacts and Mitigation Strategies**

<b>Risk</b>	<b>Potential Impacts</b>	<b>Mitigation Strategies</b>
<b>Domain I Risks</b>		
<p><i>Population Health Systems</i></p> <ul style="list-style-type: none"> <li>○ Interoperability across organizations and across information systems</li> <li>○ Need for support for development of population health tools</li> </ul>	<ul style="list-style-type: none"> <li>● Limited coordination across the various organizations that touch a patient</li> <li>● Potential for duplicative services</li> <li>● Potential for high-risk patients to fall through the cracks</li> </ul>	<p>HealthierHere is exploring the development of a CIE for the King County region, and Shared Care Planning mechanisms.</p> <p>HealthierHere will continue to provide access to population health coaching through a contract with Comagine Health and UW AIMS Center.</p>
<p><i>Workforce</i></p> <ul style="list-style-type: none"> <li>○ Behavioral health provider shortages</li> <li>○ Lack of reimbursement for community health workers and peer support specialists</li> </ul>	<ul style="list-style-type: none"> <li>● Challenges and delays with behavioral health integration efforts</li> <li>● Potential provider burnout</li> </ul>	<p>HealthierHere intends to address provider shortages through its partnership with the <a href="#">Healthcare Industry Leadership Table</a> and its policy agenda, currently under development.</p> <p>HealthierHere will continue to engage in conversations with managed care organizations (MCOs) about the value of community health workers and peer support specialists in promoting access to care, closing care gaps and supporting treatment adherence.</p>
<p><i>VBP</i></p> <ul style="list-style-type: none"> <li>○ Providers' capacity and willingness to implement VBP and continue along the Health Care Payment Learning &amp; Action Network (HCP LAN)</li> </ul>	<ul style="list-style-type: none"> <li>● VBP implementation or advancement on the HCP LAN framework is impeded</li> </ul>	<p>HealthierHere is connecting providers with training on VBP and will provide appropriate support based on their capacity and willingness to implement VBP.</p>

<b>Risk</b>	<b>Potential Impacts</b>	<b>Mitigation Strategies</b>
framework		
<b>Project-Specific Risks</b>		
<i>2A: Bidirectional Integration of Care</i>	<i>See Workforce above.</i>	<i>See Workforce above.</i>
<ul style="list-style-type: none"> <li>○ Behavioral health provider shortages</li> <li>○ Lack of shared vision for what integrated care should look like</li> </ul>	<p>Multiple pressures are put on providers from various stakeholders (MCOs, King County ICN, ACHs) that conflict with or require different processes and protocols</p>	<p>HealthierHere convened key stakeholders and is working to create a shared vision and identify care gaps to align investment strategies to advance clinical integration in the region.</p>
<i>2C: Transitional Care</i>		
<ul style="list-style-type: none"> <li>○ Challenges with release planning for incarcerated individuals</li> </ul>	<ul style="list-style-type: none"> <li>● Patients will drop out of their treatment activities if they are not connected to community resources prior to release</li> </ul>	<p>HealthierHere will be using its Innovation Fund to target resources to organizations seeking to address this challenge in innovative ways (including through enhancing centralized release planning services, and leveraging peer support specialists).</p>
<i>3A: Addressing the Opioid Use Crisis</i>		
<ul style="list-style-type: none"> <li>○ Challenges with connecting patients who are induced on MAT in jail or hospital settings with community-based resources.</li> </ul>	<ul style="list-style-type: none"> <li>● Patients will drop out of their treatment activities if they are not connected to community resources prior to release</li> </ul>	<p>HealthierHere will be using its Innovation Fund to target resources to organizations seeking to address this challenge in innovative ways (including through the development of scheduling tools, and increased MAT walk-in capacity).</p>
<i>3D: Chronic Disease Prevention and Control</i>	<i>See Population Health Systems above</i>	<i>See Population Health Systems above</i>
<ul style="list-style-type: none"> <li>○ Challenges with the development of population health tools</li> </ul>		
<b>Cross-Portfolio Risks</b>		
Duplication of efforts across partners, especially as it relates to care management activities	<ul style="list-style-type: none"> <li>● Wasted care management resources</li> <li>● Imbalances in care for patients, with some receiving uncoordinated</li> </ul>	<p>HealthierHere is planning to inventory the landscape of care coordination activities across King County with the objective</p>

<b>Risk</b>	<b>Potential Impacts</b>	<b>Mitigation Strategies</b>
	care management from multiple organizations and others receiving no care management services	of engaging with partners to better match supply with demand.
Limited ability to measure the impact of transformation efforts given data lag issues	<ul style="list-style-type: none"> <li>Partners may continue with implementing activities that are of limited impact because they do not have data to know if their efforts are successful</li> </ul>	HealthierHere is planning to publish a dashboard of performance on key project metrics – it will still suffer from data lag issues – but can help provide directional insights to partners.
Sustainability of transformation beyond the MTP	<ul style="list-style-type: none"> <li>There is a risk that progress stalls if funding for transformation activities ends abruptly with the end of the MTP</li> </ul>	HealthierHere will continue to engage in conversations with partners, MCOs and the HCA about opportunities to sustain transformation activities beyond the MTP.

## 19. Regional integrated managed care implementation update

- For **January 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 to address these challenges?

### **HealthierHere Response**

King County transitioned to IMC on January 1, 2019, and HealthierHere has continued to be an active and supportive partner to the county and BHAs throughout the transition. HealthierHere participates in the King County ICN planning committees (leadership, early warning systems and communications committees), as well as committees related to the development of the King County ICN (executive, clinical operations, finance and joint operations committees). In this role, HealthierHere has been working with the county and BHAs to identify and address challenges as they arise as well as ensure activities related to the transition are aligned with the MTP work. The challenges identified to date and mitigating strategies are described below.

- **Lack of a common vision for IMC.** Stakeholders lack a common definition of and vision for IMC, particularly integration at the clinical level, resulting in confusion regarding the requirements and roadmap for implementation. HealthierHere convened an Integration Design (IDC) Steering Committee, comprising a representative from each stakeholder group, including MCOs, FQHCs, BHAs and the ICN, to support development of a common vision and define the core components of integration. The IDC Steering Committee is reviewing work completed in 2017 in King County through a multisector design team that identified a vision and core components for integrated care. Using the previous work as a starting point, the Steering Committee is reviewing a) what activities/components have been completed or are in process, b) what activities/core components remain, c) where care gaps remain and d) how HealthierHere can best invest the IMC incentive dollars to support achieving clinical integration. The IDC Steering Committee efforts will be aligned with partners engaging in the bidirectional care project, the work of the ICN and other HealthierHere investments. It is anticipated that this work will be completed by fall 2019, and the outcome will inform how HealthierHere will invest IMC funds for the remainder of 2019.
- **BHA support.** BHAs continue to lag behind hospitals, health systems and FQHCs in their readiness for IMC. Specifically, BHAs require infrastructure and support to adopt and implement population health, quality improvement and VBP strategies. Recognizing these needs, HealthierHere has offered relevant and actionable training, TA and practice coaching to contracted BHAs. Training and TA that began during the January–June 2019 time frame includes:
  - **VBP Academy:** BHAs are participating in a ten-month VBP Academy conducted and supported through a contract with Comagine Health and in partnership with the National Council for Behavioral Health and Washington State Council on Behavioral Health.

- **Collaborative Care:** BHAs, FQHCs and primary care clinics are participating in training and practice coaching related to implementation of the Collaborative Care model, including population health management strategies. This work is supported through a contract with the UW AIMS Center.
- **Collective Ambulatory:** Comagine Health is supporting BHAs to optimize the Collective Ambulatory platform. Practice coaches are working closely with BHAs to enhance their use of Collective Ambulatory, initiate PDSA cycles to improve clinical workflows and adapt the platform to their patient populations.

Through these trainings, TA and practice coaching activities, HealthierHere is learning what additional support BHAs need and will use these findings to make continuous improvements to its IMC training and TA offerings in the second half of 2019 and beyond. HealthierHere also plans to begin identifying a second cohort of BHAs to participate in these and other training opportunities in 2020 and beyond.

- **Shifting roles and responsibilities.** As described in HealthierHere’s Implementation Plan, the King County ICN was organized to provide the infrastructure necessary for BHAs to participate in integrated care. However, 2019 was considered a transition year for contracts between the ICN and each of the five MCOs. The ICN, the MCOs and the HCA are currently working to identify and confirm contracts for 2020, including the role of the ICN in managing a network of BHAs. While the region awaits clarification, HealthierHere will work with the ICN and the MCOs to identify ongoing needs of BHAs and support the transition of services and responsibilities as needed through the remainder of 2019.

Moving forward, HealthierHere will continue to engage BHAs, MCOs, FQHCs and King County government to identify and address needs, and identify the best investments and uses of IMC funds. Additionally, HealthierHere will continue to support BHAs through its portfolio-level approach to system transformation, including project 2A (bidirectional care) and investments and activities focused on quality improvement, health information exchange and technology and VBP.

## 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"><li>• Identification of partnering provider candidates for key informant interviews.</li><li>• ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.</li><li>• 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.</li></ul>	X	

If the ACH checked "No" in item 20 above, provide the ACH's rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.

## Section 3. Pay-for-Reporting (P4R) metrics

### Documentation.

#### 21. P4R Metrics

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress at a clinic/site level.<sup>8</sup> Twice per year, ACHs will request partnering providers respond to a set of questions. ACHs will gather the responses and report them 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.](#)<sup>9</sup>
- Full P4R metric specifications are available on the [Medicaid Transformation metrics](#) webpage, under *ACH pay for reporting metrics.*<sup>10</sup>
- P4R metric responses are gathered at the site-level. Each P4R metric is specified for response at the level of the practice/clinic site or community-based organization. Practice/clinic sites are defined as sites that provide physical and behavioral health services paid by Medicaid. Community-based organizations and other providers are defined as any participating sites that are not Medicaid-paid providers.
- It is HCA's expectation that ACHs will facilitate participation of practice/clinic sites and CBOs, and strive for as much participation as possible of practice/clinic sites and CBOs. HCA has not set a specific minimum response rate. However, the state would like the ACH to summarize the number of potential sites and actual respondents by provider type for each reporting period.

#### *Instructions:*

- Submit line-level P4R metric responses collected from partnering provider sites. Include partnering provider organization name and site name for each respondent.
- Provide a count of partnering provider sites participating in Project 2A and 3A, and a count of P4R metric respondents, stratified by provider type (practice/clinic site and community based organization).

#### *Format:*

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<sup>8</sup> 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>

<sup>9</sup> <https://www.hca.wa.gov/assets/how-to-read-p4p-metric-specifications.pdf>

<sup>10</sup> <https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-metrics>

- ACHs have the option to submit P4R metric information using the workbook provided by the state or via an alternative format (as long as all data fields are represented and consistent with the P4R metric required data fields list).

***Submit P4R metric information.***

# HealthierHere Tribal Land Acknowledgement Protocol

## Purpose:

This document will serve as a guide for HealthierHere staff on properly and respectfully providing a land acknowledgement before public meetings and events.

## Delivery Protocols:

1. Consider inviting a tribal elder, Tribal Council member, or tribal representative to give a welcome prior to your land acknowledgment. (This should be on a case by case basis. Ask the individual prior to the meeting starting, do not put him/her on the spot.)
2. Otherwise, the Land Acknowledgement should be the first element of a welcome on the agenda.
3. These words should be offered with respect, grounded in authentic reflection, presence, and awareness.

## Be Mindful of:

- There's a danger that a practice like this becomes just another piece of protocol, delivered flatly and falling on deaf ears. Acknowledgment should not be approached as a set of obligatory words to rush through.
- Breathe in awareness of both the present and of the histories that connect you with the people you are naming.
- Consider your own place in the story of colonization and of undoing its legacy.

## Might Consider:

- Taking a photo of the Land Acknowledgement at a public meeting or event if given by local tribal elder, Tribal Council member, or designated representative for the Healthier website or blog.
- #HonorNativeLand (a hashtag on website or blog)
- Include a form of mini land acknowledgment in email signatures

## King County Area Acknowledgement Language:

Every community owes its existence and vitality to generations from around the world who contributed their hopes, dreams, and energy to making the history that led to this moment. Some were brought here against their will, some were drawn to leave their distant homes in hope of a better life, and some have lived on this land for more generations than can be counted. Truth and acknowledgment are critical to building mutual respect and connection across all barriers of heritage and difference. We begin this effort to acknowledge what has been buried by honoring the truth. We want to respectfully acknowledge the Coast Salish peoples, whose ancestors and descendants have stewarded this land for generations. We pay respects to their elders past and present. Please take a moment to consider the many legacies of violence, displacement, migration, and settlement that bring us together here today. And please join us in uncovering such truths at any and all public events.

# HealthierHere Tribal Land Acknowledgement Protocol

## **Seattle Boundary Area Acknowledgement Language:**

Every community owes its existence and vitality to generations from around the world who contributed their hopes, dreams, and energy to making the history that led to this moment. Some were brought here against their will, some were drawn to leave their distant homes in hope of a better life, and some have lived on this land for more generations than can be counted. Truth and acknowledgment are critical to building mutual respect and connection across all barriers of heritage and difference. We begin this effort to acknowledge what has been buried by honoring the truth. We are standing on the ancestral lands of the Coast Salish People. We are in the city of Seattle, named after Chief Sealth a signatory Chief on the Point Elliott Treaty of 1855. We pay respects to their elders past and present. Please take a moment to consider the many legacies of violence, displacement, migration, and settlement that bring us together here today. And please join us in uncovering such truths at any and all public events.

DRAFT



August 23, 2019  
Dear Mr. Morgan:

Thank you for the submission of Healthier Here's Semi-Annual Report Assessment 3. As the contracted Independent Assessor for the Washington Health Care Authority's Section 1115 Medicaid Transformation Project, Myers and Stauffer LC (Myers and Stauffer) has assessed the Semi-Annual Review 3 submission requirements.

Upon review of the documentation submitted, we have identified the below areas within your submission where we have requests for additional information.

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

Please post your response in PDF, Excel or Word format following the resubmission instructions below to WA CPAS (<https://cpaswa.mslc.com/>) within the Request for Information folder (pathway is Semi-Annual Report > Semi-Annual Report 3 – July 31, 2019 > Request for Information). **We ask for your response no later than 5:00 p.m. PST, September 9, 2019.** Information received after this date will not be considered.

Thank you,  
Myers and Stauffer LC



**Healthier Washington Medicaid Transformation  
Accountable Communities of Health  
Semi-Annual Report 3 Assessment  
Reporting Period: January 1 to June 30, 2019**

**Request for Supplemental Information**

Upon review of the ACH’s Semi-Annual Report Assessment, the Independent Assessor has identified the below areas where we have additional questions or requests for clarification.

- If the question applies to the project narrative, please provide a response within this document. The naming convention should be as follows: “RESPONSE ACH name.SAR3.RFI.Date”
- If the question applies to any attachments, please respond with an **updated** attachment. The naming convention should be as follows: “REVISED ACH Name.SAR3 Attachment Name”

**Section 2: Project Implementation Status Update**

**Question 15 - Implementation work plan:** The ACH must submit an updated implementation plan reflecting progress made during the reporting period. The updated implementation plan must clearly indicate progress made during the reporting period.

1. **Independent Assessor Question:** Do clinical summaries include all components of the evidence-based models required to be adopted for each project?

**HealthierHere Response:**

HealthierHere is taking a broad, portfolio approach to inform King County’s transformation efforts. HealthierHere’s clinical summaries were developed in alignment with the evidence-based models identified by the Health Care Authority (HCA) in the Medicaid Transformation Project (MTP) Toolkit and each clinical summary references at least one, and often several, of the evidence-based models required for the respective project. Consistent with guidance in the Project Toolkit, HealthierHere specified at least one of the evidence-based approaches for each project. At the end of each clinical summary, HealthierHere provides references and guidelines to the required evidence-based models.

HCA identified evidence-based models (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model) with congruent underlying principles that are foundational to system and service delivery transformation. HealthierHere leveraged these underlying principles to craft clinical summaries with six key project elements:



- Utilize population health management tools;
- Assess whole-person care needs;
- Implement team-based care;
- Develop integrated care planning;
- Provide self-management supports; and
- Link to community resources.

Within these key project elements, HealthierHere touches on many of the components of the required evidence-based approaches, but also affords partners flexibility with respect to implementation. For instance, in all of the clinical summaries, partners are encouraged to form person-centered, multi-disciplinary, integrated care teams, recognizing that these teams will vary by the resources partners have available, individual needs, and risk stratification. The clinical summaries provide examples of potential team members, but are not prescriptive. In addition, HealthierHere’s behavioral health agency (BHA) practice partners are being coached on the use of Collective Ambulatory to help manage population health. Each partner’s unique circumstances determine their approach and are supported by coaching. One BHA was “astounded” to discover their clients’ high number of emergency department (ED) visits and is currently analyzing their data to determine a sub-population to focus on reducing their ED utilization.

2. **Independent Assessor Question:** Does the work step listed on row 99 produce the required materials that are confirmed when conducting work step 109?

*Note: The IA clarified via email (8/29) that this question refers to Project 2C and 3A and relates to the development of goals and objectives for the clinical summaries in relation to the partner site visits.*

**HealthierHere Response:**

HealthierHere worked closely with subject matter experts and partners in 2018 to develop the clinical summaries and site visits began in August 2019. Through the site visits (work step 109 of the Implementation Plan), HealthierHere is discussing clinical practice partners’ progress in advancing the project goals and objectives identified in the clinical summaries (row 99 of Implementation Plan). During the site visits, HealthierHere is asking



partners about their organizational and site-level goals for the projects they are implementing, results thus far, challenges and mitigation strategies, as well as areas where HealthierHere can provide support.

**Question 17 – Quality improvement strategy update:** The ACH must submit quality improvement strategy updates on a semi-annual basis to keep HCA and 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: 1) modifications to the ACH's quality improvement strategy, 2) summary of findings, adjustments, and lessons learned, 3) support provided to partnering providers to make adjustments to transformation approaches, 4) identified best practices on transformation approaches.

3. **Independent Assessor Question:** HH noted that there is a meet the partner "where they are" approach. HH also outlined differences in utilization of QI processes between hospitals, FQHCs and BHAs. BHAs will receive targeted support through the VBP Academy. What approaches does HH anticipate taking with other provider types (excluding community partners, as it was noted that an assessment has not been made to date) that have more mature QI activities?

**HealthierHere Response:**

According to HealthierHere's Current State Assessment, hospitals and health systems are the best resourced with respect to quality improvement (QI); they generally have established QI departments, processes, and committees. Federally Qualified Health Centers (FQHCs) also tend to have mature QI infrastructure, in part due to the regional focus on Patient Centered Medical Home (PCMH) accreditation over the past decade. However, both hospitals and health systems (and their networks of providers) and FQHCs still have opportunities to strengthen and standardize QI methods to support transformation and improve patient outcomes.



HealthierHere is taking the following approaches to meet our partners where they are and support hospitals and health systems, FQHCs, and other partners with more mature QI activities in strengthening their QI efforts.

- HealthierHere adopted the Plan Do Study Act (PDSA) framework for QI activities, which fosters rapid-cycle improvement strategies. Partners with more mature QI activities will be encouraged to test, or continue to test, new ways of doing things using the PDSA framework.
- HealthierHere contracted with Comagine Health (formerly Qualis Health) to support partners in optimizing their use of the Collective Ambulatory platform (formerly PreManage). The Collective Ambulatory platform gives organizations a key tool for tracking patient ED utilization. With access to ED utilization data, providers can improve and refine follow-up processes relevant to the pay-for-performance (P4P) metrics. Comagine Health practice coaches will emphasize the use of PDSA cycles in the development of clinical workflows to improve ED follow up. Other partners, generally those with less mature QI activities, are receiving assistance with implementing Collective Ambulatory. Comagine Health practice coaches use PDSA cycles to help partners new to the Collective Ambulatory platform stratify patients by risk and develop workflows to ensure appropriate follow-up care following an ED visit.
- HealthierHere contracted with the University of Washington (UW) Advancing Integrated Mental Health Solutions (AIMS) Center to provide whole person integrated care training, technical assistance (TA), and practice coaching tailored to organizational needs and capacity. Under this contract, the AIMS Center is offering both individualized and small group training and TA to clinical practice partners to help them develop sustainable models of whole-person care. AIMS Center practice coaches emphasize the use of PDSA cycles in the development of clinical workflows that support whole person integrated care. As of September 2019, the AIMS Center coaches are working with four hospital systems and three FQHCs that have more advanced QI infrastructure, in addition to eight BHAs. By tailoring the practice coaching to unique organizational needs, the AIMS Center coaches have seen high engagement from the organizations with more robust infrastructure.
- To encourage and reward ongoing QI activities, HealthierHere created a “Pay-for-Progress” incentive package. Clinical partners earn payments for completing various assessments and improving on selected metrics. While some incentives focus on hitting defined targets, others emphasize improvement over self, thereby encouraging more



mature partners to improve above and beyond their current state. HealthierHere will monitor clinical partners' progress to learn about and share best practices, adjust investments and/or training opportunities, and identify clinical partners that may need a higher level of support. For 2019, HealthierHere has structured its Pay-for-Progress incentives around four "bundles:" Clinical, Population Health, VBP, and Equity.

- HealthierHere established an Innovation Fund to support innovations proposed by clinical practice partners to test innovative care models that improve community-clinical linkages and achieve P4P metrics. HealthierHere expects more mature partners will respond to Innovation Fund opportunities because they are targeting new care delivery approaches and innovations, whereas less mature partners are focused on building their infrastructure and capacity. Included in this strategy is a focus on building organizational capacity to use community health workers and peer support specialists, as well as supporting these staff in expanding their scope related to Medicaid transformation strategies. The tests of innovation will utilize continuous QI strategies to ensure that the innovations achieve desired improvements, and to inform strategies for scaling and sustaining.
  - HealthierHere's Co-design Collaboratives allow clinical and community partners to share best practices, discuss strategies and tools for effectiveness, and work together to improve project metrics on regional and organizational levels. The focus is often on improving existing workflows, as well as testing new ways of doing things. Ideas that arise from the Collaboratives can be translated to PDSA or other rapid-cycle tests of innovation.
  - HealthierHere is in the process of establishing a Partner Training Fund that is a flexible resource to support HealthierHere's clinical partners in pursuing additional training opportunities beyond HealthierHere's system-wide training investments. HealthierHere understands that partners may be in different places with respect to their individual training needs. As a complement to the system-wide training investments HealthierHere offers, we are giving partners the opportunity to draw down additional funds to support their organization-specific training needs.
4. ***Independent Assessor Question:*** HH noted that the Learning Collaboratives evolved into Co-design Collaboratives where community and clinical partners will come to collaborate on projects and innovations. Because of the broader perspectives in the room, does HH anticipate changes to format? How will lessons from the Co-design Collaboratives be captured and disseminated by the ACH?



### **HealthierHere Response:**

HealthierHere established Learning Collaboratives for each of its four projects; the monthly Learning Collaboratives convened HealthierHere's clinical practice partners to share activities, progress, and challenges related to the four project areas, as well as collaboratively develop solutions. In anticipation of onboarding community practice partners this summer, HealthierHere transitioned the Learning Collaboratives to Co-Design Collaboratives. The Co-Design Collaboratives meet in-person, like the Learning Collaboratives, but have a broader scope and audience than the Learning Collaboratives. As such, we are employing a breakout format to ensure clinical and community partners have the opportunity to tackle project-specific issues and solutions development together. Whereas there were four distinct Learning Collaboratives, there is essentially one Co-Design Collaborative that brings community and clinical partners together and then within that Collaborative, partners have the opportunity to network and breakout to focus on project-related topics.

Lessons from the Co-design Collaboratives are captured by HealthierHere staff – primarily the Practice Transformation Team and Equity and Engagement Team who are responsible for clinical and community practice partner engagement, respectively – and disseminated through formal and informal communication mechanisms, including:

- 1:1 meetings with clinical and community practice partners, often facilitated by HealthierHere Practice Transformation Managers and a Community Engagement Manager
- Reports to HealthierHere's various committees, including the Transformation Committee and Community and Consumer Voice Committee (CCV), as well as the Governing Board
- Newsletter and email communications to partners

As the community practice partners are on boarded, we are considering additional mechanisms to enhance clinical and community practice partner collaboration and information sharing.

5. ***Independent Assessor Question:*** If partnering providers identify a need for course correction or adjustment to transformation approaches, how do partners communicate this



need with the ACH? The ACH may want to consider adding this to the QI Strategy in the future.

**HealthierHere Response:**

Partners communicate needs for course corrections or adjustments to transformation approaches through various informal and formal mechanisms, including:

- Through semi-annual reporting, partners report on their progress, approaches, and experiences implementing transformation activities. Most of the milestones in the assessment are structured to assess improvement over self, thus allowing HealthierHere to monitor individual partner progress and identify areas in need of a course correction or potential adjustment to approach. The assessment also includes free response questions for partners to provide feedback on their progress toward system transformation, including barriers, challenges, and the need for additional assistance. HealthierHere will consider updating the semi-annual assessment template to include a question on the need for course corrections or adjustments.
- At site visits, partners will have the opportunity to provide open and honest feedback on project implementation successes and challenges through small group discussions. HealthierHere's Practice Transformation Managers will ask partners about their need to adjust or course correct and subsequently work with partners to troubleshoot and provide guidance on challenges and barriers. To the extent HealthierHere identifies common barriers among partners, we will work to address such barriers at the system-level.
- Through Co-Design Collaboratives and other convenings, partners are encouraged to identify challenges and seek HealthierHere's assistance if they are struggling or need to adjust their approach. The Collaboratives are also an opportunity for partners to share their challenges and learn from their peers what mitigating strategies have worked for them.
- HealthierHere's Governing Board and Committee meetings are forums of partners as well as other community stakeholders (e.g., MCOs). During meetings, partners are invited to share their experiences and seek guidance from HealthierHere or their colleagues.



HealthierHere will update its QI strategy to clarify and emphasize that partners should communicate, via any of these or other mechanisms, their need to course correct or adjust transformation approaches. The HealthierHere team is also proactively monitoring partners’ performance through the mechanisms described above and may present opportunities for course correction to the partner if needed.

6. **Independent Assessor Question:** HH indicates that Pay for Progress milestones assess improvement over self. Please offer additional explanation regarding the methodology for calculating achievement of this model. Is it based on a composite score or individual metric improvement? What level of improvement is HH expecting? The ACH may want to consider adding this to the QI Strategy in the future.

**HealthierHere Response:**

The Pay for Progress improvement over self methodology was shared with partners in the attached “2019 Clinical Practice Transformation BHA Reporting & Payment Methodology Workbook.” The attached (see page 12) work book is for behavioral health agencies, based on the ‘up to’ amount for that sector.

HealthierHere’s partners will report on Pay for Progress milestones on a semi-annual basis. While a few of the milestones are measured as binary – completed or not completed – most of the milestones are structured to assess improvement over self, using a simple scale inspired by validated tools like the MeHAF and PCMH-A. The Pay for Progress reporting workbook includes the scale for each improvement over self milestone. Partners review the characteristics of each level of the scale and self-identify where they stand. If a partner’s progress on a metric stalls or dips, but they are still performing better than the majority of partners in the region, the partner will not receive credit for that metric. This approach allows HealthierHere to meaningfully evaluate individual partner progress.

The Pay for Progress measures fall into four bundles—clinical, population health, VBP, and equity. As shown in the table below, six out of twelve metrics will be scored on improvement over self:

Clinical	Population Health	VBP	Equity
<ul style="list-style-type: none"> <li>• MeHAF assessment*</li> <li>• Opioids survey</li> </ul>	<ul style="list-style-type: none"> <li>• Empanelment*</li> <li>• Registry functionality*</li> </ul>	<ul style="list-style-type: none"> <li>• VBP training</li> <li>• HCP LAN status**</li> </ul>	<ul style="list-style-type: none"> <li>• Equity training</li> <li>• Equity assessment</li> </ul>



Clinical	Population Health	VBP	Equity
<ul style="list-style-type: none"> <li>• Use of screenings/ assessments*</li> <li>• Use and optimization of Collective Ambulatory platform*</li> </ul>	<ul style="list-style-type: none"> <li>• Risk stratification*</li> </ul>		<ul style="list-style-type: none"> <li>• Equity action plan</li> </ul>
<p>*Measures/milestones structured as improvement over self          **HCP-LAN status is measured as MCO payments to providers made through VBP arrangements above Category 2C/total MCO payments to providers.</p>			

Improvement over self metrics are individually assessed based on two performance scores: percent change and level change, when applicable. If a partner chooses multiple “test sites” for Pay for Progress reporting, the median of all test sites for that particular incentive will be used to calculate improvement over self. Partners first completed pay for progress workbooks in July 2019; those results will serve as the baseline for the next round of partner reporting, scheduled for December. The four steps HealthierHere will take to calculate scores in December and going forward are below.

- Step 1: Calculate Percent Change
  - Percent Change = (December performance score - June baseline score) / June baseline score

*Note: Percent change is converted to an adjusted value so providers only have the option of 0%, 25%, 50%, 75%, 100%.*
- Step 2: Calculate Level Change
  - Level Change= “Y”, then partner receives 100% for level change score
  - Level Change= “N”, then partner receives 0% for level change score

*Note: If a provider is in the top tier and moves to the highest point (e.g., from a 9 to a 10) the provider gets 100% for percent change and tier movement. This is to incentive high performing providers.*
- Step 3: Use Step 1 and Step 2 to calculate Improvement over Self Score (IOS)
  - IOS Score= (Percent Change \*.5 ) + (Level Change \*.5)



- Step 4: Use Step 3 to calculate Improvement over Self (IOS) Earning
  - $\text{IOS \$} = \text{IOS "Up to amount"} * \text{IOS Score}$

Please refer to the Reference Book for additional information and example calculations.

7. ***Independent Assessor Question:*** In what manner does HH distinguish between actions taken because of agreements noted in the Change Plan or clinical summary versus actions taken as a result of identified barriers during the implementation process? The ACH may want to consider adding this to the QI Strategy in the future.

**HealthierHere Response:**

HealthierHere is actively monitoring and tracking the barriers partners identify and their mitigation strategies. This is a key topic of discussion during clinical partner site visits where Practice Transformation Managers inquire about actions taken as a result of identified barriers, as well as the support a partner may require to remove existing or anticipated barriers. Also during site visit, the Practice Transformation Manager discusses general project and transformation progress with the partner, enabling HealthierHere to distinguish between general progress and actions driven or in response to barriers.

HealthierHere also collects information across partners on the barriers they face through the semi-annual reporting process. The HealthierHere team endeavors to identify themes of common barriers and subsequently brings these themes to staff, the Governing Board and Committees, as well as Co-Design Collaboratives. Through these forums, HealthierHere identifies opportunities to resolve barriers or connect partners to share best practices.



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STAUFFER** LC  
CERTIFIED PUBLIC ACCOUNTANTS

**Attachment**

- 2019 Clinical Practice Transformation BHA Partners Reporting & Payment Methodology Workbook



HealthierHere

## **2019 Clinical Practice Transformation**

**BHA partners**

# **Reporting & Payment Methodology Workbook**

FINAL, Last revised 5/13/2019

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## About HealthierHere’s Clinical Practice Transformation Reporting Workbook

This workbook details HealthierHere’s 2019 Pay for Progress incentives. Please use this Clinical Practice Transformation Reporting & Payment Methodology Workbook as the tool to collect your responses and report your progress on HealthierHere’s Clinical Practice Transformation Pay for Progress Incentives for 2019. You are encouraged to edit this document to collect information for your organization, but your final responses must be submitted using HealthierHere’s online tool, called FormAssembly. HealthierHere will provide the link to the online tool at the start of the reporting period. Please reach out to your designated Project Manager if you have any questions.

## Reporting Requirements

Reporting requirements for each incentive will vary depending on the incentive. Some incentive metrics warrant reporting at the **organizational level**, one response for the organization as a whole. The HealthierHere champion is likely the best person to collect this information and report on behalf of the organization.

Other incentive metrics are best answered at the **individual site level**. HealthierHere has outlined three types of sites: Primary Care (**PCP**) Clinic Sites, Behavioral Health Agency (**BHA**) Clinic Sites, and Hospital Emergency Departments (**ED**).

*PCP Clinic Sites:* Both FQHC and hospital-affiliated primary care clinics are considered PCP Clinic Sites. HealthierHere requires one submission/response for each contracted reporting site.

*Behavioral Health Agency (BHA) Clinic Sites:* Community (outpatient) behavioral health clinical sites are considered BHA Clinical Sites. HealthierHere requires one submission/response for each contracted reporting site.

*Hospital Emergency Departments (ED):* The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care are considered ED sites. HealthierHere requires one submission/response for each contracted reporting site.

*What are contracted reporting sites?*

HealthierHere will negotiate with each practice partner's HealthierHere Champion to select reporting sites for 2019. The minimum number of reporting sites will vary by sector. The selected reporting sites will be listed on HealthierHere's 2019 contracts, and the FormAssembly version of the survey will have a drop-down menu with all of the reporting sites so that whomever is submitting their site's response can do so easily.

## Suggested Best Practices for Completion

Organizational level incentives can be completed by the HealthierHere Champion, with input from relevant departments. For incentives that are to be completed at the site level, the Champion is encouraged to play a coordinating role, but the clinical care team at each reporting site should respond based on the reality at their clinical site.

For all site-level metrics, HealthierHere recommends that clinical care team members respond individually, then compare their answers with other team members, editing collectively to answer as a team. A staff or team meeting is an ideal venue for that discussion. Each site will then submit their own assessment to HealthierHere using the link provided by their HealthierHere Champion. If your clinical teams need support with this process, please reach out to HealthierHere.

## Defining the Clinical Care Team

HealthierHere defines a clinical care team as group of primary care and/or behavioral health practice personnel who identify as members of a team and who work together to provide care for a panel of patients. Care teams could include the following positions depending on the setting: Primary Care Provider (MD, DO, ARNP, PA), RN Case Manager, Medical Assistant, Mental Health Professional, Chemical Dependency Professional, Social Worker, Pharmacist, Care Coordinator, Dietitian, Community Health Worker, Peer Support Specialist.

## Incentives by Designated Reporting Level

Bundles	Incentives	Designated Reporting Level			
		Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
Clinical	1) MeHAF Assessment		X	X	
	2) Opioids Survey		X	X	X
	3) Whole Person Care Screenings/Assessments		X	X	
	4) Use and Optimization of Collective Ambulatory (formerly PreManage)	X			
Population Health	1) Assignment to a Practice Panel, Care Team, or Caseload (Empanelment)		X	X	
	2) Registry Functionality		X	X	
	3) Risk Stratification		X	X	
VBP	1) <i>HCP LAN Status &amp; Goals</i>	X			
	2) <i>HH VBP Convening/Training</i>	X			
Equity	1) <i>HH Equity Training</i>	X			
	2) <i>HH Equity Assessment</i>	X			

	3) HH Equity Action Plan	X			
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### Introductory Questions for PCP and BHA Clinic Sites (July reporting period)

	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
Introductory Questions		X	X	

1. Number of primary care providers at your site (MD, DO, PA, ARNP)
2. Number of behavioral health providers at your site (Psychiatrist, Psychologist, Psychiatric ARNP, Mental Health RN, Mental Health Professional, Chemical Dependency Professional, Social Worker)
3. Number of patients served by site per year
4. Number of office visits at your site per year
5. Payor mix at your site (%)
  - a. Medicaid
  - b. Medicare
  - c. Commercial
  - d. Self-Pay
  - e. Other

### Clinical Incentive Bundle (July and December reporting periods)

	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
Incentives				
1) MeHAF Assessment		X	X	
2) Opioids Survey		X	X	X
3) Whole Person Care Screenings/Assessments		X	X	
4) Use and Optimization of Collective Ambulatory (formerly PreManage)	X			

1) [MeHAF](#) Site Self-Assessment to measure level of physical and behavioral health integration

**Background:**

The Maine Health Access Foundation (MeHAF) developed the Site Self-Assessment (SSA) Survey to assess levels of primary and behavioral care integration. The SSA Survey focuses on two domains: 1) integrated services for patient and family services and 2) practice/organization. Each domain has characteristics to rate on a scale of 1 to 10 depending on the level of integration or patient-centered care achieved.

The Washington State Health Care Authority (HCA) adopted the 21 question MeHAF+ as a required pay for reporting requirement for all Accountable Communities of Health (ACHs), all ACHs are required to have participating sites complete the survey every six months and submit the results to the HCA. HealthierHere decided to incentivize this reporting requirement in 2019.

**Instructions:**

The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site’s current extent of integration for patient and family-centered primary care and behavioral health care. Future repeated administrations of the SSA form will help to show changes your site is making over time. Organizations working with more than one site should ask each site to complete the SSA. Please respond in terms of your site’s current status on each dimension. Please rate your patient care teams on the extent to which they currently do each activity for the patients/clients in the integrated site. The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves primary care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff. Using the 1-10 scale in each row, circle select one numeric rating for each of the 21 characteristics. If you are unsure or do not know, please give your best guess.

If you would like more guidance on how to complete the MeHAF please consult the MeHAF Facilitation Guide developed by Qualis Health: [https://depts.washington.edu/fammed/wp-content/uploads/2019/01/MeHAF-Facilitation-Guide-Tool\\_190128.pdf](https://depts.washington.edu/fammed/wp-content/uploads/2019/01/MeHAF-Facilitation-Guide-Tool_190128.pdf)

A) Did a care team collectively give feedback to develop your site’s response to this incentive?

(Yes/No)

B) If yes, please list the names and roles of the care team members who contributed to your response:

---

C)

I. Integrated Services and Patient and Family-Centeredness					(Circle one NUMBER for each characteristic)
1. Level of integration: primary care and mental/behavioral health care	... none; consumers go to separate sites for services	... are coordinated; separate sites and systems, with some communication among different types of providers; active referral	.. are co-located; both are available at the same site; separate systems, regular communication among different	... are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic	

		linkages exist	types of providers; some coordination of appointments and services	health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings.
	1	2 3 4	5 6 7	8 9 10
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)  2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs)	... are not done (in this site)	... are occasionally done; screening/assessment protocols are not standardized or are nonexistent	... are integrated into care on a pilot basis; assessment results are documented prior to treatment	... tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/assessment protocols are used and documented
	1	2 3 4	5 6 7	8 9 10
3. Treatment plan(s) for primary care and behavioral/mental health care	... do not exist	... exist, but are separate and uncoordinated among providers; occasional sharing of information occurs	... Providers have separate plans, but work in consultation; needs for specialty care are served separately	... are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care
	1	2 3 4	5 6 7	8 9 10
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care	... does not exist in a systematic way	... depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases	... evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers	... follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently

	1	2	3	4	5	6	7	8	9	10
5. Patient/family involvement in care plan	.... does not occur	... is passive; clinician or educator directs care with occasional patient/family input			... is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with some patients/families and their provider(s)			... is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources		
6. Communication with patients about integrated care	...does not occur	... occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style			... occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent			... is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in how to communicate with patients about integrated care		
7. Follow-up of assessments, tests, treatment, referrals and other services	... is done at the initiative of the patient/family members	... is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up			... is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments			... is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments		
8. Social support (for patients to implement recommended treatment)	... is not addressed	... is discussed in general terms, not based on an assessment of patient's individual needs or resources			... is encouraged through collaborative exploration of resources available (e.g., significant others, education			... is part of standard practice, to assess needs, link patients with services and follow up on social		

			groups, support groups) to meet individual needs	support plans using household, community or other resources
	1	2 3 4	5 6 7	8 9 10
9. Linking to Community Resources	... does not occur	... is limited to a list or pamphlet of contact information for relevant resources	... occurs through a referral system; staff member discusses patient needs, barriers, and appropriate resources before making referral	... is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations and patients
	1	2 3 4	5 6 7	8 9 10
<b>MeHAF Plus Items</b>				
10. Patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications	... does not exist in a systematic way	... depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases	... evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers	... follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently; support provided by consulting psychiatrist or comparable expert
	1	2 3 4	5 6 7	8 9 10
11. Tracking of vulnerable patient groups that require additional monitoring and intervention	... does not occur	... is passive; clinician may track individual patients based on circumstances	... patient lists exist and individual clinicians/care managers have varying approaches to outreach with no guiding protocols or systematic tracking	... patient lists (registries) with specified criteria and outreach protocols are monitored on a regular basis and outreach is performed consistently with information flowing back to the care team
	1	2 3 4	5 6 7	8 9 10
12. Accessibility and efficiency of behavioral health practitioners	... behavioral Health practitioner(s)	... is minimal; access may occur at times but is not defined by protocol or formal agreement; unclear how much population penetration	... is partially present; behavioral health practitioners may be available for warm handoffs for some of the open clinic hours and	... is fully present; behavioral health practitioners are available for warm handoffs at all open clinic hours and average over 6 patients per clinic day per

	are not readily available	behavioral health has into primary care population	may average less than 6 patients per clinic day per clinician (or comparable number based on clinic volume)	clinician (or comparable number based on clinic volume)
	1	2 3 4	5 6 7	8 9 10
II. Practice/Organization (Circle one NUMBER for each characteristic)				
1. Organizational leadership for integrated care	... does not exist or shows little interest	... is supportive in a general way, but views this initiative as a “special project” rather than a change in usual care	... is provided by senior administrators, as one of a number of ongoing quality improvement initiatives; few internal resources supplied (such as staff time for team meetings)	... strongly supports care integration as a part of the site’s expected change in delivery strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models
	1	2 3 4	5 6 7	8 9 10
2. Patient care team for implementing integrated care	... does not exist	... exists but has little cohesiveness among team members; not central to care delivery	... is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills	... is a concept embraced, supported and rewarded by the senior leadership; “teamness” is part of the system culture; case conferences and team meetings are regularly scheduled
	1	2 3 4	5 6 7	8 9 10
3. Providers’ engagement with integrated care (“buy-in”)	... is minimal	... engaged some of the time, but some providers not enthusiastic about integrated care	... is moderately consistent, but with some concerns; some providers not fully implementing intended integration components	... all or nearly all providers are enthusiastically implementing all components of your site’s integrated care
	1	2 3 4	5 6 7	8 9 10
4. Continuity of care between	... does not exist	... is not always assured; patients	... is achieved for some patients	... systems are in place to support

primary care and behavioral/mental health		with multiple needs are responsible for their own coordination and follow-up	through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only	continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained
	1	2 3 4	5 6 7	8 9 10
5. Coordination of referrals and specialists	... does not exist	... is sporadic, lacking systematic follow-up, review or incorporation into the patient's plan of care; little specialist contact with primary care team	... occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients' care plans; specialists contribute to planning for integrated care	... is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists' involvement in primary care team training and quality improvement
	1	2 3 4	5 6 7	8 9 10
6. Data systems/patient records	... are based on paper records only; separate records used by each provider	... are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps	... use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals	... has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process
	1	2 3 4	5 6 7	8 9 10
7. Patient/family input to integration management	... does not occur	... occurs on an ad hoc basis; not promoted systematically; patients must take initiative to make	... is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current	... is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows

		suggestions	services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate	that management acts on the information
	1	2 3 4	5 6 7	8 9 10
8. Physician, team and staff education and training for integrated care	... does not occur	... occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic	... is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation	... is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration
	1	2 3 4	5 6 7	8 9 10
9. Funding sources/resources	... a single grant or funding source; no shared resource streams	... separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies	... separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training	... fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly
	1	2 3 4	5 6 7	8 9 10

D) Please provide any additional information you would like to share on your site’s progress with physical and behavioral health integration, including challenges, barriers, and any additional assistance needed.

## 2) Opioid Survey

### **Background:**

The HCA has developed a series of questions relevant to the 'Addressing the Opioid Crisis' Medicaid Transformation Project. This series of questions constitutes a required pay for reporting requirement for all ACHs. All ACHs are required to have participating sites complete the survey every six months and submit the results to the HCA. HealthierHere decided to incentivize this reporting requirement in 2019.

Please complete the applicable questions. Responses to the follow-up questions are encouraged, though not required. Your answers may inform future strategies. This incentive will be assessed for completion only.

A) Does the ED site have protocols in place to initiate Medication Assisted Treatment (MAT) and offer take home naloxone for individuals seen for opioid overdose?

*Select all that apply:*

- MAT initiation
- Take-home naloxone
- Our ED site does not offer these services.
- Not applicable. Our site is not an ED.

Follow-up questions:

- When patients present with opioid overdose, are these protocols followed always, sometimes or rarely?
- Can you describe these protocols?
- If neither of these practices are occurring, describe why not.

B) Do providers at your site follow the [AMDG / Washington State prescribing guidelines](#), [Bree Collaborative](#) and/or [CDC prescribing guidelines](#)?

*Select all that apply:*

- Agency Medical Directors' Group (AMDG) guidelines / Washington State prescribing guidelines
- Bree Collaborative (BREE) guidelines
- CDC guidelines
- None of the above

Follow-up questions (optional):

- For sites indicating at least one set of guidelines:
  - Are chart audits conducted to assess compliance with identified guidelines? Describe the findings of the most recent chart audit conducted at the site, and any next steps that may have been identified.
    - If chart audits are not conducted, why not?
- What kind of training on prescribing guidelines are practice/clinic sites offering?
- What metrics are practice/clinic sites tracking based on their training on prescribing guidelines?
- If your practice/clinic site does not use prescribing guidelines, why not?

C) What features does the practice/clinic site’s clinical decision support for opioid prescribing guidelines include?

*Select all that apply:*

- Integrated morphine equivalent dose calculators
- Links to opioid prescribing registries
- Links to Prescription Drug Monitoring Programs (PDMPs)
- Automatic flags for co-prescriptions of benzodiazepines
- None of the above

*Clinical decision support may occur through the EHR or through another system. Guidelines could include AMDG guidelines, Bree Collaborative guidelines, or others.*

Follow-up questions (optional):

- Does your practice or clinic site EHR have a clinical decision support module that prompts prescribing providers regarding opioid prescribing?
  - Can you describe the module?
  - Under what circumstances is it initiated?
  - Are you aware of any changes in provider prescribing patterns due to the module?
- If not through an EHR, do you offer clinical decision support around opioid prescribing through another system? (for example, opioid prescriptions review by a clinical pharmacist)
  - Can you describe the (non-EHR) module? Under what circumstances is it initiated?
  - Are you aware of any changes in provider prescribing patterns due to the (non-EHR) module?

D) What protocols are in place to provide a pathway for all patients with opioid use disorder to be evaluated for behavioral health interventions?

*Select all that apply:*

- Screening and treatment for depression and anxiety occurs on site
- Screening for depression and anxiety occur on site, patients are referred for treatment
- Contracting with providers who offer these services
- Formalized referral relationship (through MOU or a similar arrangement) with providers who offer these services
- Informal referral relationships with providers who offer these services
- None of the above

E) What protocols are in place to provide a pathway for all patients with opioid use disorder to be evaluated for medication-assisted treatment?

*Select all that apply:*

- Medications are provided on site
- Contracting with providers who offer these services
- Formalized referral relationship (through MOU or a similar arrangement) with providers who offer these services
- Informal referral relationships with providers who offer these services
- None of the above

Follow-up questions (optional):

- Is MAT offered to some or all patients with OUD?
- Is behavioral care offered to some or all patients that screen positive for depression and/or anxiety?
- Do patients with OUDs who get care from your practice or clinic site typically get these services from you, or do they go elsewhere?
- What systems are in place to ensure the beneficiary is connected to the acute care and recovery services that are needed?

F) Please provide any additional information you would like to share on your site's progress providing care for individuals with opioid use disorder, including challenges, barriers, and any additional assistance needed.

### 3) Whole Person Care Screenings/Assessments

#### **Background:**

As part of HealthierHere's 2019 focus on building foundational infrastructure, we are incentivizing the use of evidence-based screenings and assessments in primary care and behavioral health settings in order to improve the ability of Medicaid individuals to receive appropriate whole person care no matter the setting they first seek care. This incentive will allow HealthierHere greater visibility into how screenings are being used, whether screenings are integrated into workflows and clinical decision making, and which priority screenings are currently being used at participating organizations. The question and scale were adapted from the [MeHAF](#), question I.2.

A) Did a care team collectively give feedback to develop your site’s response to this incentive?

(Yes/No)

B) If yes, please list the names and roles of the care team members who contributed to your response:

---

C)

	Level D	Level C	Level B	Level A
<i>If I am a hospital or FQHC...</i> screening and assessment  for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)	... are not done (in this site)	...are occasionally done; screening/assessment protocols are not standardized or are nonexistent	...are integrated into care on a pilot basis; assessment results are documented prior to treatment	... tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented.
	1	2            3            4	5            6            7	8            9            10

	Level D	Level C	Level B	Level A
<i>If I am a BHA...</i> screening and assessment  for medical care needs (e.g., blood pressure, weight, body mass index (BMI) diabetes)	... are not done (in this site)	...are occasionally done; screening/assessment protocols are not standardized or are nonexistent	...are integrated into care on a pilot basis; assessment results are documented prior to treatment	... tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment protocols are used and documented.
	1	2            3            4	5            6            7	8            9            10

D) If you are a PCP site, does your site perform any of the following screenings for behavioral health conditions?

*Select all that apply*

- [Alcohol Use Disorders Identification Test \(AUDIT\)](#)
- [Drug Abuse Screening Test \(DAST\)](#)
- [Generalized Anxiety Disorder subscale \(GAD-7\)](#)
- Patient Health Questionnaire for Depression ([PHQ-2](#) / [PHQ-9](#))

E) If you are a BHA site, does your site perform any of the following screenings for physical health conditions?

*Select all that apply*

- Blood pressure
- [Body Mass Index \(BMI\)](#)
- Diabetes (A1C)

F) Please provide any additional information you would like to share on your site's integration of whole person care screenings, including challenges, barriers, and any additional assistance needed.

#### 4) Use and Optimization of Collective Ambulatory (formerly PreManage)

##### **Background:**

Improving rates of follow-up visits after Emergency Department visits and hospitalizations is a priority area for HealthierHere. In 2019 we are providing coordination, training, and technical assistance to implement and optimize use of the [Collective Ambulatory](#) (formerly PreManage) software within our region. The software provides notifications to enrolled providers when their assigned/empaneled patients experience an ED visit, providing an opportunity for the community primary care or behavioral health provider to reach out to the patient and encourage them to schedule and complete a follow-up visit. In 2019 HealthierHere is incentivizing the use and optimization of Collective Ambulatory as a tool to improve rates of ED follow-ups.

Please respond to the series of questions, the survey uses skip logic, depending on your answers the survey tool will prompt further questions. Your responses to the questions are correlated to HealthierHere's scale format to measure improvement over self, from Level D to Level A.

If your organization has the ability to run the report described below, please submit a copy of said report as a sample by uploading it to the online tool. Please do not submit a report that includes Protected Health Information (PHI), it should be an aggregate only.

	Does your organization currently use Collective Ambulatory? (Yes/No)		<i>If yes, can your organization run reports from Collective Ambulatory showing what percentage of your Collective Ambulatory notifications result in a follow-up within 7 days?</i> (Yes/No)		<i>If yes, is your organization currently working with a Qualis/Comagine Practice Coach to optimize your use of PreManage?</i> (Yes/No)	
Answer	No	Yes	No	Yes	No	Yes
Corresponding Level	Level D	Level C	Level C	Level B	Level B	Level A

Please provide any additional information you would like to share on your organization’s use of Collective Ambulatory, including challenges, barriers, and any additional assistance needed.

### Population Health Bundle (July and December reporting periods)

	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
Incentives				
1) Assignment to a Practice Panel, Care Team, or Caseload (Empanelment)		X	X	
2) Registry Functionality		X	X	
3) Risk Stratification		X	X	

## 1) Assignment to a Practice Panel, Care Team, or Caseload (Empanelment)

### Background:

Empanelment is a key building block of population health. It is the act of assigning individual patients to individual providers and care teams with sensitivity to patient and family preference. Empanelment is the basis for population health management and the key to continuity of care. The goal of focusing on a population of patients is to ensure that every established patient receives optimal care, whether he/she regularly comes in for visits or not. Accepting responsibility for a finite number of patients, instead of the universe of patients seeking care in the practice, allows the provider and care team to focus more directly on the needs of each patient.

While empanelment has been a focus for primary care providers, it is not necessarily being practiced consistently across the system in King County and behavioral health providers have largely been left out of the conversation. In 2019, HealthierHere is committed to bringing behavioral health providers along on the same journey in order to build up their population health capacity. In order to make the empanelment concept more tangible to behavioral health providers, we are using more inclusive language to describe the concept of empanelment, defining this activity as “assignment to a practice panel, care team, or caseload.” HealthierHere’s question and scale for this incentive was adapted from question 9 on the [PCMH-A](#).

A) Did a care team collectively give feedback to develop your response to this incentive?

(Yes/No)

B) If yes, please list the names and roles of the care team members who contributed to your response:

---

C)

	Level D	Level C	Level B	Level A
Patients	...are not assigned to specific practice panels, care teams, or caseloads	...are assigned to specific practice panels, care teams, or caseloads but panel/team/caseload assignments are not routinely used by the practice for administrative or other purposes	...are assigned to specific practice panels, care teams, or caseloads and panel/team/caseload assignments are routinely used by the practice mainly for scheduling purposes	...are assigned to specific practice panels, care teams, or caseloads and panel/team/caseload assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and

							demand			
	1	2	3	4	5	6	7	8	9	10

D) How does your site use the empanelment data in practice management on a day to day basis?

E) Please provide any additional information you would like to share on your site’s use of empanelment, including challenges, barriers, and any additional assistance needed.

## 2) Registry Functionality

### Background:

A registry is defined as a list of all people in a specific population, those specific populations can be based on a range of factors, including conditions (Diabetes, Asthma, Opioid Use Disorder), social determinant needs, and others. Registries help care managers see a target population and gaps in an evidence-based standard of care for the population, giving them the ability to see key health parameters of an entire population in a single view and fill those care gaps for the patients assigned to them.

HealthierHere is committed to increasing the use of registries and improving registry functionality as part of our foundational population health infrastructure building in 2019. While registries range from simple manual entry Excel spreadsheets to more advanced queries of Electronic Health Record (EHR) data, HealthierHere is encouraging our partners to use available technology, ideally advancing their use of registries that originate with real-time EHR data. HealthierHere’s primary question and scale for this incentive was adapted from question 7 on the [Quality Improvement Change Assessment](#).

A) Did a care team collectively give feedback to develop your response to this incentive?

(Yes/No)

B) If yes, please list the names and roles of the care team members who contributed to your response:

---

C)

	Level D	Level C	Level B	Level A
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Registry or panel-level data	... are not available to assess or manage care for practice populations.	... are available to assess and manage care for practice populations, but only on an ad hoc basis.	... are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	... are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.
	1	2      3      4	5      6      7	8      9      10

D) Does your organization’s EHR have registry functionality for any of the following conditions?

Select all that apply:

- Diabetes
- Depression
- Serious Mental Illness
- Opioid Use Disorder
- Asthma
- Cardiovascular Disease (CVD)
- Chronic Obstructive Pulmonary Disorder (COPD)

E) How does your site use registry data in practice management on a day to day basis?

F) Please provide any additional information you would like to share on your site’s use of registries, including challenges, barriers, and any additional assistance needed.

### 3) Risk Stratification

**Background:**

The process of separating patient populations into high-risk, low-risk, and the ever-important rising-risk groups is called risk stratification. Having a platform to stratify patients according to risk is key to the success of any population health management initiative. HealthierHere sees risk stratification as one of the three focus areas for building population health infrastructure in 2019. We are interested in improving routine use of risk stratification at our partner organizations. For the purposes of this incentive we are defining risk as risk of a bad clinical outcome. HealthierHere’s primary question and scale for this incentive was adapted from question 9 on the [Quality Improvement Change Assessment](#).

A) Did a care team collectively give feedback to develop your response to this incentive?

(Yes/No)

B) If yes, please list the names and roles of the care team members who contributed to your response:

---

C)

	Level D	Level C	Level B	Level A
A standard method or tool(s) to stratify patients by risk level	... is not available.	... is available but not consistently used to stratify all patients.	... is available and is consistently used to stratify all patients but is inconsistently integrated into all aspects of care delivery.	... is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.
	1	2      3      4	5      6      7	8      9      10

D) What data does your site use to stratify risk?

*Select all that apply:*

- Diagnosis codes (including complicated behavioral and physical health conditions)
- Medication lists
- Insurance status
- Geocoding (by home address)
- Social Determinants of Health (housing status, food insecurity, etc.)
- Emergency Department utilization
- Other (free text box)

E) How does your site use risk stratification data in practice management on a day to day basis?

F) Please provide any additional information you would like to share on your site’s use of risk stratification, including challenges, barriers, and any additional assistance needed.

### Value Based Payment Bundle (December reporting period)

	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
Incentives				
1) HCP LAN Status & Goals	X			
2) HH VBP Convening/Training	X			

**Background:**

The activities in the Value Based Payment Bundle align with the HCA’s goal of reaching 90% VBP provider payments by 2021. To support this statewide goal, HealthierHere will incentivize partners to provide an indication of the percentage of their revenues as it relates to the HCP LAN (<http://hcp-lan.org/workproducts/apm-figure-1-final.pdf>, <http://hcp-lan.org/workproducts/apm-figure-2-final.pdf>) and participate in HealthierHere’s VBP convening activities and/or training in support of advancing Value Based Payment. This bundle will be active in the December reporting period.

#### 1) HCP LAN status and goals

1. Indicate the level of VBP adoption % using the below formula to indicate the proportion of your organization’s revenues in relation to the overall HCP LAN. Please note that the numerator is the total dollar value of contracts with the quality component (*e.g. the VBP contract is \$100, with 1% tied to quality, then the reporting dollar is \$100 **not** \$1*)
2. Describe the organization’s goals to increase the VBP adoption percentage in 2020 and 2021, if this goal is in alignment and appropriate.

Equation 1. Level of VBP adoption (%)

$$\text{Level of VBP adoption (\%)} = \frac{\text{MCO payments to providers (in \$) made through VBP arrangements above Category 2C}}{\text{Total MCO payments to providers (in \$)}}$$

2) VBP convening

HealthierHere will serve as a neutral convener and organize a meeting between participating Managed Care Organizations in our region and practice partners between July and September 2019. In addition, practice partners will be required to attend/participate in one VBP training by December 31, 2019.

Equity Bundle (December reporting period)

	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
Incentives				
1) HH Equity Training	X			
2) HH Equity Assessment	X			
3) HH Equity Action Plan	X			

1) HealthierHere Equity Training

**Background:**

HealthierHere is committed to advancing health equity and reducing health disparities in our region. In the second reporting period of 2019 we will reward clinical partners for attending an 8-hour, full-day HealthierHere equity training. The training will be provided free of charge for the clinical partners.

**Instructions:**

HealthierHere's Equity Trainings will be held in July-August 2019, exact dates TBD. Sending a team to attend the Equity Training will allow partners to receive this incentive. The team should consist of at least 2, but no more than 4 people from the clinical partner's organization. Team members should be individuals within the organization who have a good understanding of the clinical partner's organizational culture and climate; are engaged with the organization's equity, cultural competence, CLAS and/or community engagement efforts; and, are best positioned to implement organizational change related to equity within the organization. Possible team members might include, but are not limited to, individuals who work in the following areas: data analysis, quality improvement, community/patient engagement, administrative staff, clinical staff, organizational affinity groups, employee engagement, human resources, etc.

A) Did a team from your organization attend HealthierHere's Equity Training in 2019?

(Yes/No)

B) Please list the individuals who attended. HealthierHere will cross-reference that list with our own records.

## 2) HealthierHere Equity Assessment

**Background:**

HealthierHere is committed to advancing health equity and reducing health disparities in our region. In the second reporting period of 2019 we will reward clinical partners for completing a HealthierHere Equity Assessment. The Equity Assessment will include questions related to your organization's commitment to Equity, Cultural Competence and efforts related to your organization's provision of Culturally and Linguistically Appropriate Services (CLAS).

Completing your Equity Assessment will provide HealthierHere with baseline information about your organization's commitment to equity and any steps that you have taken to incorporate equity within the delivery of your programs and services. The Equity Assessment is for informational rather than evaluative purposes and will provide a general sense of your organization's commitment to advancing equity. HealthierHere recognizes that organizations are at various places in terms of operationalizing equity and cultural competence within their organization's business policies, practices and procedures. Consequently, the Equity Assessment includes questions that will document your organization's Equity and Cultural Competence work while also building a shared vision for Equity in a health care setting within King County.

**Instructions:**

HealthierHere will provide more information about the Equity Assessment following the completion of HealthierHere's Equity Training. The HealthierHere Equity Assessment will be a self-assessment, likely released in September-October 2019. Completing the Equity Assessment and submitting it by the deadline will allow partners to receive this incentive.

A) HealthierHere Equity Assessment: TBD

### 3) HealthierHere Equity Action Plan

**Background:**

HealthierHere is committed to advancing health equity and reducing health disparities in our region. In the second reporting period of 2019 we will reward clinical partners for completing a HealthierHere Equity Action Plan.

HealthierHere recognizes that equity is both a process and a product that is developed over time through intentional efforts and planning. Achieving equity is not a one-size fits all approach; consequently, HealthierHere acknowledges that organizations are at various stages of development in their efforts to address equity. The Equity Action Plan will give your organization the opportunity to create customized goals and worksteps related to equity, that align with your needs and capacity as demonstrated on the Equity Assessment.

**Instructions:**

HealthierHere will provide more information about the Equity Action Plan following completion of the Equity Assessment. We will provide a template and technical assistance to support your completion of this deliverable. Completing the Equity Action Plan and submitting it by the deadline will allow partners to receive this incentive.

- A) Completion and on-time submission of HealthierHere's Equity Action Plan: TBD

## Payment Methodology

The following section should be used by Medicaid Provider organizations to determine 2019 Pay for Progress payments.

### Medicaid Provider Organization “up to” Amounts: Dollar Amounts Available

As specified in the Pay for Progress contract, **BHA** Medicaid Provider Organizations can earn “up to” **\$204,000** for 2019 Pay for Progress. Actual payments will be based on submission of reporting requirements or improvement over self. There will be two performance periods. The first is in July 2019. The second is in December 2019.

### Test Sites vs. Reporting Sites

Medicaid Provider Organizations will be required to provide HealthierHere with their responses to the metrics on the semiannual assessment at the designated reporting levels (either test site only or all reporting sites).

**Reporting sites** will be listed in the HealthierHere 2019 contract. **All** reporting sites will need to submit **site specific responses** to the incentive metrics designated to be reported at reporting specific sites for the organization to receive credit for ‘flat rate for submission.’

**Test sites** are Behavioral Health or Primary Care clinics where your organization is focusing innovation efforts. **Improvement over self will be measured based on your test site only.** If your organization chooses multiple test sites, the median of all test sites for a particular incentive will be used to calculate improvement over self. HealthierHere will work with your organization to select the most appropriate test site in early Q3 2019 and the test site will be formalized in a contract addendum.

## July Metrics

**BHA** Medicaid Provider Organizations can earn “up to” **\$72,000** in July. The initial payment will be based on seven metrics. These metrics will be clinical and population health focused. Payments will be flat rates based on submission of required reporting for each reporting site.

## December Metrics

**BHA** Medicaid Provider Organizations can earn “up to” **\$132,000** in December. The second payment will be based on 12 metrics. Payments will be made for submission (for all reporting sites) of required reporting plus improvement over self for the Medicaid Provider Organizations’ test site.

**Table1: Metrics required in July: BHA**

<u>Metric</u>	<u>Bundle</u>	<u>Max Amount</u>	<u>Deliverable</u>
MeHAF Assessment*	Clinical	\$ 10,500	Flat Rate for Submission
Opioid Survey*	Clinical	\$ 5,250	Flat Rate for Submission
Whole Person Care Screening/Assessments	Clinical	\$ 7,875	Flat Rate for Submission
Use & Optimization of Collective Ambulatory	Clinical	\$ 7,875	Flat Rate for Submission
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	Population Health	\$ 13,500	Flat Rate for Submission
Registry Functionality	Population Health	\$ 13,500	Flat Rate for Submission
Risk stratification	Population Health	\$ 13,500	Flat Rate for Submission
<b>Total</b>		<b>\$ 72,000</b>	

**Table 2: Metrics required in December: BHA**

<u>Metric</u>	<u>Bundle</u>	<u>Max Amount</u>	<u>Deliverable</u>
MeHAF Assessment*	Clinical	\$ 10,500	<b>Improvement over Self</b>
Opioid Survey*	Clinical	\$ 5,250	Flat Rate for Submission

Whole Person Care Screening/Assessments	Clinical	\$ 7,875	Improvement over Self
Use & Optimization of Collective Ambulatory	Clinical	\$ 7,875	Improvement over Self
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	Population Health	\$ 13,500	Improvement over Self
Registry Functionality	Population Health	\$ 13,500	Improvement over Self
Risk stratification	Population Health	\$ 13,500	Improvement over Self
HCP Lan status and goals	Value Based Purchasing	\$ 7,500	Flat Rate for Submission
VBP Convening	Value Based Purchasing	\$ 7,500	Flat Rate for Submission
HH Equity Assessment	Equity	\$ 15,000	Flat Rate for Submission
HH Equity Training	Equity	\$ 15,000	Flat Rate for Submission
HH Equity Action Plan	Equity	\$ 15,000	Flat Rate for Submission
<b>Total</b>		<b>\$ 132,000</b>	

## Total Payments for Flat Rate Submission (July and December)

BHA “up to” amount for Submission: **\$137,250**

Payments are flat rates for submission of required reporting at all reporting sites, meaning Medicaid Provider Organizations will earn the full “up to” amount with successful submission of all required metrics.

## Total Improvement over Self (December only)

BHA “up to” amount for Submission: **\$66,750**

**Improvement over self will be measured based for Medicaid Provider Organizations’ test site only.** If an organization chooses multiple test sites, the median of all test sites for a particular incentive will be used to calculate improvement over self. HealthierHere will work with each organization to select the most appropriate test site in early Q3 2019 and the test site will be formalized in a contract addendum.

Payments will be calculated based on an organization’s Medicaid Provider Organizations’ improvement over self-score (IOS) for specified test site(s). A Medicaid Provider Organizations’ IOS is based on two performance scores<sup>1</sup>. The first performance score will use a Medicaid Provider Organizations’ baseline score (reported in July) and calculate the percent improvement by December. Percent scores are then tiered using the HealthCare

<sup>1</sup> When applicable.

Authority's Achievement Value (AV) methodology<sup>2</sup>. Scores will be limited to 0<sup>3</sup>%, 25%, 50%, 75%, and 100%<sup>4</sup>. The second performance score will use a Medicaid Provider Organizations' baseline score (reported in July) and calculate whether the Medicaid Provider Organization advanced<sup>5</sup> a tier in December. The two performance scores will then be equally weighted and used to calculate the final IOS score. The final IOS score is proportional to what the Medicaid Provider Organization will earn.

Note, there are only 6/12 metrics that will be scored on IOS. Metrics are scored on percent change and tier change when applicable. Where not applicable, the IOS method used to score is noted. See the table below for a summary of this.

**Table 3: Improvement over Self Metric Summary**

<u>Metric</u>	<u>IOS Eligible</u>	<u>PERCENT CHANGE</u>	<u>LEVEL CHANGE</u>
MeHAF Assessment*	Improvement over Self	X	X
Opioid Survey*	Flat Rate for Submission	N/A	N/A
Whole Person Care Screening/Assessments	Improvement over Self	X	X
Use & Optimization of Collective Ambulatory	Improvement over Self	N/A	X
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	Improvement over Self	X	X
Registry Functionality	Improvement over Self	X	X

<sup>2</sup> <https://www.hca.wa.gov/assets/program/mtp-measurement-guide.pdf> (pg. 64). Scores are bound between 0-100%. Medicaid Provider Organizations who achieve a top score (e.g. 10/10) will be awarded a 100% on the percent change component, even if their move from baseline was not 100%.

<sup>3</sup> Negative percentage change will be tiered to 0% AV.

<sup>4</sup> High performing Medicaid Provider Organizations (e.g. top tier baseline performance) that have a top score during their performance period will automatically earn a 100% for tier change.

<sup>5</sup> High performing Medicaid Provider Organizations that are already in the top tier will automatically earn a 100% for tier change in the performance period

<u>Metric</u>	<u>IOS Eligible</u>	<u>PERCENT CHANGE</u>	<u>LEVEL CHANGE</u>
Risk stratification	Improvement over Self	X	X
HCP Lan status and goals	Flat Rate for Submission	N/A	N/A
VBP Convening	Flat Rate for Submission	N/A	N/A
HH Equity Assessment	Flat Rate for Submission	N/A	N/A
HH Equity Training	Flat Rate for Submission	N/A	N/A
HH Equity Action Plan	Flat Rate for Submission	N/A	N/A

**Step 1: Calculate PERCENT CHANGE**

*PERCENT CHANGE = (December performance score - July baseline score) / July baseline score*

**Step 2: Calculate LEVEL CHANGE**

*LEVEL CHANGE= "Y", then 100%*

**LEVEL CHANGE= “N”, then 0%**

**Step 3: Use Step 1 and Step 2 to calculate Improvement over Self Score**

**$IOS = (PERCENT\ CHANGE * .5) + (LEVEL\ CHANGE * .5)$**

**Step 4: Use Step 3 to calculate Improvement over Self Earnings**

**$IOS\ \$ = IOS\ "Up\ to" * IOS\ Score$**

Improvement over Self Example: Whole Person Screening/Assessment

**Base score: 3**  
**Performance score: 5**

**Table 4: Whole Person Screening/Assessment Example**

	Level D	Level C	Level B	Level A
<i>If I am a BHA...</i> screening and assessment for medical care needs (e.g., blood pressure, weight, body mass index (BMI) diabetes)	... are not done (in this site)	... are occasionally done; screening/assessment protocols are not standardized or are nonexistent	... are integrated into care on a pilot basis; assessment results are documented prior to treatment	... tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/ assessment

							protocols are used and documented.			
	1	2	3	4	5	6	7	8	9	10

**Step 1: Calculate PERCENT CHANGE**

$$67\% = (5-3) / 3$$

PERCENT CHANGE is then tiered using HCA Achievement Value methodology. **67% is tiered to 50% AV.**

**Step 2: Calculate LEVEL CHANGE**

LEVEL CHANGE= "Y", then **100%**

**Step 3: Use Step 1 and Step 2 to calculate Improvement over Self Score**

$$75\% \text{ IOS} = (50\% \cdot .5) + (100\% \cdot .5)$$

**Step 4: Use Step 3 to calculate Improvement over Self Earnings**

$$\$5,906 \text{ IOS Earnings} = \$7,875 \text{ "Up to"} \cdot 75\%$$

[Improvement over Self Reference Table \(December only\)](#)

Please use the following reference table to determine what percentage of the 'IOS "up to" Amount' can be earned. Providers' 'IOS score' will be determined based on a weighted average of 'PERCENT CHANGE' and 'LEVEL CHANGE'. Those scores will be equally weighted (when applicable) to calculate the 'IOS score'. The IOS score will be proportional to the IOS payment.

**Table 5: Improvement over Self (IOS) Payment Reference Table**

<u>Metric</u>	<u>Deliverable</u>	<u>"Up to" Amount</u>	<u>PERCENT CHANGE (A)</u>	<u>LEVEL CHANGE (B)</u>	<u>IOS Score (A+B/2)</u>	<u>IOS Earned</u>
MeHAF Assessment*	<b>IOS</b>	\$ 10,500	0%	Y	50%	\$ 5,250
MeHAF Assessment*	<b>IOS</b>	\$ 10,500	25%	Y	63%	\$ 6,563
MeHAF Assessment*	<b>IOS</b>	\$ 10,500	50%	Y	75%	\$ 7,875

<u>Metric</u>	<u>Deliverable</u>	<u>“Up to” Amount</u>	<u>PERCENT</u>	<u>LEVEL</u>	<u>IOS Score</u>	<u>IOS Earned</u>
MeHAF Assessment*	IOS	\$ 10,500	75%	Y	88%	\$ 9,188
MeHAF Assessment*	IOS	\$ 10,500	100%	Y	100%	\$ 10,500
MeHAF Assessment*	IOS	\$ 10,500	0%	N	0%	\$ -
MeHAF Assessment*	IOS	\$ 10,500	25%	N	13%	\$ 1,313
MeHAF Assessment*	IOS	\$ 10,500	50%	N	25%	\$ 2,625
MeHAF Assessment*	IOS	\$ 10,500	75%	N	38%	\$ 3,938
MeHAF Assessment*	IOS	\$ 10,500	100%	N	50%	\$ 5,250
Whole Person Care Screening/Assessments	IOS	\$ 7,875	0%	Y	50%	\$ 3,938
Whole Person Care Screening/Assessments	IOS	\$ 7,875	25%	Y	63%	\$ 4,922
Whole Person Care Screening/Assessments	IOS	\$ 7,875	50%	Y	75%	\$ 5,906
Whole Person Care Screening/Assessments	IOS	\$ 7,875	75%	Y	88%	\$ 6,891
Whole Person Care Screening/Assessments	IOS	\$ 7,875	100%	Y	100%	\$ 7,875
Whole Person Care Screening/Assessments	IOS	\$ 7,875	0%	N	0%	\$ -
Whole Person Care Screening/Assessments	IOS	\$ 7,875	25%	N	13%	\$ 984
Whole Person Care Screening/Assessments	IOS	\$ 7,875	50%	N	25%	\$ 1,969
Whole Person Care Screening/Assessments	IOS	\$ 7,875	75%	N	38%	\$ 2,953
Whole Person Care Screening/Assessments	IOS	\$ 7,875	100%	N	50%	\$ 3,938
Use & Optimization of Collective Ambulatory	IOS	\$ 7,875	0%	Y	100%	\$ 7,875
Use & Optimization of Collective Ambulatory	IOS	\$ 7,875	25%	Y	100%	\$ 7,875
Use & Optimization of Collective Ambulatory	IOS	\$ 7,875	50%	Y	100%	\$ 7,875

<u>Metric</u>	<u>Deliverable</u>	<u>“Up to” Amount</u>	<u>PERCENT</u>	<u>LEVEL</u>	<u>IOS Score</u>	<u>IOS Earned</u>
Use & Optimization of Collective Ambulatory	<b>IOS</b>	\$ 7,875	75%	Y	100%	\$ 7,875
Use & Optimization of Collective Ambulatory	<b>IOS</b>	\$ 7,875	100%	Y	100%	\$ 7,875
Use & Optimization of Collective Ambulatory	<b>IOS</b>	\$ 7,875	0%	N	0%	\$ -
Use & Optimization of Collective Ambulatory	<b>IOS</b>	\$ 7,875	25%	N	0%	\$ -
Use & Optimization of Collective Ambulatory	<b>IOS</b>	\$ 7,875	50%	N	0%	\$ -
Use & Optimization of Collective Ambulatory	<b>IOS</b>	\$ 7,875	75%	N	0%	\$ -
Use & Optimization of Collective Ambulatory	<b>IOS</b>	\$ 7,875	100%	N	0%	\$ -
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	0%	Y	50%	\$ 6,750
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	25%	Y	63%	\$ 8,438
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	50%	Y	75%	\$ 10,125
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	75%	Y	88%	\$ 11,813
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	100%	Y	100%	\$ 13,500
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	0%	N	0%	\$ -
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	25%	N	13%	\$ 1,688

<u>Metric</u>	<u>Deliverable</u>	<u>“Up to” Amount</u>	<u>PERCENT</u>	<u>LEVEL</u>	<u>IOS Score</u>	<u>IOS Earned</u>
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	50%	N	25%	\$ 3,375
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	75%	N	38%	\$ 5,063
Assignment to a Practice Panel, Care Team, or Caseload (empanelment)	<b>IOS</b>	\$ 13,500	100%	N	50%	\$ 6,750
Registry Functionality	<b>IOS</b>	\$ 13,500	0%	Y	50%	\$ 6,750
Registry Functionality	<b>IOS</b>	\$ 13,500	25%	Y	63%	\$ 8,438
Registry Functionality	<b>IOS</b>	\$ 13,500	50%	Y	75%	\$ 10,125
Registry Functionality	<b>IOS</b>	\$ 13,500	75%	Y	88%	\$ 11,813
Registry Functionality	<b>IOS</b>	\$ 13,500	100%	Y	100%	\$ 13,500
Registry Functionality	<b>IOS</b>	\$ 13,500	0%	N	0%	\$ -
Registry Functionality	<b>IOS</b>	\$ 13,500	25%	N	13%	\$ 1,688
Registry Functionality	<b>IOS</b>	\$ 13,500	50%	N	25%	\$ 3,375
Registry Functionality	<b>IOS</b>	\$ 13,500	75%	N	38%	\$ 5,063
Registry Functionality	<b>IOS</b>	\$ 13,500	100%	N	50%	\$ 6,750
Risk stratification	<b>IOS</b>	\$ 13,500	0%	Y	50%	\$ 6,750
Risk stratification	<b>IOS</b>	\$ 13,500	25%	Y	63%	\$ 8,438
Risk stratification	<b>IOS</b>	\$ 13,500	50%	Y	75%	\$ 10,125
Risk stratification	<b>IOS</b>	\$ 13,500	75%	Y	88%	\$ 11,813
Risk stratification	<b>IOS</b>	\$ 13,500	100%	Y	100%	\$ 13,500
Risk stratification	<b>IOS</b>	\$ 13,500	0%	N	0%	\$ -
Risk stratification	<b>IOS</b>	\$ 13,500	25%	N	13%	\$ 1,688
Risk stratification	<b>IOS</b>	\$ 13,500	50%	N	25%	\$ 3,375
Risk stratification	<b>IOS</b>	\$ 13,500	75%	N	38%	\$ 5,063
Risk stratification	<b>IOS</b>	\$ 13,500	100%	N	50%	\$ 6,750

## HealthierHere

### ACH Earned Incentives and Expenditures

January 1, 2019 - June 30, 2019

Source: Financial Executor Portal

Prepared by: Health Care Authority<sup>1</sup>

Funds Earned by ACH During Reporting Period <sup>2</sup>		
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$	13,603,000.50
2B: Community-Based Care Coordination	\$	-
2C: Transitional Care	\$	5,526,218.00
2D: Diversion Interventions	\$	-
3A: Addressing the Opioid Use Public Health Crisis	\$	1,700,375.00
3B: Reproductive and Maternal/Child Health	\$	-
3C: Access to Oral Health Services	\$	-
3D: Chronic Disease Prevention and Control	\$	3,400,750.00
Integration Incentives	\$	8,933,275.00
Value-Based Payment (VBP) Incentives	\$	300,000.00
IHCP-Specific Projects	\$	-
Bonus Pool/High Performance Pool	\$	-
<b>Total Funds Earned</b>	<b>\$</b>	<b>33,463,618.50</b>

Funds Distributed by ACH During Reporting Period, by Use Category <sup>3</sup>		
Administration	\$	2,717,842.95
Community Health Fund	\$	-
Health Systems and Community Capacity Building	\$	42,582.00
Integration Incentives	\$	24,791.42
Project Management	\$	-
Provider Engagement, Participation and Implementation	\$	1,730,787.00
Provider Performance and Quality Incentives	\$	-
Reserve / Contingency Fund	\$	-
Shared Domain 1 Incentives	\$	4,018,642.00
<b>Total</b>	<b>\$</b>	<b>8,534,645.37</b>

Funds Distributed by ACH During Reporting Period, by Provider Type <sup>3</sup>		
ACH	\$	2,728,489.95
Non-Traditional Provider	\$	1,562,605.42
Traditional Medicaid Provider	\$	224,908.00
Tribal Provider (Tribe)	\$	-
Tribal Provider (UIHP)	\$	-
Shared Domain 1 Provider	\$	4,018,642.00
<b>Total Funds Distributed During Reporting Period</b>	<b>\$</b>	<b>8,534,645.37</b>

<b>Total Funds Earned During Reporting Period</b>	<b>\$</b>	<b>33,463,618.50</b>
<b>Total Funds Distributed During Reporting Period</b>	<b>\$</b>	<b>8,534,645.37</b>

<sup>1</sup> Note: Data presented in this report comes from the Financial Executor Portal and was prepared by the Health Care Authority (HCA). Data was extracted and compiled on July 5, 2019 to accompany the second Semi-Annual Report submission for the reporting period January 1 to June 30, 2019.

<sup>2</sup> For detailed information on projects and earned incentives please refer to the below links.

- The [Medicaid Transformation Toolkit](#) contains the final projects, evidence-based approaches/strategies for pay-for-performance metrics for the ACHs.
- The [Measurement Guide](#) describes how the ACH selected projects are measured and the requirements to earn incentives.

<sup>3</sup> Definitions for [Use Categories and Provider Types](#)