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

SAR 4.0
Reporting Period:
July 1, 2019 – December 31, 2019

January 31, 2020
Prepared by HealthierHere
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Purpose and objectives of ACH semi-annual reporting

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

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

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

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

Reporting requirements

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

<table>
<thead>
<tr>
<th>Semi-annual reporting requirements (July 1, 2019 – December 31, 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section</strong></td>
</tr>
<tr>
<td>Section 1. ACH organizational updates</td>
</tr>
<tr>
<td></td>
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<td>Section 2. Project implementation status update</td>
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</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Section 3. Value-based payment</td>
</tr>
</tbody>
</table>
There is no set template for the semi-annual report. ACHs have flexibility in how to put together the report, as long as all required elements are clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

**Achievement values**

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

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

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

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

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

<table>
<thead>
<tr>
<th>ACH</th>
<th>2A</th>
<th>2B</th>
<th>2C</th>
<th>2D</th>
<th>3A</th>
<th>3B</th>
<th>3C</th>
<th>3D</th>
<th>Total Potential AVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Health Together</td>
<td>6</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>Cascade Pacific Action Alliance</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>-</td>
<td>7</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>34</td>
</tr>
<tr>
<td>Greater Columbia ACH</td>
<td>6</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>23</td>
</tr>
<tr>
<td>HealthierHere</td>
<td>6</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>23</td>
</tr>
<tr>
<td>North Central ACH</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>34</td>
</tr>
<tr>
<td>North Sound ACH</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>44</td>
</tr>
<tr>
<td>Olympic Community of Health</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Pierce County ACH</td>
<td>6</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>SWACH</td>
<td>6</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>24</td>
</tr>
</tbody>
</table>
For DY 3, up to 75% of VBP Incentives can be earned through achievement of P4R VBP milestones. Reporting is for the period of January 1 through December 31, 2019 and is reviewed to determine achievement for all available P4R-associated VBP Incentives.

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

| Table 2. Potential P4R VBP Achievement Values (AVs) by Milestone by ACH, Period January 1, 2019 – December 31, 2019 |
|-------------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| **Milestone**                                   | **BHT** | **CPAA** | **GCACH** | **HH** | **NC** | **NS** | **OCH** | **Pierce** | **SWACH** |
| Identification of providers struggling to implement practice transformation and move toward value-based care | 1      | 1      | 1      | 1      | 1      | 1      | 1      | 1      | 1      |
| Support providers to implement strategies to move toward value-based care | 1      | 1      | 1      | 1      | 1      | 1      | 1      | 1      | 1      |
| Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of state-issued Paying for Value Provider Survey | 1      | 1      | 1      | 1      | 1      | 1      | 1      | 1      | 1      |
| **Potential AVs**                               | **3/3** | **3/3** | **3/3** | **3/3** | **3/3** | **3/3** | **3/3** | **3/3** | **3/3** |

**Semi-annual report submission instructions**

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

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

ACHs must submit their semi-annual reports through the WA CPAS: [https://cpaswa.mslc.com/](https://cpaswa.mslc.com/).

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

The folder path in the ACH’s directory is:


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

**File format**

ACHs must include all required attachments. ACHs must label and refer to the attachments in their responses, where applicable. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.
Files should be submitted in Microsoft Word, Microsoft Excel, and/or a searchable PDF format. Below are examples of the file naming conventions ACHs should use:

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

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

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

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

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

**Contact information**

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

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

<table>
<thead>
<tr>
<th>ACH name:</th>
<th>HealthierHere</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary contact name</td>
<td>Gena Morgan, Chief Operating Officer</td>
</tr>
<tr>
<td>Phone number</td>
<td>206.849.6262</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:gmorgan@healthierhere.org">gmorgan@healthierhere.org</a></td>
</tr>
<tr>
<td>Secondary contact name</td>
<td>Susan McLaughlin, Executive Director</td>
</tr>
<tr>
<td>Phone number</td>
<td>206.790.3709</td>
</tr>
<tr>
<td>E-mail address</td>
<td><a href="mailto:smclaughlin@healthierhere.org">smclaughlin@healthierhere.org</a></td>
</tr>
</tbody>
</table>
## 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.

<table>
<thead>
<tr>
<th>Foundational ACH requirements</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. The ACH has an Executive Director.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Primary care providers</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Behavioral health providers</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Health plans, hospitals or health systems</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Local public health jurisdictions</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. At least 50 percent of the ACH’s decision-making body consists of non-clinic, non-payer participants.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Meetings of the ACH’s decision-making body are open to the public.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>6. Within the last 12 months, the ACH has completed an organizational self-assessment of internal controls and risks (using this <a href="https://wahec.box.com/s/nfesjakde5m1ye6aobhiouu5xemeoh26">template</a> or a similar format) that addresses internal controls, including financial audits.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7. The ACH maintained ongoing compliance with the Model ACH Tribal Collaboration and Communication Policy.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
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 organizational chart as of December 31, 2019, is below.

Figure 1. **HealthierHere Organizational Chart (as of December 31, 2019)**

10. **Budget/funds flow.**
a) **Financial Executor Portal activity for the reporting period.** The Financial Executor will provide to the Independent Assessor an ACH-specific report from the Financial Executor Portal, representing activity in the Portal during the reporting period. The Independent Assessor will append this document to the semi-annual report. *No action is required by the ACH for this item.*

- Optional: The ACH may provide any context that may add clarity regarding the portal activity reports (e.g., inaccurate provider type designations, payments made outside the portal).

**HealthierHere Response**

As of the SAR 3.0 reporting period, HealthierHere had drawn down $10,647 from the Financial Executor (FE) Portal for integrated managed care (IMC) and technical assistance (TA) expenses. Prior to the drawdown of these dollars, HealthierHere had issued IMC- and TA-related payment to vendors directly from its administrative budget due to the inability of its vendors to register in the FE portal to effectuate payment. The intention of the $10,647 drawdown was to offset future IMC and TA dollars paid from the administrative budget with FE portal dollars. However, vendors were subsequently successful in registering within the FE portal, and IMC and TA dollars were issued directly from the portal. As a result, $0 of the originally drawn down $10,647 IMC and TA dollars have been spent to date.

The IMC and TA dollars that were drawn down from the portal remain allocated to IMC and TA and are tracked in HealthierHere’s administrative budget. The drawn down amount, and any funds subsequently allocated to IMC and TA expenses within the administrative budget, will be identified within future SAR submissions.

During 2019, HealthierHere issued $73,976 in project cost-related payments paid outside the FE Portal. Some of the charges were incurred during the first six months of calendar year (CY) 2019 and were paid from HealthierHere’s administrative budget and later reclassified to project charges. Due to the timing of payments, these dollars were not included in prior SAR submissions.

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

<table>
<thead>
<tr>
<th>Payment To</th>
<th>Amount (Payment Date)</th>
<th>Expenditure Detail (Narrative)</th>
<th>Notes/Why Payment Is Outside FE Portal</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Diego 211</td>
<td>$7,148 <em>(June 2019)</em></td>
<td>Consulting services for Community Information Exchange (CIE).</td>
<td>Consulting fees that were unable to be processed through the FE portal; these fees were paid through invoices submitted to HealthierHere.</td>
</tr>
<tr>
<td></td>
<td>$10,048 <em>(August 2019)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$17,196 <em>(Total)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment To</td>
<td>Amount (Payment Date)</td>
<td>Expenditure Detail (Narrative)</td>
<td>Notes/Why Payment Is Outside FE Portal</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Collaborative Consulting</td>
<td>$15,000 (May 2019)</td>
<td>Consulting services to build clinical and community partner linkages through training.</td>
<td>Contractor requested payment outside the portal; fees were paid through invoices submitted to HealthierHere.</td>
</tr>
<tr>
<td></td>
<td>$15,000 (June 2019)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$30,000 (Total)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seattle Jobs Initiative</td>
<td>$9,000 (October 2019)</td>
<td>HealthierHere co-sponsored the regional “Chart Your Path” healthcare career day with the Healthcare Industry Leadership Table (HILT) to support workforce development through encouraging high school students toward healthcare careers.</td>
<td>Vendor requested payment outside the FE; fees were paid through invoices submitted to HealthierHere.</td>
</tr>
<tr>
<td>Lancer at Highline Community College</td>
<td>$4,159 (June 2019)</td>
<td>Venue and catering fees for a HealthierHere-sponsored event supporting linkages between clinical and community partners.</td>
<td>Vendor requested payment outside the FE; fees were paid through invoices submitted to HealthierHere.</td>
</tr>
<tr>
<td>Highline Community College</td>
<td>$1,400 (June 2019)</td>
<td>Venue and catering fees for HealthierHere-sponsored event supporting linkages</td>
<td>Vendor requested payment outside the portal; fees were paid through invoices</td>
</tr>
</tbody>
</table>

June figures outside the July 1–December 31, 2019, reporting period were not included in SAR 3.0 due to payment timing.
### Payment Details

<table>
<thead>
<tr>
<th>Payment To</th>
<th>Amount (Payment Date)</th>
<th>Expenditure Detail (Narrative)</th>
<th>Notes/Why Payment Is Outside FE Portal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert (Rim) Cothren</td>
<td>$9,153 (December 2019)</td>
<td>Consulting services for CIE.</td>
<td>Vendor requested payment outside the portal; fees were paid through invoices submitted to HealthierHere.</td>
</tr>
<tr>
<td>Other Convening Fees</td>
<td>$3,068 (Various)</td>
<td>Convening fees related to venue rental and catering for events associated with Domain 1 activities.</td>
<td>Payment for venues and catering could not be processed in the portal; fees were paid through invoices submitted to HealthierHere.</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$73,976</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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 strengthened relationships with tribal nations and governments, Indian Health Services (IHS) facilities, Indian Health Care Providers (IHCPs), and tribal and native serving community-based organizations (CBOs). 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 (1) the establishment of the Indigenous Nations Committee; and (2) development of culturally responsive and appropriate transformation strategies. Both are described below.

- **Indigenous Nations Committee.** HealthierHere recognized the need to create a

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3 Indigenous is defined as “Indigenous in particular attention to those original peoples of Turtle Island – with definition to Turtle Island.”
mechanism to authentically incorporate native and tribal voices into HealthierHere’s tribal investment strategy as well as overall transformation efforts. In response, HealthierHere established the Indigenous Nations Committee to inform the tribal investment strategy and educate HealthierHere about the needs of tribal partners and the populations they serve, critical gaps in healthcare access for tribal and native communities, and opportunities to scale existing programs and make new investments. Committee members include tribal and native serving CBOs, representatives from a tribal Federally Qualified Health Center (FQHC) and Behavioral Health Agency (BHA), and community members; two-thirds of the Committee is composed of American Indian/Alaska Native/Indigenous (AI/AN/I) members.

The Indigenous Nations Committee created a charter that will be presented to the HealthierHere Executive Committee in January 2020; upon approval, the Indigenous Nations Committee will become a formal committee of the Governing Board. The Committee will meet monthly and provide regular updates to HealthierHere’s Governing Board. The Executive Committee will also vote on the Indigenous Nations Committee’s request to add a representative of the Indigenous Nations Committee to the Governing Board; if approved, five of the 27 Governing Board seats will represent tribes.

As stated in its charter, the Committee seeks “to proactively engage Native serving CBOs, Indigenous professionals, traditional healers, AI/AN/I story-tellers, AI/AN/I Elders, AI/AN/I cultural experts and beneficiaries of services to ensure that their voices guide the decision-making of HealthierHere. The Indigenous Nations Committee helps HealthierHere co-design its priorities and projects with respect for trust and treaty obligations, sovereignty, historical and intergenerational trauma, and other effects of colonization, using culturally attuned, Indigenous and community-led approaches.”

At its launch meeting, the Committee focused on exploring what “In Good Health” means for tribal and native people. The graphic below depicts the Committee’s output from that discussion, and reflects the importance of spiritual, emotional, and community health in addition to physical and mental health.
The Committee also discussed what is working well regarding native/Indigenous health and opportunities for improvement, developing the below list.

**Figure 4. What Is Working Well and Opportunities for Improvement**

<table>
<thead>
<tr>
<th>What Is Working Well</th>
<th>Opportunities for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inculturation</td>
<td>Lack of visibility into emergency department visits</td>
</tr>
<tr>
<td>Cultural healing</td>
<td>Cultural advocates needed in clinics</td>
</tr>
<tr>
<td>Healing through healthy/traditional foods and water</td>
<td>Measuring outcomes of traditional/cultural healing</td>
</tr>
<tr>
<td></td>
<td>Centering Two-Spirit care</td>
</tr>
<tr>
<td></td>
<td>Need caregiver support</td>
</tr>
<tr>
<td></td>
<td>Need community support</td>
</tr>
<tr>
<td></td>
<td>Culturally competent and responsive training for healthcare staff</td>
</tr>
</tbody>
</table>

- **Culturally Responsive and Appropriate Transformation Strategies.** As HealthierHere continues to engage with and learn from tribal nations, governments, and other tribal and native serving partners, HealthierHere is learning about and implementing opportunities to make its transformation work more culturally responsive and appropriate. For example, the Cowlitz Tribe and Seattle Indian Health Board are leading efforts to educate HealthierHere and its partners on culturally appropriate administration of the Maine Health Access Foundation’s (MeHAF) assessment or a similar survey for bidirectional integration. HealthierHere also enhanced the Community Grants Program to be more culturally responsive; four of 16 grant recipients
are native serving CBOs and the community outreach survey was modified to better reflect tribal health practices and capture the use of traditional healers.

HealthierHere is committed to working with partners to identify how it can continuously refine transformation initiatives to be more culturally responsive and appropriate, including its work to promote and support the use of community health workers (CHWs), engagement of tribal and native serving community partners, and designing and supporting CBO innovations.

12. Design Funds.

a) 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 5. **HealthierHere Total Design Fund Expenditures**

<table>
<thead>
<tr>
<th>Use Categories</th>
<th>Design Fund Expenditures</th>
<th>Expenditure Details (Narrative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>HealthierHere has spent the $6 million Design Funds</td>
<td>HealthierHere received $6 million in Design Funds in 2017. These dollars are dedicated to funding direct administrative costs. The first $3.3 million in Design Funds were spent from 2017 to 2018 to support HealthierHere’s 2017 and 2018 administrative budget. These funds were used for direct administrative functions such as staff salaries/benefits, office space lease, fiscal sponsor fees, consulting contracts for various services, office supplies/equipment, etc. HealthierHere’s administrative budget for 2019 was $5.6 million, which was partially funded by the $2.7 million remaining from the Design Funds. HealthierHere monitors its administrative budget on a monthly basis by reporting to the Finance Committee. As of November 30, 2019, HealthierHere had $4.2 million in actual administrative expenditures; of the $4.2 million, $2.7 million was charged against the Design Funds.</td>
</tr>
<tr>
<td>Community Health Fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Systems and Community Capacity Building</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integration Incentives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Engagement, Participation and Implementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Performance and Quality Incentives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reserve/Contingency Fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Domain 1 Incentives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (describe below):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$6.0 million</td>
<td></td>
</tr>
</tbody>
</table>
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 fully expended the $6.0 million in Design Funds to support its administrative budgets from 2017 through 2019.

### 13. Incentives to support integrated managed care.

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

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

b) ACHs may use the table below or an alternative format as long as the required information is captured.

c) Description of use should be specific but concise.

d) List of use and expenditures should reflect a cumulative accounting of all incentives distributed or projected to support behavioral health providers transitioning to integrated managed care. It is not limited to the reporting period.

**HealthierHere Response**

Figure 6. **Use of Incentives to Assist Medicaid Behavioral Health Providers**

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual</th>
<th>Projected</th>
<th>Fund Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds directed to contracted Medicaid BHAs to support infrastructure needs required for transition to IMC.</td>
<td>$3,955,078</td>
<td>$4,168,862</td>
<td>DY1: IMC</td>
</tr>
</tbody>
</table>
**Description**

HealthierHere is overseeing and maintaining training and TA. The ACH will purchase system-wide 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:

- VBP Academy for 17 BHAs (the Academy was offered to 28 BHAs)
- Managed care contracting TA for BHAs
- University of Washington Advancing Integrated Mental Health Solutions (AIMS) training for providers
- Comagine/Qualis and UW AIMS provider training and TA to support integrated care and value-based payment (VBP)

<table>
<thead>
<tr>
<th>Description</th>
<th>Expenditures ($)</th>
<th>Fund Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Projected</td>
</tr>
<tr>
<td>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.</td>
<td>$297,776</td>
<td>$297,776</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$4,680,375</td>
<td>$5,955,517</td>
</tr>
<tr>
<td>UW AIMS-DY2</td>
<td>$89,290</td>
<td>$89,290</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$4,769,665</td>
<td>$6,044,807</td>
</tr>
<tr>
<td>TBD¹</td>
<td>$0</td>
<td>$9,233,275</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$0</td>
<td>$9,233,275</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$4,769,665</td>
<td>$15,278,082</td>
</tr>
</tbody>
</table>

**Note:** (1) 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.
Section 2. Project implementation status update

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

Attachments

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

14. Implementation work plan

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

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

a) The updated implementation plan must clearly indicate progress made during the reporting period. The ACH may decide how to indicate progress, so long as it allows for the IA to review and understand implementation progress, specifically:

i. Work steps and their status.

1. At minimum, work steps should be updated as either in progress, completed, or not started. The ACH may provide a work step status legend that defines and indicates the different work step statuses defined by the ACH. Recommended work step status options include:

   • Completed, Deliverable Met: The work step deliverable has been completed. The ACH is able to provide supporting documentation regarding the completion of the deliverable upon request.

   • Fulfilled for Quarter, Remains in Progress: Actions were taken toward achieving the work step deliverable, but the deliverable has a target end date in the future. The ACH is able to provide supporting documentation regarding activities fulfilled in the quarter upon request.

   • Delayed, Remains in Progress: Work step deliverable is past due. Work step was scheduled to be complete, but the ACH is still working towards completion.

   • Not Started: Work step has not been started.

2. The ACH is to assign a status for each work step provided in the implementation plan.

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4 Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.
plan work plan. This applies to work steps that have yet to be started.

b) If the ACH has made minor changes for any work step from their originally submitted work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.

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

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

15. Partnering provider roster.

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

Instructions:

a) HCA will process the partnering provider roster submissions for SAR 3 during August-September. The processing step is to update the state database, and apply consistent formatting for ease of maintenance for future reporting periods.

b) By October 15, HCA will provide ACHs a clean version of the ACH’s partnering provider roster (based on SAR 3 submissions) to update for the SAR 4 reporting period.

i. This will be the version that ACHs maintain for the remaining semi-annual reporting periods.

c) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:

i. Whether the partnering provider site is pursing tactics or strategies in support of specific project areas from the Project Toolkit. Place an “X” in the appropriate project column(s).

ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.

d) Update partnering provider site information as needed over each reporting period.

Submit updated partnering provider roster.

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

The ACH should provide documentation that addresses the following:

16. **Quality improvement strategy update**

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

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

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

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

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

*Attach or insert quality improvement strategy update.*

**HealthierHere Response**

HealthierHere is attaching the updated QI Strategy (see attachment) that incorporates feedback from the Independent Assessor (IA) as well as updates to reflect the onboarding of community partners. A summary of these updates, what HealthierHere has learned over the past six months, and support provided to clinical partners is included below. For additional detail, please refer to the QI Strategy.

**Modifications to HealthierHere’s QI Strategy**

HealthierHere updated its QI Strategy based on feedback from the IA following submission of the third Semi-annual Report. HealthierHere also made updates to reflect the onboarding of community partners and the addition of a QI project for clinical partners.

- *Updates based on IA feedback.* In response to the IA’s request for additional
information, HealthierHere made the following updates to the QI Strategy:

- HealthierHere clarified the approach it is taking with partners that have more mature QI capabilities, including:
  - Encouraging Plan-Do-Study-Act (PDSA) cycles;
  - Supporting the optimization of Collective Ambulatory;
  - Offering targeted and individual QI support through its contracts with UW AIMS and Comagine Health;
  - Incenting progress through Pay for Progress contracts; and
  - Funding opportunities through HealthierHere’s Innovation Fund (described in HealthierHere’s response to question #17).

- In January 2020, HealthierHere will continue to support partners’ QI capabilities through additional investments, including but not limited to:
  - Enabling partner access to the Institute for Healthcare Improvement Open School training platform through the purchase of licenses.
  - Funding opportunities through the Training Fund launching in January 2020; the Fund will allow partners to request funding to support their organization’s specific training needs.

- HealthierHere included additional detail on the structure and goals of the Co-Design Collaborative, which brings together community and clinical partners to collaborate on projects and innovations.

- HealthierHere further described how it will work with partners to monitor, identify the need for, and implement course corrections, including through partners’ semi-annual reporting, site visits, Co-Design Collaborative meetings, and Governing Board and Committee meetings.

- HealthierHere clarified how it monitors progress in transformation activities and identifies actions driven by or in response to barriers. Monitoring activities include site visits, partners’ semi-annual reporting, and ongoing conversations among partner staff and HealthierHere practice transformation managers.

- HealthierHere included the Pay for Progress methodology as an appendix to the QI Strategy.

- **Pay for Progress Requirement.** As part of their 2020 Pay for Progress contracts, partners will be incentivized to develop a QI project that ties to one of HealthierHere’s pay-for-performance (P4P) metrics. HealthierHere will review partners’ proposed projects prior to launch to ensure that all required components, including equity, are included. HealthierHere staff, UW AIMS, and Comagine Health will support partners in both project development and implementation.

- **Community Partner QI Strategy.** HealthierHere onboarded community partners in fall
2019 and updated the QI Strategy to reflect QI expectations and support for community partners. As with clinical partners, HealthierHere’s approach is to meet community partners “where they are” with QI and set reasonable expectations to help them improve. When creating the community partner QI Strategy, HealthierHere considered long-standing disparities, at both the individual and organizational levels. The community partner QI strategy seeks to build a shared understanding of QI language, strategies, and goals. The strategy integrates a culturally responsive and respectful framework, including an approach that seeks to understand appropriate measures of progress based on where partners are in their work and how they define culturally responsive and appropriate care.

HealthierHere’s QI expectation for community partners is that their quality monitoring approaches are value-driven and based on the unique needs of the organizations and the communities they serve. Informed by clinical measures, HealthierHere will work with community partners in 2020 to establish culturally responsive measures, including “proxy measures” that track progress related to the impact of social determinants of health (SDoH) on clinical metrics. While proxy measures will be developed with community partners by Q2, anticipated examples of proxy measures may include, but are not limited to, the following: increased numbers of clients accessing the physical and behavioral healthcare system; increased numbers of clients accessing substance use disorder (SUD) treatment and prevention services; increased numbers of community-based chronic disease support and self-management programs; and increased numbers of community members utilizing the services of traditional healing and medicine to achieve improved health outcomes. These proxy measures will capture the impact of SDoH services provided in a community setting and the anticipated correlation to improved health outcomes through demonstrating a positive impact on the Medicaid Transformation Project (MTP) metrics by reducing the numbers of unnecessary emergency department (ED) visits and improving the metrics related to each of the four MTP Project Portfolio areas. HealthierHere will assess progress and changes over six-month periods through site visits, reporting, co-design collaboratives, and ongoing communication supported by training and TA. Community partners will also report on their progress twice a year and be eligible for financial incentives based on quantitative and qualitative measurements of progress.

Please refer to the QI Strategy for additional information on HealthierHere’s support for community partners.

**Summary of Findings and Lessons Learned, Including Best Practices**

Through site visits and continuous dialogue with partners, HealthierHere is identifying the challenges partners face in developing and executing QI approaches as well as their mitigation strategies and best practices. Examples of challenges and best practices identified over the past six months are described below.
Challenges

• BHAs need additional support to build QI capabilities and develop a shared organizational understanding of QI and its importance. Many BHAs are implementing foundational tools (e.g., electronic health records [EHRs] and registries) to collect baseline data and monitor their performance. As capabilities mature in 2020, BHAs will be better equipped to measure improvements in quality of care and implement changes to improve performance and outcomes. BHAs would also benefit from additional training related to providing integrated physical health services.

• Clinical partners implementing QI activities can become overwhelmed by the magnitude of potential activities they could implement. HealthierHere and UW AIMS are recommending that partners start small when developing new or enhancing existing QI activities. For example, partners might target a specific sub-population, focus on one or two metrics, or implement rapid tests of isolated workflow changes.

• HealthierHere is gaining deeper insight into partner readiness for value-based contracting with Managed Care Organizations (MCOs). BHAs have never engaged in value-based contracting and require additional support to understand the measures for which they will be accountable, their attributed populations, and methods to drive improvement in these metrics. In 2020, HealthierHere will support partners in continuing to implement foundational QI capabilities and evolve existing capabilities to better prepare them for value-based care. For example, HealthierHere recently hosted a training for BHAs on negotiating managed care contracts from a position of strength. HealthierHere is planning a roundtable in early 2020 where MCOs will present examples of current value-based arrangements and HealthierHere will educate partners on strategies to promote success in these arrangements.

Best Practices – These best practices are examples of how HealthierHere partners are impacting MTP metrics, such as reduction of all cause ED visits and increasing mental health penetration and child and adolescent access to primary care practitioners.

• When establishing new partnerships, it is best to start small, with clear delegation of responsibilities for a particular program or process. For example, FQHCs and BHAs have been successful in setting up partnerships for bidirectional referrals where a behavioral health provider from the BHA is in a consulting role for the FQHC and vice versa.

• Assigning staff to centrally manage registries and population health information, including Collective Ambulatory data, has improved workflows and freed up time for clinical staff to focus on patient care.

• Co-location of behavioral and physical health providers has been successful in advancing collaborative care and increasing communication among care team members.

• In efforts to not overload current staff, partners have created new positions and hired additional staff to support QI activities, for example, Consejo hired a medical assistant to track data and work with the care team.
• FQHCs are implementing new workflows to identify patients who should be seen by a behavioral health provider. For example, International Community Health Services includes behavioral health staff in their “primary care huddle” and, based on past screenings, identifies patients for referral to a behavioral health provider.

• Country Doctor Community Health Centers implemented a “behavioral health floater” model, in which they have an unscheduled provider available to provide consults as needed.

**QI Support**

HealthierHere continues to provide QI support through its contracts with UW AIMS, Comagine Health, and site visits:

• UW AIMS is working with partners to implement workflow changes to improve care delivery and implement continuous QI strategies. For example, UW AIMS worked with Downtown Emergency Service Center (DESC) to streamline data collection efforts for their office-based opioid treatment (OBOT) program registry. Previously, duplicative data were collected by DESC staff, pharmacy staff, and other providers. UW AIMS and DESC eliminated duplicative efforts by requesting reports from pharmacy staff and providers’ EHRs. These changes allowed DESC to eliminate 50% of the data fields in the original data collection approach, thereby freeing up clinical staff time to focus on patient care.

• Comagine Health continues to support partners with Collective Ambulatory implementation and optimization, giving partners tools for tracking patient ED utilization and hospital transitions, leading to improved patient follow-up and the potential to improve P4P metrics across all of HealthierHere’s projects. BHAs are also getting support through the VBP Academy on population health, risk stratification, QI, and PDSA cycles. Participating BHAs are implementing QI transformation projects focused on a P4P metric within HealthierHere’s project portfolio.

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

**Narrative responses**

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

**17. General implementation update**

a) *Description of training and implementation activities:* Implementation of transformation approaches requires specific training and activities.

i. Across the project portfolio, provide three examples of *each* of the following:

1. Trainings and technical assistance resources provided to or secured by partnering
providers or members of care teams necessary to follow required guidelines and to perform their roles in an approach in a culturally competent manner. Be specific when describing the project(s), partnering provider(s), the guidelines or evidence-based approaches, specific needs that the training and/or technical assistance addresses and describe how the training and/or technical assistance promoted successful performance of roles in a culturally competent manner. Detail the gaps that remain for partnering providers to follow required evidence-based guidelines and the types of training and/or technical assistance that are anticipated to be addressed in the future.

**HealthierHere Response**

Three examples of how HealthierHere provided partners with training and technical assistance to help them follow evidence-based guidelines and perform their roles in a more culturally relevant and appropriate manner are (1) hosting a training on equity and targeted universalism; (2) supporting partners’ equity assessments and action plans; and (3) providing clinical partners with training on reducing readmissions and improving care for multi-visit patients (MVPs).

- **Equity and Targeted Universalism Training.** HealthierHere is committed to advancing health equity and reducing health disparities in King County. Since mid-2018, clinical partners have been working to implement HealthierHere’s Clinical Summaries, which lay out expectations, evidence-based approaches, and recommended policies, procedures, and protocols for clinical partners implementing HealthierHere’s selected projects. With over a year of implementation underway, HealthierHere recognized the need and interest by partners for guidance and training on equity and contracted the SEED Collaborative to provide clinical partners with training on equity and targeted universalism; the SEED Collaborative is focused on developing and operationalizing strategies that support equitable institutions and communities. The goal of the training is to give partners tools to implement evidence-based guidelines and perform their roles in a more culturally relevant and appropriate manner.

  One hundred individuals representing 30 organizations participated in the Seed Collaborative training on October 3-4, 2019. Participants included clinical partner staff working in data analysis, quality improvement, and community/patient engagement, as well as administrative staff, clinical staff, organizational affinity groups, and employee engagement and human resources specialists. The training provided partners with a better understanding of how racism shows up in healthcare delivery and gave partners capacity to take the language, principles, and concepts of the course back to their institutions and sectors.

- **Equity Assessment and Action Plan.** Clinical partners have been charged with moving the concepts learned during the SEED Collaborative training into practice, including through completion of an Equity Assessment and Equity Plan as part of Pay for Progress reporting. HealthierHere is supporting partners as they develop these deliverables. Both the Assessment and Action Plan will inform HealthierHere’s approach to and investments in
partner training in 2020.

- **Equity Assessment.** Clinical partners will be rewarded for completing a HealthierHere Equity Assessment between July and December 2019. The Equity Assessment includes questions related to partners’ commitments to equity, cultural competence, and provision of Culturally and Linguistically Appropriate Services (CLAS). The completed Equity Assessments will provide HealthierHere with baseline information about clinical partners’ commitments to equity and the steps they have taken to incorporate equity into service delivery and transformation initiatives.

- **Equity Action Plan.** Clinical partners will also be rewarded for developing an Equity Action Plan. The Equity Action Plan will give partners the opportunity to create customized goals and work steps related to equity that align with their needs and capacity as identified through the Equity Assessment described above. HealthierHere recognizes that equity is both a process and a product that is developed over time through intentional efforts and planning. Advancing equity cannot be done with a one-size-fits-all approach; HealthierHere acknowledges that organizations are at various stages of development in their efforts to address equity.

- **MVP Method to Improve Care for Multi-Visit Patients.** HealthierHere partnered with the Washington State Hospital Association (WSHA) to provide clinical partners with training on reducing readmissions and improving care for MVPs. The evidence-based MVP method emphasizes that MVPs have unmet medical, social, and behavioral needs that are driving their utilization and require a whole-person approach to transitional care. The training builds on HealthierHere’s Clinical Summaries, as patients across all four of HealthierHere’s projects are at risk for frequent readmission. Forty-one individuals participated in an MVP webinar hosted by HealthierHere and WSHA on August 16, 2019, and a recording is available on HealthierHere’s website for partners not able to join the live webinar. The webinar introduced partners to the MVP method’s core concepts and implementation strategy. HealthierHere believes that if providers are trained in the MVP method, they will be better positioned to deliver culturally competent care focused on addressing patients’ unmet needs that are driving utilization.

  Partners have expressed that limited capacity, especially for smaller organizations, is a barrier to implementing the MVP method. For example, BHAs and FQHCs may not have the staff, training, or workflows to conduct screenings for unmet social needs (e.g., housing and employment). HealthierHere continues to look for opportunities to address these gaps, including through providing opportunities for additional trainings and funding that partners may use to enhance their capacity.

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

HealthierHere supported the implementation of bidirectional communication strategies/interoperable health information exchange (HIE) tools, specifically the deployment of Collective Ambulatory, development of a shared care plan, and planning for a community information exchange (CIE). HealthierHere’s Executive Director also participated in cross-ACH efforts to develop recommendations for advancing statewide HIE. Brief descriptions of each are below.

- **Collective Ambulatory.** HealthierHere contracted with Comagine Health to support clinical partners in the implementation and optimization of Collective Ambulatory, a software platform that provides notifications to enrolled providers when their patients visit the ED. The Collective Ambulatory platform gives organizations a key tool for tracking patient ED utilization and hospital transitions, leading to improved patient follow-up and the potential to improve P4P metrics across all of HealthierHere’s projects. Comagine Health practice coaches work one on one with clinical partners in their “home” settings, emphasizing the use of PDSA cycles in the development of clinical workflows to improve ED follow-up. As of December 2019, 25 BHAs were receiving TA and practice coaching, 13 of which had previously not used Collective Ambulatory. In addition, four BHAs and three FQHCs were receiving coaching to optimize their use of Collective Ambulatory.

In response to HealthierHere’s stakeholder survey, Navos, a clinical partner, noted that because of HealthierHere’s partnership and funding, it was able to “sustain and develop Collective Ambulatory as well as invest in a Nurse Care Manager role to bridge silos in our organization.”

In partnership with the HCA, HealthierHere participated in the Medicaid Transformation Learning Symposium in October 2019, raising awareness and engagement among the ACHs, MCOs, and HCA staff about the potential for Collective Ambulatory to help achieve shared goals, as well as address the risk of duplicative follow-up work, which could result in further complicating the healthcare landscape. To address this issue, HealthierHere spearheaded an opportunity to partner with the WSHA, and convened a Statewide Collective Platform Work Group to address concerns raised about standardizing how Collective Ambulatory supports healthcare delivery across ACHs and MCOs.

- **Shared Care Plan Workgroup and Pilot.** HealthierHere launched the Shared Care Plan (SCP) Workgroup to help achieve Project 2A and 2C milestones, and in response to partners’ calls for a single interoperable platform with complete and up-to-date patient information to facilitate coordinated and patient-centered care. The longer-term vision for this Workgroup is to develop a client-driven care plan owned by the individual. The

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6 2A: Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities. 2C: Implement bidirectional communication strategies/interoperable HIE tools to support project priorities.
Workgroup’s priorities for 2019-2020 are to:

- Agree on the purpose, owners, and target client population(s) of a shared care plan.
- Recommend the elements of a shared care plan.
- Develop guidelines around organizational roles, workflows, and expectations for use of a shared care plan.
- Recommend technical specifications for a platform to host a shared care plan.
- Develop a blueprint for a SCP pilot. (See pilot description below.)

The Workgroup is coordinating with relevant patient information-sharing efforts in the region, including HealthierHere’s CIE Workgroup.

The SCP Workgroup comprises clinical and community partners and subject matter experts, representing:

- BHAs
- Primary care providers
- Acute care providers
- Provider associations
- CBOs
- MCOs
- Health information technology experts
- Healthcare quality improvement organizations
- HealthierHere’s Integration Design Workgroup
- HealthierHere’s CIE Workgroup

In the third and fourth quarters of 2019, HealthierHere met with interested partners and developed a strategy to launch the pilot in November 2019. HealthierHere developed an SCP pilot team that includes clinical and administrative staff from Harborview Medical Center (hospital and primary care), Sound Mental Health (behavioral health), and Evergreen Treatment Services (SUD). There is a plan to engage with an FQHC in early 2020, pending the FQHC’s organizational capacity due to competing demands of EHR implementation. The pilot design includes the following components:

- **Purpose** – To facilitate a transition of care from the hospital setting.
- **Population** – Medically complex individuals meeting the following criteria:
  - Discharged from inpatient hospital or ED settings within the past three months
  - Primarily medical and/or behavioral-health oriented
  - Have two or more chronic conditions
  - Received care from two or more organizations on the SCP pilot team
• Social complexity may or may not be present

• Owner – Clinical providers with patient input

• Technology – Explore the use of “Care History” section or “Attachments” feature on the Collective Platform

• **CIE.** HealthierHere is exploring the development of a CIE for the King County region. A CIE is a network of cross-sector partners (e.g., social service, community, tribal, physical and behavioral health providers) that use a shared technology platform and resource database to coordinate care so that individuals have better access to the healthcare and social supports they need to improve their health. HealthierHere envisions that participating clinical and community partners, as well as many others from the King County health ecosystem, will be able to access a network database where they contribute to a single longitudinal client record, share information, and make bidirectional, closed-loop referrals.

HealthierHere is making investments to support the start-up of a CIE as a “public utility” with shared community ownership. In this reporting period, HealthierHere contracted with an experienced Chief Technology Officer who will be closely involved with CIE development. HealthierHere is also recruiting for additional staff to support CIE work, including operational and community engagement support. HealthierHere is also recruiting for a Development Director and considering various fundraising approaches to support the CIE.

HealthierHere hosted a CIE launch meeting in the second half of 2019 after a successful initial meeting in the summer. Stakeholders agreed on a shared vision and to work collaboratively with each other, including with several organizations currently using CIE-like networks. HealthierHere launched a CIE Workgroup in fall 2019 to address key data, technology, and legal issues. Additionally, the Workgroup developed shared principles to guide the CIE work:

1. Keep the client/patient at the center
2. Respect and protect client/patient privacy
3. Exchange only information that will improve care and equity
4. Relationships are key to success
5. Make the solution simple and efficient for end users and clients/patients
6. Optimize workflows and minimize duplication of effort

In May 2019, Kaiser Permanente (KP) announced it will roll out a CIE using the Unite Us platform in KP regions across the country. The platform is a closed-loop referral system that will connect KP clinicians with CBOs to address KP members’ SDoH. HealthierHere has learned through discussions with KP that they are aligned with HealthierHere’s vision of CIE as a “public utility” for all healthcare and community partners. In King County, KP has committed to pay for CBO and FQHC licenses. HealthierHere is engaging with KP to identify
opportunities to leverage their investments and coordinate efforts. Unite Us presented at the December 6, 2019 Co-design Collaborative and demonstrated the platform to clinical and community partners.

- **ACH Health IT Strategy.** All ACH Executive Directors are collaborating to develop an *ACH Health IT Strategy* comprised of a vision for health IT in Washington, goals and recommendations, and near-, mid-, and long-term ACH activities.

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

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

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

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

The ACHs plan to share the Health IT Strategy with HCA in the first quarter of 2020 and look forward to discussing partnership opportunities in pursuit of the collective ACH vision.

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

**HealthierHere Response**

To coordinate care management and/or transitional care plans with related community-based services and supports, HealthierHere established the Innovation Fund, is building a Partner Resource Directory, and is leveraging the Co-design Collaborative.

**Innovation Fund**

In 2019, 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 P4P outcome metrics. As of December 31, 2019, three projects have been launched, each of which is taking a novel approach to care management and/or transitional care among clinical
partners (described below). For the first year of implementation, each partner can receive up to $300,000; if mutually agreed-upon project milestones are met, funding may be renewed for a second year. A third-party evaluator will conduct project evaluations.

- **Country Doctor Community Health Centers (CDCHC)** and **Public Health Seattle King County (PHSKC)** are both implementing projects to connect people who completed induction in jails or EDs with community-based treatment so they do not fall through the cracks. The innovations were designed to support achievement of Project 3A goals and P4P metrics.
  - **CDCHC** is expanding in-house hours for permanent, low-barrier medication-assisted treatment (MAT), including evening and weekend hours. Additionally, CDCHC is offering walk-in services, on-demand behavioral health intakes and assessments, transportation support, and patient navigation. To ensure patients released from temporary MAT sites are successful in transitioning to the CDCHC OBOT program, CDCHC is offering transportation to the patient’s first appointment as well as care coordination support. A CDCHC CHW is proactively developing referral relationships and workflows with local jails and EDs to support smooth transitions between sites. CDCHC is partnering with Sound Mental Health for on-demand intakes and assessments and other behavioral health services. CDCHC is partnering with Hepatitis Education Project (HEP), a CBO and HealthierHere community partner, to provide harm reduction services with integrated infectious disease testing and case management. HealthierHere’s funding is enhancing HEP’s patient navigation services (e.g., services related to homelessness or post-release from incarceration) for MAT clients referred by CDCHC.
  - **PHSKC** is expanding its *Buprenorphine at Navos Mental Health and Wellness Center (Bupe NoW)* project and is working with King County ED Buprenorphine Learning Collaborative participants in South King County to support care coordination, warm hand-offs, and ongoing MAT and recovery support services for patients with ED-initiated buprenorphine. Bupe NoW is offering a suite of support services including transportation assistance and a navigator to provide intensive support with visits and scheduling. The navigator also supports warm hand-offs from jail and the ED, provides linkages to and coordination with Navos’s mental health and SUD treatment services, assists with community resources, and provides follow-up and re-engagement for missed appointments.

- **The Seattle Fire Department (SFD)**, in partnership with Seattle Aging and Disability Services (ADS, the Seattle/King County Area Agency on Aging), has designed a Mobile Integrated Health (MIH) program, which provides an immediate response to individuals who have activated 9-1-1 for low-acuity conditions. A mobile unit equipped with two firefighters and one ADS case manager will respond to calls for assistance. SFD is partnering with various community, healthcare, and governmental partners in this effort, with the objective of reducing unnecessary ED visits.
**Partner Resource Directory**

In response to clinical and community partners’ requests to help them connect and learn about one another, HealthierHere developed and launched a Partner Resource Directory in December 2019. The Directory is a web-based repository of all partners involved in HealthierHere’s transformation work. HealthierHere included all interested clinical and community partners in the directory and will augment it as HealthierHere engages with new organizations. Partners are able to use the directory to browse or search by organization type, geographic area served, or type of service provided. For example, a partner could search for an organization in South King County that provides social services navigation support as well as health literacy education. HealthierHere sees the directory as a tool to help partners build new relationships and enhance existing partnerships, and as an input to the CIE effort described above.

**Care Coordination/Management and Co-Design Collaborative**

Through the Co-Design Collaborative, HealthierHere is engaging partners in ongoing discussions and work related to care management/coordination strategies and tools. During the October meeting, clinical and community practice partners:

- Discussed challenges and opportunities that community and clinical partners encounter when trying to coordinate care for shared clients;
- Identified potential approaches, strategies, and system-wide tools to explore that might enhance the ability of community and clinical partners to coordinate care for shared clients;
- Reviewed information about some of the care coordination efforts currently underway within King County; and
- Expressed interest in engaging with HealthierHere on the co-design of a CIE as a tool to promote the coordination of care for shared clients.

During the December meeting, the Co-Design Collaborative expanded this care coordination conversation and tied it directly to the Unite Us initiative in partnership with KP. Participants were able to further problem solve how to best implement a CIE tool that would be congruent with local expectations and capacity. The Co-Design Collaborative meetings will continue to be leveraged as a resource in care coordination/management discussions, with some partners joining the CIE and SCP Workgroups.

It is HealthierHere’s hope that through the Co-design Collaborative, community and clinical partners are able to learn about each other’s strengths, build deeper relationships, and develop new partnerships. For example, Falis Community Service (a community partner) developed a partnership with Valley Medical Center (a clinical partner) focused on culturally appropriate referrals. Every other Tuesday, Falis has a nurse conduct on-site screenings, which include blood pressure screenings and pre-diabetic testing. The nurse and Falis staff identify patients that need follow-up care, complete an in-house-developed referral form, and refer patients to Valley Medical. Falis staff then make themselves available to Valley...
Medical staff for help with culturally appropriate and relevant care, including language barriers. Falis and HealthPoint are also working to identify opportunities for partnership.

4. Systems or rapid-cycle quality improvement processes that have been developed to monitor performance, provide performance feedback, implement changes and track outcomes.

**HealthierHere Response**

HealthierHere monitors partners’ progress on implementation of Medicaid transformation activities through:

1. A [dashboard](#) based on Medicaid claims data that provides insight into regional performance
2. A semi-annual report and assessment measuring partners’ progress on foundational incentive measures
3. Site visits to discuss partners’ progress, challenges, and best practices relative to project implementation
4. Co-Design Collaborative meetings that provide a forum for clinical and community partners to learn about each other and share progress on transformation efforts
5. Ongoing communication with training and TA practice coaches

These mechanisms provide an opportunity for HealthierHere to track performance at the regional, project, and partner levels and collaboratively identify the need to change course and provide assistance.

Through site visits conducted in fall 2019, HealthierHere learned that partners are at various stages of implementing systems and/or rapid-cycle QI processes, with some being limited by staff capacity, data, or technology. As described elsewhere in the semi-annual report, HealthierHere provides training and TA relative to QI strategies and processes through contracts with Comagine Health and UW AIMS. Three examples of partners implementing systems or rapid-cycle QI processes are described below.

- **International Community Health Services** has a QI team that is working to increase QI capacity across the organization. They work collaboratively with the data analytics team, which pulls and analyzes data to implement and monitor QI activities. The QI team has developed a PDSA tracker and is encouraging greater uptake across the organization to further streamline and simplify processes.

- **Navos** built a dashboard to provide deeper insight into information gathered from Collective Ambulatory. They are creating and refining workflows to improve follow-up with patients, as well as looking for ways to stratify risk.

- **Seattle Children’s Care Network** has a centralized QI team that has recently focused on streamlining QI activities, including providing more actionable data and analytics to clinics. This process reduces clinic staff burden to process data and helps inform their QI activities, including clinic-led PDSA cycles.
HealthierHere conducted a survey of over 100 stakeholders – including clinical partners, community partners, Board members, committee members, and others – to gauge the organization’s impact on advancing transformation in the region. The following figure shares representative quotes describing positive changes that stakeholder organizations in King County have been able to make as a result of partnership with HealthierHere.

**Figure 7. Representative Quotes Describing Positive Changes Resulting from HealthierHere Partnership**

**Q11: Examples of changes in your organization and/or our region that happened as a result of partnership with HealthierHere?**

- **Scaling Programs/Expanding Reach**
  - “We were able to invest in new tools to help us be better able to provide more comprehensive care.” - *Community practice partner*
  - “We were able to purchase an EHR that is not only much more user friendly, it will allow us to have real time analytics.” – *Clinical practice partner*
  - “We’ve been able to test some new models of care coordination with a hospital and expand our partnership with paramedicine.” – *Community innovation partner*

- **Forming Partnerships**
  - “We have made connections with other health care organizations that may benefit from the services we provide.” – *Community innovation partner*
  - “Connect with organizations that are not as easily accessible.” – *Committee member*
  - “We were able to connect with a clinic to start the partnership.” – *Community practice partner*

- **Tell Our Story/Raise awareness of SDOH**
  - “Increased general awareness of housing as a platform for health for the broad non-profit and public housing authorities in King county” – *Board member*
  - “The rising recognition of SDoH as impacts overall health.” – *Community practice partner*
  - “We have been able to more explicitly link our homelessness prevention work to building community health.” – *Community innovation partner*

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

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

**HealthierHere Response**
Clinical partners implementing project 2A are receiving financial support for integrated care infrastructure and activities through direct funding and training and technical assistance. These resources are described below.

**Direct Funding**
- **IMC Funding.** To date, as part of the transition to integrated managed care in King County, HealthierHere has directed approximately $4.8 million in IMC funds to support BHAs’ infrastructure needs, training, and TA. HealthierHere has also funded temporary
staffing to support the King County Behavioral Health and Recovery Division in transitioning to the new Behavioral Health Administrative Services Organization.

- **Pay for Progress.** Twenty-one out of 25 clinical partners are implementing project 2A. These partners are eligible for incentive payments for positive workflow changes and the establishment of foundational infrastructure. Available funding varies by partner type (i.e., FQHC, hospital, BHA) and is dependent on each partner’s demonstrating progress in four categories: clinical, population health, VBP, and equity. Eligible funding amounts by partner type for the current reporting cycle are below.

  **Figure 8. Eligible Funding Amounts by Partner Type, July – December 2019**

<table>
<thead>
<tr>
<th>Partner Type</th>
<th>Number of Partners</th>
<th>Available Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHA</td>
<td>10</td>
<td>$132,000</td>
</tr>
<tr>
<td>FQHC/Primary Care</td>
<td>8</td>
<td>$110,000</td>
</tr>
<tr>
<td>Hospital</td>
<td>6</td>
<td>$88,000</td>
</tr>
</tbody>
</table>

**Training and Technical Assistance**

- **Whole-person Integrated Care.** HealthierHere is contracting with UW AIMS to provide 14 partners (seven BHAs, three FQHCs, and four hospitals) with ongoing whole-person integrated care training, TA, and practice coaching tailored to their organizational needs and capacity. UW AIMS offers both individualized and small group training and offers TA to clinical partners to help them develop sustainable models of whole-person integrated care. This training and TA include the Bree Collaborative, Collaborative Care, co-location of services, and enhanced collaboration/integrated whole-person care.

- **VBP Academy.** Seventeen BHAs completed a 10-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. The curriculum included population health, risk stratification, QI, and PDSA cycles. Participating BHAs are implementing QI transformation projects focused on a P4P metric within HealthierHere’s project portfolio.

- **Collective Ambulatory Optimization.** Comagine Health is helping BHAs implement and optimize use of 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.
2. Project 2B: Provide information related the following: NOT APPLICABLE

   a. Schedule of initial implementation for each Pathway.

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Date of implementation (actual or anticipated)</th>
<th>Notes (optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult education</td>
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<tr>
<td>Employment</td>
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<tr>
<td>Health insurance</td>
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<td>Housing</td>
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<td>Medical home</td>
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<td>Medical referral</td>
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<tr>
<td>Medication assessment</td>
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<tr>
<td>Medication management</td>
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<tr>
<td>Smoking cessation</td>
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<tr>
<td>Social service referral</td>
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<tr>
<td>Behavioral referral</td>
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<tr>
<td>Developmental screening</td>
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<tr>
<td>Developmental referral</td>
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<tr>
<td>Education</td>
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<tr>
<td>Family planning</td>
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<tr>
<td>Immunization referral</td>
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<tr>
<td>Lead screening</td>
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<td></td>
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<tr>
<td>Pregnancy</td>
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<tr>
<td>Postpartum</td>
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</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>CCA Name</th>
<th>Total # of Referrals to CCA for any Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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

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

   f. Describe the training plan for community health workers, and the number trained. What is the feedback loop for the identification and offering of continuing education training and development? What evaluation and assessment does the ACH conduct, if any, post-training to determine if trained individuals have increased skills, competencies, or performance? How does the ACH use such information or other feedback to determine trainings to provide either to individuals or groups, what trainings to require as
mandatory versus individual goals-based, and key partners to include in offering trainings.
g. Describe technology enabled care coordination tools being used, and how information being captured by care coordinators is integrated with clinical information captured through the statewide health information exchange.
h. Include two examples of checklists or related documents developed for care coordinators.

3. Project 2C: Provide a summary of activities that increase the availability of POLST forms across communities/agencies, where appropriate and when applicable based on the strategies the ACH has promoted. Describe activities that have been most successful as well as any continued challenges in increasing the availability of POLST forms, as applicable.

**HealthierHere Response**
HealthierHere has begun work to increase the availability of Physician Orders for Life Sustaining Treatment (POLST) forms. During partner site visits in fall 2019, HealthierHere asked partners how their organizations support patients in completing POLST forms, with the goal of identifying best practices in King County and informing a webinar planned for early 2020. Partners are using various strategies to increase the availability of POLST forms. Several FQHCs make POLST forms available to patients in every exam room. One FQHC incorporated POLST form completion into their standard of care guidelines for hospitalizations. Another FQHC has developed workflows for POLST forms where a medical assistant raises the need to complete the form during care team huddles. The medical assistant then supports the patient in completing the form, and completion is tracked in the EHR. All medical assistants and interested staff were trained on POLST forms by Honorng Choices.

Through partner site visits, HealthierHere also identified opportunities for additional support and improvement in increasing POLST availability and completion. Key factors in POLST completion are staff capacity to administer and complete forms and HIE infrastructure to track form completion. One FQHC noted that while POLST forms are available in every exam room, their EHR does not have the capability to track form completion, a feature that would improve completion rates and streamline processes. HealthierHere is following up with partners identified as having successful practices for increasing POLST availability and will invite them to present their best practices in the 2020 webinar.

4. Project 3A: Provide two examples of the following:
   a. Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recovery supports.

**HealthierHere Response**
The state and King County have invested significantly in the development of programs and services to combat the opioid crisis, with a focus on prevention, treatment expansion, overdose
prevention, and recovery supports. HealthierHere is working to support and amplify these efforts. Below are examples of strategies and approaches taken by HealthierHere and its partners.

**Prevention**

- HealthierHere participates in various King County opioid-focused initiatives, including educational events (e.g., *Take Back Your Meds*), public safety campaigns (e.g., increasing awareness of illicit drugs being laced with fentanyl), and a new convening for older adults.

- Thanks to HealthierHere and the MTP, some partners are developing chronic pain registries. For example, NeighborCare has an opioid and suboxone registry they are planning to update and integrate with Epic; once integrated, they plan to further define staff roles and responsibilities relative to the registry.

**Treatment**

- Through the Innovation Fund, HealthierHere is investing $600,000 in initiatives to promote continuity of care for individuals with opioid use disorder (OUD) who have received MAT induction in an ED or jail and are released into the community. HealthierHere is funding two projects that will increase warm hand-offs and reduce barriers for individuals to continue their MAT with community-based, low-barrier MAT providers.

- HealthierHere partners are implementing and enhancing MAT. Increasingly, clinical partners are using the nurse care manager model to expand MAT programs, and more providers are becoming waivered for treatment. Hospitals are also encouraging ED physicians to induct patients on MAT.

- Therapeutic Health Services redesigned their approach to identifying and treating high-risk patients with OUD. They simplified and streamlined their care model by focusing on only the highest-need patients, identified through a homegrown assessment tool. They also began providing on-site integrated care to patients seeking opioid treatment. This model better allows the care team to earn the trust of patients, removes the stigma of OUD when seeking primary care, and simplifies patient visits.

**Overdose Prevention**

- HealthierHere, in partnership with Collective Medical, hosted a webinar on July 19, 2019, to educate partners on HB 1427, which established an overdose event notification system in the state and is intended to provide clinicians with meaningful information to help stop overdose deaths. During the webinar, physicians and other prescribers were invited to participate in Washington’s Overdose Notification System pilot, a first-of-its-kind approach to help address the opioid epidemic. The pilot will run for six months and is led by Collective Medical in association with the WSHA, Washington State Medical Association, and Washington State Department of Health. HealthierHere is encouraging partners to participate in the pilot, which seeks to:
  - Identify patients at risk for opioid addiction and opportunities to select non-opioid treatment options
Increase and enhance timely coordinated communication to all prescribers, care managers, and case managers regarding opioid overdose events

Streamline engagement of patients in opioid use disorder interventions to improve long-term outcomes


- Seattle – King County Public Health used incentive funding to purchase naloxone, and one hospital partner (CHI Franciscan) is distributing free naloxone kits.

**Recovery Supports**

- HealthierHere distributed funding to CBOs that provide recovery support services, including Peer Seattle and Recovery Cafe. These community partners collaborate with clinical opioid partners in the Co-Design Collaborative. HealthierHere funds have helped CBO partners enhance their services and hire additional staff, including a CHW and an outreach manager.

- HealthierHere partners are providing recovery support services with assistance from HealthierHere’s Innovation Fund.

- The HealthierHere Partner Resource Directory will contain information about partners’ recovery support offerings.

b. Methods the ACH is using to monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan.

**HealthierHere Response**

- HealthierHere staff monitors the stopoverdose.org website, which maintains the Washington State Interagency Opioid Plan and offers “education and technical assistance for individuals, professionals, and communities in Washington State who want to learn how to prevent and intervene in opioid addiction and overdose.” The Plan was last updated in 2018, and staff incorporated its recommendations into the opioid project strategies and approach. HealthierHere will continue to monitor the Plan and incorporate changes into the opioid project strategies.

- Through the Co-Design Collaborative, clinical and community partners discuss updates to the Plan and other opioid-related guidelines, and share changes to their implementation approaches as well as challenges and best practices.

c. A description of existing local partnerships the ACH has convened or leveraged to implement strategies under this project, including a summary of the structure, frequency of meeting, and confirmation that the partnership includes all required individuals and entities (e.g., consumer representatives,
community-based service providers, and law enforcement). Describe any successes and challenges with identification of partnership leaders and champions.

**HealthierHere Response**

In 2016, King County, in partnership with the cities of Seattle, Renton, and Auburn, formed the Heroin and Prescription Opioid Task Force (Task Force), comprising consumer representatives, community-based service providers, law enforcement, and other stakeholders. The Task Force met regularly over six months and released its recommendations in September 2016. The Task Force is continuing to meet, both as a body and in small subcommittees, to move the recommendations forward. The three active workgroups are prevention, a quarterly MAT provider meeting, and an ED buprenorphine learning collaborative. While HealthierHere did not exist when the Task Force was formed, it has been able to leverage the relationships between and among various Task Force members, attend meetings, and support the efforts of King County. For example, HealthierHere has supported sharing the Task Force’s and King County’s training announcements, marketing campaigns, and updated educational materials. As the Task Force continues to evolve, HealthierHere will seek to be an active member and thought partner.

Through projects funded by the Innovation Fund (described in HealthierHere’s response to question #17), community and clinical partners are testing innovations to establish or expand access to MAT, including the use of peers as outreach and navigation support for newly induced individuals. As part of their innovations, partners are convening stakeholders in the region, including community-based service providers, law enforcement, healthcare providers, and other stakeholders. The projects launched in late 2019, and in 2020 HealthierHere will begin monitoring and evaluation to identify barriers and challenges. One challenge HealthierHere has noted to date is identifying clinical and community champions with the bandwidth to test new models. The Innovation Fund Request for Application received few responses, reflecting such bandwidth challenges within King County.

d. Describe gaps in access and availability of providers offering recovery support services, and provide an overview of the ACH’s planned approach to address gaps. Describe whether the approach will impact the number, or location of current providers.

**HealthierHere Response:**

As is the case across the country, King County is under-resourced with respect to mental health and SUD providers delivering acute care and recovery services for OUD. As a result, individuals with OUD face barriers in accessing ongoing recovery supports and establishing linkages to primary care, creating obstacles to their long-term stabilization. HealthierHere is seeking to improve this gap by partnering with 37 community partners and working to increase capacity for recovery support services in King County as well as targeting funding to these services. Today, many CBOs are facing high demands for their services. With HealthierHere’s support, community partners plan to increase program slots, hire additional staff, and develop new
programs. Community partners are also actively working to reduce the stigma associated with OUD treatment, hopefully resulting in increasing numbers of individuals seeking treatment. Furthermore, through the Co-Design Collaborative, community and clinical partners are exploring ways to build new partnerships to increase and enhance recovery support services in the region.

HealthierHere is also addressing the gap through the Innovation Fund, through which two partners are making targeted efforts to increase MAT and provide recovery support services (described in HealthierHere’s response to question #17). In addition, HealthierHere continues to explore strategies to enhance recovery support services through workforce solutions (e.g., peer support specialists), targeted support to partners serving homeless and native/tribal populations, and training and technical assistance to BHAs. While HealthierHere plans to continue such investments, it is also actively coordinating with King County to ensure investments are not duplicative. HealthierHere anticipates its efforts will increase the capacity of providers and therefore increase the number of individuals receiving recovery support services.

5. Project 3C: Provide the following: **NOT APPLICABLE**
   a. A summary of mechanisms established for coordinating care with related community-based services and supports, as well as referral relationships that have been established with dentists and other specialists, such as ENTs and periodontists.
   b. Two examples of workflows developed to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed.
   c. A summary of methods used to engage with payers in discussion of payment approaches to support access to oral health services. If applicable, indicate payment approaches that have been agreed upon.

6. Project 3D: Provide the following:
   a. Description of status of activities that have been conducted based on the Chronic Care Implementation Plan, including a summary of how the ACH is ensuring integration of clinical and community-based strategies through communication, referral, and data sharing strategies.

**HealthierHere Response**

Partners continue to implement HealthierHere's Chronic Care Implementation Plan, which is laid out in the [Project 3D Clinical Summaries](#). HealthierHere’s Practice Transformation Team regularly checks in with partners on their progress in implementing the plan, including through site visits conducted in fall 2019.

In this reporting period, partners advanced toward chronic care transformation and integration
of clinical and community-based strategies through communication, referrals, and data sharing:

**Communication**

- **Webinar on CHWs and Asthma.** In partnership with PHSKC, HealthierHere hosted a webinar on November 8, 2019, to inform partners of upcoming training on the CHW Asthma Home Visit Model and CHW supervisor training. The webinar focused on sharing training opportunities being offered through the “PCORI Disseminating Community Health Worker Training from the Guidelines to Practice Project.” CHWs help patients identify asthma triggers; they also provide asthma education and supplies like pillow and mattress covers. An evaluation of the CHW Asthma Home Visit Model showed that individuals with poorly controlled asthma who had home visits from CHWs had more days without asthma symptoms than patients who did not have home visits. Patients who had home visits also went to the ED less often, missed fewer days of work and school, and reported better quality of life.

**Referrals**

- **Partner Resource Directory.** As described in the response to question #17(a)i.3. regarding mechanisms for coordinating care management and transitional care plans with community-based services and supports, HealthierHere is developing a directory of its clinical and community partners. The Partner Resource Directory will help clinical and community partners connect with one another, build new relationships, enhance existing partnerships, and learn more about local resources. When the Directory goes live, partners will be able to identify organizations most relevant to the target populations for Project 3D, such as organizations providing services related to food, health screening, and healthy living.

- **Swedish Medical Center, Valley Medical Center, and Virginia Mason partner with the YMCA to refer patients to diabetes prevention programming.** The YMCA of Greater Seattle works with these three health systems and more to connect eligible patients from clinical care to community-based diabetes prevention programming (DPP) through electronic referrals. Health system partners work together, learning from each other’s progress, to establish e-referral pathways from their EHR to the YMCA’s secure platform. Clinical staff are trained on optimal processes for identifying, screening, and referring at-risk patients to the YMCA. This partnership aims to help individuals in making sustainable behavior changes to daily life, reducing their risk for Type 2 diabetes and other chronic diseases pervasive in King County.

**Data Sharing**

- **CIE.** As described previously, HealthierHere is working to develop a CIE to facilitate information sharing and closed-loop referrals between clinical and community partners. In November 2019, the Data, Technology and Legal Workgroup held its first meeting. The group, comprising subject matter experts from among
HealthierHere’s clinical and community partners, met to define and agree on shared principles to guide work planning and decision making.

- **Shared Care Plan Pilot.** As described above in HealthierHere’s response to question #17, the shared care plan pilot will engage hospital, BHA, FQHC, and community partners to develop and implement a shared care plan that supports transitioning medically complex individuals out of the hospital. HealthierHere is working with partners to explore the use of Collective Medical software to support the pilot.

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

**HealthierHere Response**

Partners’ work in this reporting cycle included a focus on implementing SDoH screenings and identifying strategies to refer patients to and better coordinate with CBOs through screening tools and disease-specific community-based supports and services. This work is consistent with the Chronic Condition/Transition Management plans laid out in HealthierHere’s implementation plan and Clinical Summaries.

- **SDoH screening.** Many partners are implementing SDoH screening tools to better and more systematically identify individuals’ social needs and incorporate findings into their plans of care. For example, Valley Cities is using the Daily Living Activities-20 tool, which includes questions to assess the status of patients’ chronic diseases and their SDoH needs. Care coordinators and clinical case managers are being trained on the tool and treatment plans. Treatment and changes in health status will be tracked over time.

- **Disease-specific community-based supports and services.** Asian Counseling & Referral Service (ACRS) offers community-based supports and services, including cooking and exercise classes, for patients with diabetes and cardiovascular disease. Additionally, ACRS offers housing assistance, wellness activities, employment supports, and other interventions focused on social needs.

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

**HealthierHere Response**

Key risks, their potential impacts, and respective mitigation strategies are summarized in the table below.
Figure 9. **Key Risks, Potential Impacts, and Mitigation Strategies**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Potential Impacts</th>
<th>Mitigation Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain I Risks</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Population Health Systems</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lack of interoperability across organizations and across information systems</td>
<td>• Limited coordination across the various organizations that touch a patient</td>
<td>HealthierHere is focusing on making catalytic population health system investments that have far-reaching impact as opposed to one-off investments targeted at individual providers. Priority areas of investment include a CIE and shared care planning tools for the King County region.</td>
</tr>
<tr>
<td>• Lack of support for development of population health tools</td>
<td>• Potential for duplicative services</td>
<td></td>
</tr>
<tr>
<td>• Limited registry functionality, especially among BHAs</td>
<td>• Potential for high-risk patients to fall through the cracks</td>
<td>HealthierHere will continue to provide access to population health coaching and system optimization through a contract with Comagine Health and UW AIMS.</td>
</tr>
<tr>
<td>• OneHealthPort limitations, including search functionality, multifactor authentication, lack of fee-for-service claims data, and difficulty in applying data for population health management purposes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Behavioral health provider shortages, including as many as 160 vacancies at BHAs in King County as well as vacancies at FQHCs</td>
<td>• Challenges and delays with behavioral health integration and QI efforts</td>
<td>HealthierHere partners are using Innovation Fund dollars to fill vacant positions and enhance their workforce.</td>
</tr>
<tr>
<td>• Lack of reimbursement for community health workers</td>
<td>• Potential provider burnout</td>
<td></td>
</tr>
<tr>
<td>• King County housing costs are a barrier to recruiting and retaining a robust healthcare workforce</td>
<td>• Many organizations are not able to recruit, hire, and retain critically important healthcare workers, such as nurse aides, chemical dependency professionals, community health workers, and peer support specialists</td>
<td>HealthierHere is also addressing workforce challenges through its partnership with the Healthcare Industry Leadership Table (HILT), including participation in the HILT Pipeline and Recruitment Committee and the Affordable Housing Committee. The cross-sector committees are actively</td>
</tr>
<tr>
<td>Risk</td>
<td>Potential Impacts</td>
<td>Mitigation Strategies</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>exploring strategies that address the intersection of the workforce pipeline and housing issues.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HealthierHere co-sponsored and volunteered at HILT’s “Chart Your Way to a Healthcare Career” event on October 16, 2019, an event that brought over 500 middle and high school students together with area healthcare providers and educational support partners for the first time to bring practical information to local students interested in healthcare careers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HealthierHere will continue to engage in conversations with MCOs about the value of CHW and peer support specialists in promoting access to care, closing care gaps, and supporting treatment adherence.</td>
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<tr>
<td></td>
<td></td>
<td>HealthierHere continues to provide clinical partners with TA for quality improvement efforts, and has incorporated QI/PDSA activities into pay-for-progress contracts with partners.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The HealthierHere Policy Committee has been working on defining a policy approach and agenda for the region, which includes workforce</td>
</tr>
</tbody>
</table>
## Risk

### VBP
- Providers’ capacity and willingness to implement VBP and continue along the Health Care Payment Learning & Action Network (HCP LAN) framework
- CBOs’ understanding of and capacity to participate in VBP models

### Potential Impacts
- VBP implementation or advancement on the HCP LAN framework is impeded

### Mitigation Strategies
- HealthierHere hosted a webinar for clinical and community partners’ frontline staff, “Introduction to VBP in Washington State,” on November 11, 2019. In response to partners’ requests, HealthierHere is planning a follow-up webinar focused on real-world examples of VBP arrangements. HealthierHere has also begun to engage MCO partners in VBP discussions and will invite them to present examples of their VBP arrangements at the webinar.
- HealthierHere continues to convene key stakeholders and is working to create a shared vision and identify care gaps to align investment strategies and advance clinical integration in the region.

### Project-Specific Risks

#### 2A: Bidirectional Integration of Care
- Behavioral health provider shortages
- Lack of shared vision for what integrated care should look like
- Market consolidation and shifting
- Fragmented support

- See Workforce above.
- Multiple pressures are put on providers from various stakeholders (MCOs, King County ICN, ACHs) that conflict with or require different processes and protocols. As a result, providers may both be confused and risk burnout relative to compliance with disparate protocols.

- See Workforce above.
<table>
<thead>
<tr>
<th>Risk</th>
<th>Potential Impacts</th>
<th>Mitigation Strategies</th>
</tr>
</thead>
</table>
| **2C: Transitional Care** | • Challenges with release planning for incarcerated individuals  
  • Patients will drop out of their treatment activities if they are not connected to community resources prior to release | HealthierHere partners are using funding to address this challenge in innovative ways. For example, one organization hired a CHW to expand their capacity. Others are leveraging peer support specialists and transition coaches. |
| **3A: Addressing the Opioid Use Crisis** | • Challenges with connecting patients who are inducted on MAT in jail or hospital settings with community-based resources.  
  • Patients will drop out of their treatment activities if they are not connected to community resources prior to release | Through the Innovation Fund, HealthierHere is investing up to $600,000 to target resources to organizations seeking to address this challenge in innovative ways, including through increased MAT walk-in capacity and clinical-community linkages. As HealthierHere evaluates these investments, it intends to spread best practices and learnings to partners as well as explore opportunities for scaling. |
| **3D: Chronic Disease Prevention and Control** | See Population Health Systems above | See Population Health Systems above |
| **Cross-Portfolio Risks** | • Duplication of efforts across partners, especially as it relates to care management activities  
  • Wasted care management resources  
  • Imbalances in care for patients, with some receiving uncoordinated care management from multiple organizations and others receiving no care management services | In 2020, HealthierHere will inventory the landscape of care coordination activities across King County with the objective of engaging with partners to better match supply with demand. |
### Risk
- Limited ability to measure the impact of transformation efforts given data lag, lack of organized data, and lack of analytical capacity
- Sustainability of transformation beyond the MTP

### Potential Impacts
- Partners may continue with implementing activities that are of limited impact because they do not have data to know whether their efforts are successful
- There is a risk that progress will stall if funding for transformation activities ends abruptly with the end of the MTP

### Mitigation Strategies
- HealthierHere has developed a dashboard of performance on key project metrics. While it suffers from data lag issues, it can help provide directional insights to partners.
- HealthierHere will continue to engage in conversations with partners, MCOs, and the HCA about opportunities to sustain transformation activities beyond the MTP.

### 18. Pre- and post-project implementation example

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

#### HealthierHere Response

Evergreen Treatment Services (ETS) implemented Collective Ambulatory through Delivery System Reform Incentive Payment (DSRIP) investments, enabling the organization to identify and enhance care for individuals with OUD admitted to the ED and at high risk for poor outcomes. ETS offers MAT for adults with OUD, serving approximately 1,500 patients in Seattle, 600 in South King County, and an additional 730 in Olympia, the majority of whom are on Medicaid or are uninsured. ETS provides methadone and buprenorphine-based medications with supportive wraparound services including medical monitoring, counseling, and drug screening.

Prior to implementing Collective Ambulatory in May 2019, ETS was often unaware of when their patients visited the ED, the cause for their visits (e.g., overdose), the length of stay, the treatments received, and follow-up needs. Patients with recent ED visits were at heightened risk for complications when restarting OUD treatment.

In mid-2019, ETS received support from HealthierHere to optimize its use of Collective Ambulatory, including through ongoing TA and practice coaching from Comagine. Since going live with Collective Ambulatory, ETS has received notifications and collected data for 800 ETS patient ED visits. This data not only informs ETS staff about patients’ ED visits but also helps them determine appropriate follow-up outreach and care, such as providing case management, connecting the patient to a primary care provider, and continued monitoring.

As part of their Collective Ambulatory implementation, ETS introduced workflow changes, with
support from Comagine, to intake, analyze, and act on ED visit data. Staff leading the implementation developed a methodology to stratify and prioritize patients based on various factors, including diagnosis and recent incarceration. As staff members review ED visit data, they prioritize it and notify ETS clinical providers of their patients’ hospitalizations. ETS providers have also been trained to access Collective Ambulatory and look up patient ED visit information (e.g., admission, diagnosis, demographics, and discharge information). Providers then develop follow-up plans based on their review of the data and connect with high-priority patients within seven days of discharge. ETS continues to refine its methodology and workflows and is planning to create a new position for a clinical coordinator/care manager to do additional monitoring, chart reviews, patient outreach, and tracking.

Building on the early successes of implementation, ETS is exploring how to do more with Collective Ambulatory data, including identifying new services to better meet patient needs. For example, when looking at individuals with five or more ED visits, staff identified 26 visits with a cellulitis diagnosis and now ETS is exploring expanding their service offering to include wound care. Staff is also exploring the possibility of providing on-site, integrated mental health services.

ETS’s largest challenge to successful implementation and future scaling of their Collective Ambulatory efforts has been restrictions on sharing of Collective Ambulatory data with providers and members of the care team who do not have access to the platform.

19. Regional integrated managed care implementation update

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

HealthierHere Response
HealthierHere continues to actively support King County and BHAs during the first year of the IMC transition. HealthierHere participates in the King County ICN committees related to the development of the ICN (executive, clinical operations, finance, and joint operations committees). The challenges identified to date and mitigating strategies are described below. HealthierHere notes that the challenges described in the third Semi-annual Report remain and has updated the descriptions of these challenges to reflect the developments in the past six months.

• Lack of a common vision for IMC. HealthierHere continues to lead the Integration Design Committee (IDC) to support development of a common vision for IMC in King County and define the core components of integration. The IDC reviewed past work on the vision for IMC, and HealthierHere is in the process of conducting key informant interviews – with MCOs, FQHCs, BHAs, and the ICN – on the path forward and how HealthierHere investments can best support IMC in King County.
To help establish a common vision for IMC, HealthierHere will launch innovation projects in 2020 focused on testing an integrated care delivery model that supports the whole health of Medicaid beneficiaries with co-occurring physical and behavioral health needs. HealthierHere is seeking to fund innovative partnerships between BHAs and primary care providers; awardees are eligible for up to $500,000 for one year, renewable for another year depending on progress and scope. This work is being conducted in partnership with the UW AIMS Center, which will provide ongoing training and TA to awardees and focus on developing tools for scaling and spreading to other partners. These projects will inform HealthierHere’s blueprint for IMC in King County, including the development of:

- A model and roadmap for integration that does not require co-location of physical and behavioral health services
- A model and roadmap for integration that includes intermittent co-location of services
- Care coordination standards, roles, and responsibilities for individuals who receive care from multiple providers (e.g., primary care, behavioral health, hospitals)
- Accountability for distinct processes and outcomes of care
- Types of referrals (including management of secondary referrals), coordination, and co-management arrangements
- Integrated, team-based care regardless of entry point into the system to ensure member access
- Recommendations for funding models that sustain integrated workflows

HealthierHere anticipates selecting projects and launching innovations in the first quarter of 2020.

- **Lack of BHA capabilities.** As documented in prior reports, BHAs lag behind hospitals, health systems, and FQHCs in their readiness for IMC. Recognizing this gap, HealthierHere has made the majority of clinical partner incentive dollars available to BHAs as well as focused training and TA efforts on BHAs through the VBP Academy, Whole Person Integrated Care through the UW AIMS Center, and practice coaching and optimization relative to Collective Ambulatory.

There are other parallel efforts in King County offering training to BHAs, sometimes leading to confusion and an overall lack of coordination relative to a shared IMC vision. While BHAs find monetary and training support helpful, it is not enough to close the gap nor do they always have staff capacity to navigate opportunities and participate in a meaningful way. To facilitate enhanced coordination, HealthierHere and King County participate in biweekly training alignment calls and have co-sponsored some trainings to increase impact.

- **BHA consolidation:** Adding to this challenge is the evolving BHA market in King County, with mergers and acquisitions leading to further consolidation and detracting from the affected partners’ abilities to dedicate time to the IMC transition and overall delivery system transformation. HealthierHere is staying abreast of market dynamics and maintaining relationships with BHA partners through transitions.
HealthierHere recognizes that BHA partners are stretched thin and is working in partnership with them, the King County ICN, and MCOs to find the most meaningful avenues for support that are respectful of their time and resources.

- **Payment models.** Today’s payment models are not well aligned with the integrated delivery of physical and behavioral health. HealthierHere is working with a leadership table that includes the five MCOs in King County as well as county leadership to discuss sustainable payment structures to support IMC. This group is also thinking about current reimbursement opportunities, such as through current procedural terminology (CPT) collaborative care codes, and how to tackle the barriers BHAs face in taking advantage of such opportunities. Specifically, the EHRs utilized by many BHAs are not compatible with the codes, therefore requiring a dual process – paper and electronic – should a BHA want to seek reimbursement for collaborative care work. Future payment models will also be informed by the innovation projects planned for 2020 (discussed above).

b) For **2020 adopters**, briefly describe progress made during the reporting period on the development and participation in the region’s early warning system, communications workgroup, and provider readiness/technical assistance workgroup.

c) For **2020 adopters**, briefly describe behavioral health provider readiness and/or technical assistance needs (financial and/or non-financial) the region has identified as it pertains to integrated managed care. What steps has the ACH taken, in partnership with providers and MCOs, to address these needs?

### Attestations

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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</table>

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:

- Identification of partnering provider candidates for key informant interviews.
- ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.
- Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.

If the ACH checked “No” in item above, provide the ACH’s rationale for not supporting IEE activities for evaluation of Medicaid Transformation during the reporting period.
Section 3. Value-based Payment

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

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

**Narrative responses**

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

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

**HealthierHere Response**

HealthierHere uses multiple methods to monitor providers’ progress in implementing practice transformation and moving toward value-based care. These methods include formal partner reporting as well as information gathering by HealthierHere staff, such as:

- In-person site visits with all partners, conducted approximately annually
- Semi-annual Pay for Progress reporting through which HealthierHere collects information about partners’ capabilities critical to value-based care, such as the development of registries and risk stratification
- The VBP Academy for BHAs, an intensive 10-month curriculum that guides BHAs through practice transformation with practice coaching
- Discussion of the transition to value-based care through HealthierHere’s Co-Design Collaborative
- Other informal partner interactions and communications
- Trainings and webinars on practice transformation and value-based care

HealthierHere is supporting providers in practice transformation and the move to value-based care through hands-on training/TA and funding. In 2019, 19 BHAs enrolled in the VBP Academy, and 17 are on course to complete the academy by currently working on implementation of QI transformation projects focused on a P4P metric. HealthierHere also continues to engage the UW AIMS Center to provide partners with 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.
For many providers, the task of transitioning to value-based care is daunting and there is no clear place for them to start. HealthierHere is addressing this by offering individualized TA that considers individual partners’ current states, resources, and short- and long-term goals. For example, UW AIMS has been working with Sea Mar Community Health Centers (Sea Mar) to support their journey to value-based care. Sea Mar, like many partners, was unsure where to start with quality improvement and population health management. With the counsel of UW AIMS, Sea Mar was able to take one aspect of its behavioral health program – the blood pressure and body mass index (BMI) workflow – and consider how to immediately make improvements and collect data on its efficacy and impact.

Sea Mar implemented a workflow whereby a psychiatric aide records a patient’s blood pressure and BMI, and if the blood pressure is outside the specified range, the aide notifies the patient’s psychiatric provider. During the same visit, the psychiatric provider sees the patient and blood pressure is taken again before the visit concludes. If the second blood pressure reading is also outside the specified range, the psychiatric provider refers the patient to a Sea Mar primary care provider for clinical follow-up. All of the patient’s blood pressure and BMI readings as well as the referral are documented in Sea Mar’s EHR.

This transition would not have been possible for Sea Mar without the hands-on support of UW AIMS. UW AIMS is now taking this practice of “starting small” to other partners and gaining traction.

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

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

HealthierHere Response

Please see the figure below.

Figure 10. Examples of HealthierHere Support for Providers in Move Toward Value-Based Care

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Provider Needs</th>
<th>Supportive Activities</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider with low VBP knowledge</td>
<td>CBOs/ community partners (multiple)</td>
<td>Develop a basic understanding of VBP concepts, Washington</td>
<td>As HealthierHere onboards community partners, it will reinforce basic</td>
</tr>
<tr>
<td>or significant barriers/challenges</td>
<td></td>
<td>HealthierHere hosted a webinar on Introduction to VBP in Washington</td>
<td>November 12 webinar: Introduction to VBP in Washington State</td>
</tr>
</tbody>
</table>

Semi-annual reporting guidance
Reporting period: July 1, 2019 – December 31, 2019
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Provider</th>
<th>Provider Needs</th>
<th>Supportive Activities</th>
<th>Action Plan</th>
<th>Key Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small provider (25 FTEs or fewer)</td>
<td>Integrative Counseling Services (ICS)</td>
<td>Population health management, quality improvement, and managed care contracting skills</td>
<td><em>State for community and clinical partners on November 12. The webinar covered capabilities needed to succeed in value-based arrangements and described CBOs’ roles in the transition to value-based care.</em></td>
<td>VBP concepts and also seek to communicate in plain language. HealthierHere plans to host a roundtable in early 2020 with MCOs, providers, and CBOs, with real examples of VBP arrangements.</td>
<td>• Roundtable planned for early 2020</td>
</tr>
</tbody>
</table>
| Behavioral health provider | Ryther | Collective Ambulatory, population health management, | Ryther is participating in the VBP Academy to gain the skills | Ryther is currently working on a quality improvement project to improve access to care for clients with SUD who are re-engaging in treatment services, and receiving 1:1 coaching from Comagine Health | • Completion of the VBP Academy  
• Completion of quality improvement project |
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Provider Needs</th>
<th>Supportive Activities</th>
<th>Action Plan</th>
<th>Key Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>addressing the SDoH</td>
<td>needed to engage in value-based care and receive 1:1 TA and coaching</td>
<td>and ED use for children, youth, and young adults with asthma; they are also building the case about how their interventions help reduce costly ED use so that they can be compensated for their services</td>
<td>of quality improvement project</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Speaker in November 12, 2019 HealthierHere webinar</td>
</tr>
</tbody>
</table>

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

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

**HealthierHere Response**

HealthierHere continued its support for the state-issued Paying for Value Provider Survey by encouraging partners to complete the survey in a timely manner. Specifically, HealthierHere:

1. Posted the Survey on the HealthierHere [website](#) with a description of the Survey and request for providers to complete it.

2. Emailed all HealthierHere partners and committees, including over 1,500 recipients from HealthierHere’s practice and community partners, Transformation Committee, and Co-Design Collaborative members.

3. Announced the Survey at HealthierHere Governing Board and Committee meetings and encouraged Board members to ensure their organizations complete the Survey.
These tactics were the same as the actions HealthierHere took in 2018, but reached a larger audience given HealthierHere’s continuously expanding relationships across King County. As in 2018, HealthierHere did not offer any incentives for completion of the survey.

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

**HealthierHere Response**

Prior to December 2019, HealthierHere received aggregate data from HCA but did not receive individual responses. HealthierHere reviewed the information and used it to inform VBP TA and training, including the recent VBP webinar offered to partners. On December 5, 2019, HCA supplied this year’s survey data, including individual responses. HealthierHere will review the data and use it to inform the investment strategy and goals for 2020 and 2021, as well as to identify specific organizations to target with TA, training and/or the VBP Academy.
Section 4. Pay-for-Reporting (P4R) metrics

24. P4R Metrics

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

Related resources and guidance:

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

Instructions:

a) Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g., count of sites that selected each response option).

b) Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the reporting template.

Format:

a) ACHs submit P4R metric information using the reporting template provided by the state.

Submit P4R metric information.

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7 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
Healthier Here (HH)

July 1, 2019 - December 31, 2019

Source: Financial Executor Portal
Prepared by: Washington State Health Care Authority

Table 1: Incentives earned

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project 2A</td>
<td>$</td>
<td>-</td>
<td>$ 2,889,500.00</td>
</tr>
<tr>
<td>Project 2C</td>
<td>$</td>
<td>-</td>
<td>$ 1,173,860.00</td>
</tr>
<tr>
<td>Project 3A</td>
<td>$</td>
<td>-</td>
<td>$ 361,188.00</td>
</tr>
<tr>
<td>Project 3D</td>
<td>$</td>
<td>-</td>
<td>$ 722,375.00</td>
</tr>
<tr>
<td>Integration</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>VBP</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>-</td>
<td>$ 5,146,923.00</td>
</tr>
</tbody>
</table>

Table 2: Interest accrued for funds in FE portal

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest accrued</td>
<td>$ 80,303.64</td>
<td>$ 112,406.83</td>
<td>$ 192,710.47</td>
</tr>
</tbody>
</table>

Table 3: distribution of funds for shared domain 1 partners

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared domain 1</td>
<td>$</td>
<td>-</td>
<td>$</td>
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</table>

Table 4: incentive funds distributed, by use category

<table>
<thead>
<tr>
<th></th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>Community health fund</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>Health systems and community capacity building</td>
<td>$</td>
<td>-</td>
<td>$ 421,108.34</td>
</tr>
<tr>
<td>Integration incentives</td>
<td>$ 145,201.00</td>
<td>$ 242,528.49</td>
<td>$ 387,729.49</td>
</tr>
<tr>
<td>Project management</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
<tr>
<td>Provider engagement, participation, and implementation</td>
<td>$1,760,070.00</td>
<td>$2,545,671.00</td>
<td>$4,305,741.00</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Provider performance and quality incentives</td>
<td>$1,483,417.00</td>
<td>$180,000.00</td>
<td>$1,663,417.00</td>
</tr>
<tr>
<td>reserve/contingency fund</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Total</td>
<td>$3,388,688.00</td>
<td>$3,389,307.83</td>
<td>$6,777,995.83</td>
</tr>
</tbody>
</table>