

SECTION I: ACH-LEVEL

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Regional Health Needs Inventory

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

North Central Accountable Community of Health (NCACH) used data to assess regional health needs, assets, and disparities, to select projects and preliminary target populations, to engage partners and providers, to inform strategic direction, to prioritize focus areas, and to identify key questions or gaps that need to be addressed in project planning and implementation. NCACH staff have presented data to its various governance committees and groups to inform planning and decisions. The NCACH governance structure includes multiple committees and workgroups to guide planning and decision making. Key groups and committees include: the Governing Board, the Whole Person Care Collaborative (WPCC), Coalitions for Health Improvement (CHIs), (representing each local health jurisdiction: Chelan-Douglas, Okanogan, and Grant), the Transitional Care and Diversion Interventions Workgroup, and the Regional Opioid Workgroup. A Pathways Community HUB Workgroup will be convened once NCACH clarifies engagement of outside contractors involved in the HUB implementation in Washington State.

The region has used data extensively to examine project toolkit measures, including potential earnings, alignment across toolkit projects, and alignment with other statewide and regional performance measurement efforts. For example, NCACH developed proxy improvement targets for pay-for-performance measures and estimated the number of events or individuals that needed to be counted in the numerator for a measure to reach those targets by using the Health Care Authority’s (HCA) Historical Data file for toolkit measures, draft methodology from HCA, and National Committee for Quality Assurance (NCQA) Medicaid 90th percentile benchmarks. This preliminary proxy information is being used by NCACH staff and may be shared with committees and workgroups to help refine target populations and project approaches and strategies when HCA finalizes the improvement methodologies for project measures

NCACH has leveraged data partnerships with multiple stakeholder groups. In October 2017, our staff initiated monthly meetings with the MCOs in the region (Amerigroup, Molina, and Coordinated Care), providing a forum to address data-related issues, such as measure alignment, Value-Based Payments (VBP), Fully-Integrated Managed Care (FIMC) implementation, and data sharing. The ACH collaborates regularly with local health jurisdictions (LHJs), particularly the Chelan-Douglas Health District, which serves as a backbone organization for the ACH via a hosting services agreement. NCACH staff will reach out to quality improvement and evaluation staff from partnering providers starting in 2018, while also leveraging the expertise of our workgroup members and our contractors at the Center for Outcomes Research and Education (CORE), to support data and analytic needs of the ACH. This includes developing a regional data strategy, identifying data needs and gaps, selecting regional quality improvement metrics, and recommending solutions to meet our regional tracking and reporting needs. NCACH in

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partnership with CORE will compile the information gathered from our partners, develop an overall ACH data strategy, and create a recommendation of potential data solutions. And finally, NCACH staff have collaborated with data leads from other ACHs including Greater Columbia, King County, Southwest Washington, North Sound, Olympic, and Pierce County. Cross-ACH partnerships have been useful to align strategies, share learnings, and identify priorities.

As project planning, design, and implementation continues, NCACH will continue to use data to drive decisions. Some key uses of data will include:

- Refining target populations and key partners for piloting or testing project strategies
- Identifying partners and providers
- Estimating project impact and assessing the viability of project strategies
- Identifying barriers in implementation as well as success and learnings that can be shared among partners
- Identifying opportunities to spread and scale projects
- Monitoring progress toward partner, regional, and statewide goals
- Evaluating the progress and impact of project activities

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

NCACH has leveraged a variety of data sources to inform decision-making, project and target population selection, and regional assessment. The ACH has worked closely with its Regional Coordinator, data consultant (CORE), local health jurisdiction, and HCA Analytics, Interoperability, and Measurement (AIM) Team liaison to identify, procure, analyze, and interpret data from a variety of data sources. Key data sources have included HCA AIM data products (such as the Regional Health Needs Inventory (RHNI) Starter Kit, Provider Report, and Historical Data), Department of Social and Health Services (DSHS) Research and Data Analysis division data products (including ACH Profile and Measure Decomposition), Comprehensive Hospital Abstract Reporting System (CHARS) data, Office of Financial Management population data, and a variety of other sources. Community partners and local health jurisdictions have shared chronic conditions reports, housing survey results, and survey results from the Together for Youth Survey (an annual survey looking at health and social issues for youth).

One key data source for NCACH has been the 2016 Chelan-Douglas Health District Community Health Needs Assessment (CHNA), which was conducted for the entire NCACH region and completed in December 2016. For this assessment, the region fielded a community voice survey to

Community Voice Survey Key Questions and Responses

What do you think are the three most important factors that will improve the quality of life in your community?

1. Improved access to mental health care
2. Healthy economy
3. Good jobs

What do you think are the three most important "health problems" that impact your community?

1. Mental health problems
2. Overweight/obesity
3. Access to health care

What do you think are the three most important "unhealthy behaviors" seen in your community?

1. Drug abuse
2. Alcohol abuse
3. Poor eating habits

gather feedback from stakeholders across multiple sectors. The survey had 169 participants and asked a number of questions about community health priorities, needs, and strengths. The survey helped identify community priorities through responses to key questions (see side bar).

NCACH collected information from stakeholders in person and through via email and in-person meetings to inform planning and decisions. The region’s three local Coalitions for Health Improvement (CHIs) have been instrumental in supporting NCACH in providing feedback from stakeholders on project selection and planning. For example, through a “shift and share” format at a recent Chelan-Douglas CHI meeting (where breakout groups rotated through four different stations focused on our selected projects), CHI members provided feedback on target populations for project planning. This kind of community input is a rich source of qualitative data; staff can pull out key themes, and synthesize results to share with decision-making bodies. NCACH also conducted another short survey during three outreach events in August and September 2017 to collect additional information about regional priorities, by asking community members what they felt was the biggest health concern in the region.

Provide a high-level summary of the region’s health needs relevant to Demonstration project planning. Highlight key sub-regions or sub-population groups if/as appropriate. For each identified topic, cite the data sources and the processes/methods used:

As described above, NCACH partnered with CORE to analyze multiple data sources to better understand the region’s health needs, including the use of data software programs such as Tableau and reviewing the data using various graphs and tables such as pivot tables. Working with our partners, other community stakeholders, and CORE to review qualitative and quantitative data, we have a strong understanding of our region’s health needs.



Summary of Regional Health Needs

North Central Accountable Community of Health (NCACH) includes four counties: Chelan, Douglas, Grant, and Okanogan. The geography of the area is diverse. It includes the eastern side of the Cascade Mountain range, and many lakes. The Columbia River runs through the region, dividing Chelan and Douglas counties. The major industries in the region are agriculture, livestock ranching, and tourism, with outdoor recreation being a big draw for tourists¹. Part of the Colville Native American Reservation overlaps with Okanogan County.

The NCACH region is overwhelmingly rural, with an estimated population of 255,990, or 3.5% of the total population of Washington State in 2017². The region is geographically large, covering 12,684 square miles. It is sparsely populated, with 19.4 people per square mile, compared with the state average of 101.2 per square mile³. The highest population density is in the greater Wenatchee area in Chelan and Douglas counties and Moses Lake in Grant County. Because the region is sparsely populated,

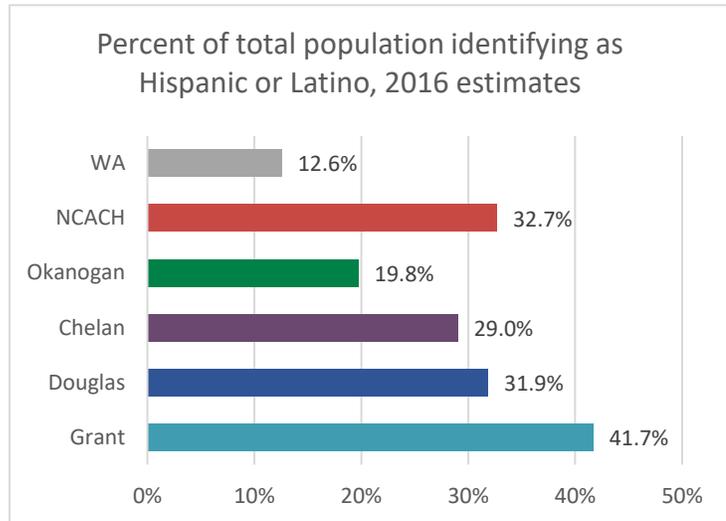
¹ Employment Security Department, County Labor Profiles: <https://esd.wa.gov/labormarketinfo/county-profiles>

² WA State Office of Financial Management, 2017 population estimates: <http://www.ofm.wa.gov/pop/april1/>

³ Chelan-Douglas Health District, 2016 Community Health Needs Assessment: <http://www.cdhd.wa.gov/Health%20Data/HealthData.aspx>

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residents often have to travel long distances to receive health care. According to 2016 data from the Washington State Office of Financial Management, more than half (54.5%) of the population are adults ages 20-64, about 28% of the population is age 19 and younger, and 17% is older adults ages 65+⁴. In addition, a greater proportion of residents in the NCACH region are white (91.7%) compared with the state average (80.4%). Okanogan County has a large Native American/Alaskan Native population, comprising 12.6% of the population, compared with around 2% in the other NCACH counties.⁵ About a third of the population identifies as Hispanic, though this trend varies by county.



Source: Washington State Office of Financial Management, 2016 population estimates

NCACH has high rates of individuals who lack health insurance coverage. Medicaid expansion helped uninsured rates decrease across the state, and in 2015, 5.8% of Washington State residents were uninsured across the state (compared to 8.2% in 2014)⁶. Specific to our four-county region, uninsured rates ranged from 6.4% in Douglas and Chelan counties to 12.0% in Grant County (the second highest uninsured rate in Washington State).

The region faces economic challenges. The annual median household income for all counties in the NCACH region are below the state average of \$64,000, ranging from \$41,800 in Okanogan County to \$53,600 in Chelan County⁷. All counties in the region have higher rates of childhood poverty than the state average of 16%; Chelan has the lowest childhood poverty rate at 18%, while Okanogan is highest at 28%⁸.

The region has high rates of incarceration. In 2015, NCACH counties had an average of 875 adult prisoners in a state correctional facility per 100,000 population, compared with the state average of 522 per 100,000 population⁹. Adolescent arrests for alcohol and drug related crimes are also higher than the

⁴ WA State Office of Financial Management 2016 age, sex, race, and Hispanic ethnicity population estimates: <http://www.ofm.wa.gov/pop/asr/default.asp>

⁵ HCA RHNI Starter Kit, *Demographics-Medicaid* tab. Based on HCA Medicaid enrollment and claims data for the 2015 calendar year.

⁶ Washington State Office of Financial Management (OFM), (March 2017) *Trends in County Uninsured Rates in Washington: 2013-15*. (Washington State Health Services Research Project, Research Brief No. 81): <https://ofm.wa.gov/sites/default/files/public/legacy/researchbriefs/2017/brief081.pdf>

⁷ HCA RHNI Starter Kit, *Social Det. Of Health-Overall* tab. Based on United State Census Bureau Small Area Income and Poverty Estimates (2015). <https://www.census.gov/programs-surveys/saippe.html>

⁸ Robert Wood Johnson Foundation, *County Health Rankings* (2017)

⁹ DSHS Risk and Protection Profile for Substance Abuse Prevention by county, July 2017: <https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state>

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state average¹⁰. Juvenile detention is also high in the region. Okanogan County has the highest rate of juvenile detention in the state at 36.4 per 1,000 youth, almost four times the state average of 9.3 per 1,000 youth¹¹. Other counties in the region have high rates of juvenile detention as well: rates per 1,000 youth were 21.1 for Chelan County, 18.1 for Douglas County, and 16.2 for Grant County.

High school graduation rates vary across the region. In 2016, 87.5% of high school students in Douglas County graduated within 5 years, compared with 77.8% in Grant County, 79.7% in Chelan County, 85.9% in Okanogan County, and 81.9% statewide¹². Adults in the region are less likely to have received a bachelor's degree compared with the state average (17.9% for the NCACH region vs. 28.3% statewide)¹³. About 20% of the adult population has no high school diploma, which is twice the state average¹⁴.

Overweight and obesity rates are high in the region with 65% of adults considered overweight or obese¹⁵. In a survey of community stakeholders (we received a total of 323 responses from three outreach events), obesity was identified as the second most important health problem affecting the community. In addition, the data collection process during our CHNA in 2016, which included quantitative and qualitative data, resulted in the identification of the top 16 health needs of the community. Obesity was ranked fourth when 39 community leaders (including representatives from the health and social services sector) convened to prioritize the health needs based on a set of criteria. Over the 2013-2015 time-period, adult smoking rates were high in Okanogan County (22.1%) and Douglas County (21.4%) compared with the state average (15.6%), Chelan County (11.0%) and Grant County (16.8%)¹⁶. During that same time period, nearly 10% of adults in the region reported having diabetes compared to 8% statewide. Teen pregnancy rates are also high in the region. Compared with the state average of 77.2 per 1,000 teens ages 15-19, regional rates range from 80.3 per 1,000 in Douglas County to 92.4 per 1,000 in Grant County¹⁷.

¹⁰ HCA RHNI Starter Kit, *Social Det. Of Health-Overall* tab. Based on DSHS Risk and Protection Profiles by county, July 2017.

¹¹ Washington State Center for Court Research, Juvenile Detention 2016 Annual Report:

<http://www.courts.wa.gov/subsite/wscrc/docs/2016DetentionAnnualReport.pdf>

¹² HCA RHNI Starter Kit, *Social Det. Of Health-Overall* tab. Based on Washington State Office of Superintendent of Public Instruction data for 2016.

¹³ HCA RHNI Starter Kit, *Social Det. Of Health-Overall* tab. Based on Department of Health Washington Tracking Network for 2009-2013.

¹⁴ Chelan-Douglas Health District, 2016 Community Health Needs Assessment. See:

http://www.cdhd.wa.gov/Health%20Data/Docs/2016_Chelan-Douglas_Health_District_CHNA.pdf

¹⁵ Ibid.

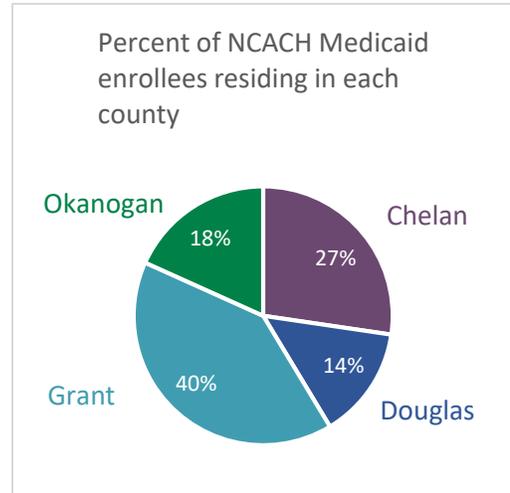
¹⁶ HCA RHNI Starter Kit, *Prevalence Estimates – Overall* tab. Based on the annual Behavioral Risk Factor Surveillance System (BRFSS) using three years combined data (2013-2015).

¹⁷ HCA RHNI Starter Kit, *Project – MCH Repro. Overall* tab. Based on Department of Health data from 2015.

Medicaid Beneficiary Population Profile

About 94,000 Medicaid enrollees live in NCACH counties, accounting for about 5% of statewide Medicaid enrollment. High rates of residents in the region rely on Medicaid for health care coverage compared to the state average (26%), ranging from 33% in Douglas County to 41% in Okanogan County¹⁸. Children make up a greater proportion of Medicaid enrollment in the NCACH region; 46% of statewide Medicaid enrollees are ages 19 and under, compared with 55% of enrollees in the NCACH region.

We know that a variety of social and environmental factors – also referred to as “social determinants of health” or SDH – impact people’s health. The previous section details the region-wide SDH factors. Those same factors impact the Medicaid population. A smaller percentage of enrollees in NCACH counties are homeless than in other regions in the state; 2.8% of adult enrollees in the region were homeless for one month or longer in 2015 compared to 4.9% statewide¹⁹. Adult enrollees who identify as Black, have a substance use disorder (SUD) treatment need, or have co-occurring mental illness and SUD diagnoses are more likely to be homeless²⁰.



Source: Healthier Washington Dashboard, Population Explorer tab. Measurement period Oct 2015 – Sep 2016.

NCACH has the highest rate of employment among adult Medicaid enrollees of all ACH regions. In 2015, 64.7% of adult Medicaid enrollees in the NCACH were employed, compared with 51.9% statewide²¹. NCACH has a higher arrest rate than the statewide average. In 2015, 6.8% of Medicaid enrollees in the NCACH region were arrested compared to 6.5% statewide²². Enrollees who identify as Black or American Indian/Alaskan Native were twice as likely to be arrested; enrollees with an SUD treatment need or co-occurring mental health and SUD diagnosis were about five times more likely to be arrested²³. Racial and ethnic groups vary by county; overall, the region has lower rates of Black, Asian, and Native Hawaiian/Pacific Islander enrollees than the statewide average. The region has higher than state average rates of Medicaid enrollees who identify as American Indian/Alaskan Native, white, and other. More Medicaid enrollees in the region identify as Hispanic compared to the state average (47% and 21%, respectively)²⁴. The charts below show the percent of Medicaid enrollees in the NCACH region by selected racial and ethnic groups.

¹⁸ Healthier Washington Dashboard, *Population Explorer* tab. Measurement period Oct 2015 – Sep 2016.

¹⁹ DSHS Research and Data Analysis Division, “Cross-System Outcome Measures for Adults Enrolled in Medicaid”, *sce_mco_wa* data set (Medicaid clients enrolled with Managed Care Organizations). Data for CY 2015. See: <https://www.dshs.wa.gov/sesa/research-and-data-analysis/cross-system-outcome-measures-adults-enrolled-medicaid-0>

²⁰ Ibid.

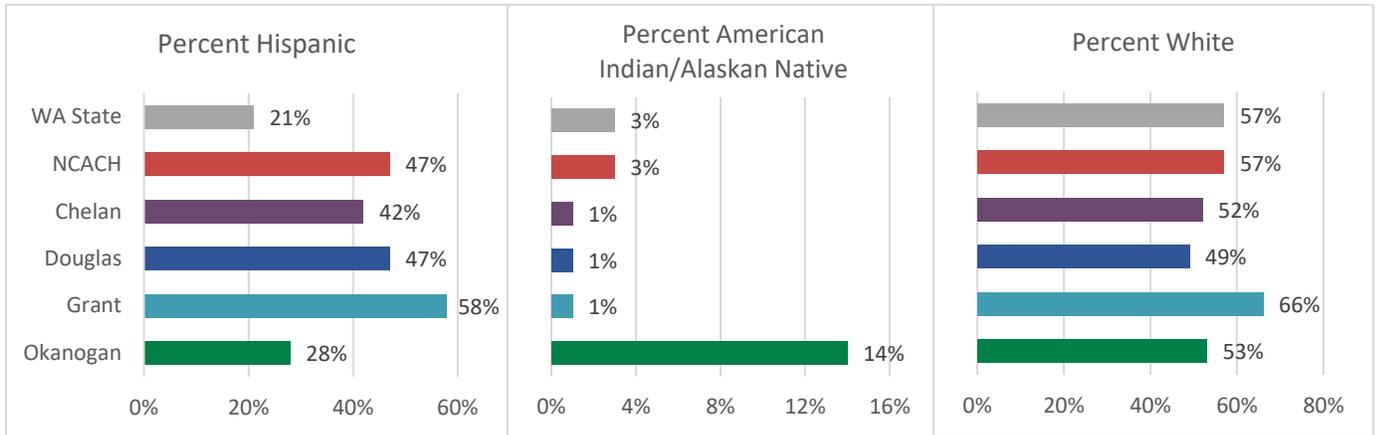
²¹ DSHS Research and Data Analysis Division, “Cross-System Outcome Measures for Adults Enrolled in Medicaid”.

²² Ibid.

²³ DSHS Research and Data Analysis Division, “Measure Decomposition Data” file. As indicated by RDA, likelihood ratios are “designed to identify demographic and health risk factor characteristics associated with favorable and adverse outcomes on selected metrics, to help inform ACH project planning. Demographic and health risk characteristics that are much more prevalent among persons experiencing adverse outcomes may identify high-opportunity populations for intervention.”

²⁴ Healthier Washington Dashboard, *Population Explorer* tab. Measurement period Oct 2015 – Sep 2016.

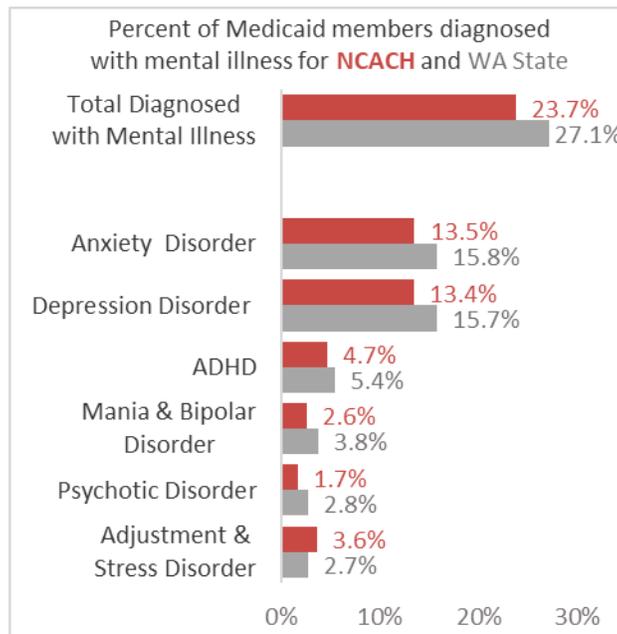
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Source: Healthier Washington Dashboard, Population Explorer tab. Measurement period Oct 2015 – Sep 2016.

Medicaid Beneficiary Population Health Status

Behavioral health conditions are widespread in the region. Nearly 25% of Medicaid members in the NCACH region have been diagnosed with mental illness, with anxiety disorders and depression being the most prevalent conditions (see chart). More than 5,000 Medicaid members have co-occurring mental illness and substance use disorder diagnoses²⁵. Mental and behavioral disorders are a top cause of hospitalization, comprising 8% of all hospitalizations that are not related to pregnancy or childbirth²⁶.



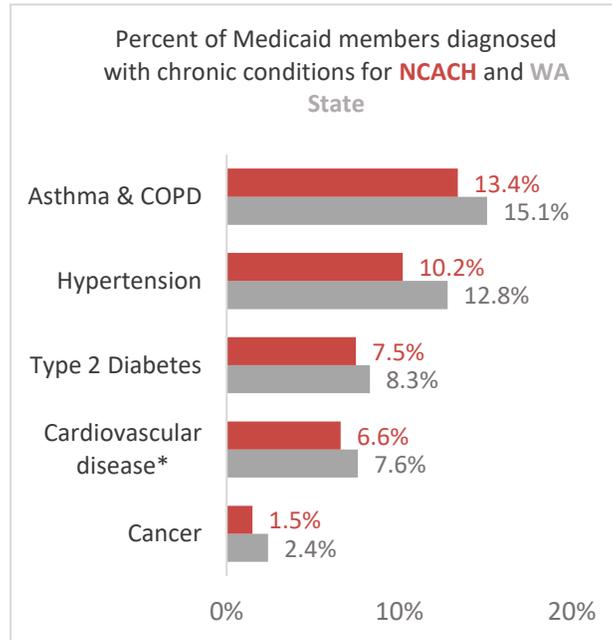
Source: DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.

²⁵ DSHS Research and Data Analysis Division, ACH Profiles - North Central Current State spreadsheet, Behavioral Health and Diagnoses tabs. Measurement period based on a 24-month lookback period from June 2016.

²⁶ HCA RHNI Starter Kit, "Top Ten Most Common Causes of Statewide Acute Hospitalizations Among Medicaid Recipients, Excluding Pregnancy and Child Delivery Related Hospitalizations, During Jan 1, 2015-Oct 31, 2015"

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Overall, the region has lower rates of chronic conditions than the statewide average (see chart below). Management of chronic conditions varies across the region. The region's rate of medication management for asthma (23%) is lower than the state average (28%), and county rates range from 19% in Chelan County to 32% in Okanogan County²⁷. The region's rates are higher than the state average for diabetes care measures such as blood sugar testing, diabetic eye exams, and kidney disease screening. In fact, we are the highest performing ACH on these measures indicating that comprehensive diabetes care is an area of strength²⁸.



Source: DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.

Opioid use in the region has mirrored national trends showing increases in the number of individuals using prescription opioids. From 2002 to 2013, treatment admissions for opiates increased for all four counties in the region. Okanogan County had 21.6 publicly funded opiate treatment admissions per 100,000 population in 2002-2004, and in 2011-2013 there were 99.4 admissions²⁹. The region has 492 providers who prescribe opioids³⁰. There are 11,068 Medicaid members with opioid prescriptions; 88% of those have no history of cancer diagnosis. Of members with opioid prescriptions and no history of cancer diagnosis, 19% (1,742) are considered heavy users and 19% (1,815) are chronic users with prescriptions for 30 days or more. NCACH rates of prescription opioid use are similar to statewide rates³¹.

Geographic variation is present for birth outcomes. Across the ACH, 4.2% of babies born in the region's hospitals to mothers enrolled in Medicaid have low birth weights. In Chelan County, the rate is 3.8%, while Okanogan County's rate is 5.8%.

²⁷ Healthier Washington Dashboard, *Measure Explorer* tab. Measurement period Oct 2015 – Sep 2016.

²⁸ Ibid.

²⁹ UW Alcohol and Drug Abuse Institute: <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>

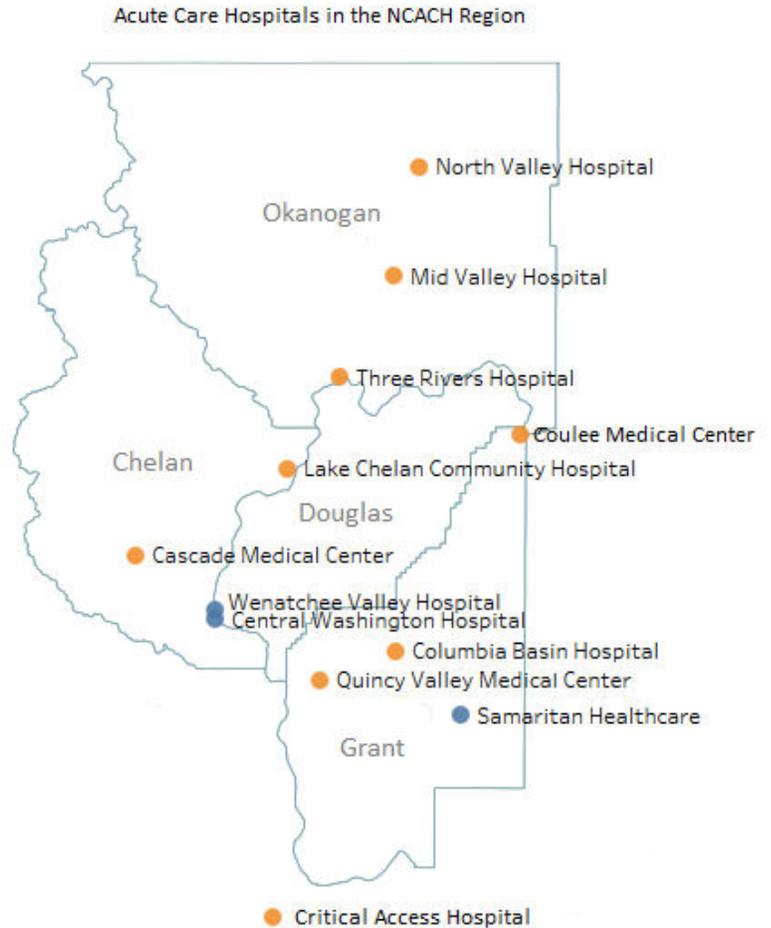
³⁰ HCA RHNI Starter Kit, *Project-Opioid-Medicaid* tab. Data for Fiscal Year 2016.

³¹ Ibid.

Regional Health System Capacity

The NCACH region has 11 acute care hospitals, most of which are operated by Public Hospital Districts (Wenatchee Valley and Central Washington are the exception; they are operated by Confluence Health). See the table and map below for more information about acute care hospitals. The region has no psychiatric inpatient beds and no licensed mental health crisis facilities³². While NCACH counties have used inpatient mental health facilities in other parts of the state (including Eastern State Hospital), plans are underway to convert a former nursing home in Wenatchee into a 32-bed inpatient mental health facility. This will fill a significant capacity gap in our region, providing additional intensive mental health services in the region.

There are also 17 Federally Qualified Health Clinics (FQHCs), and 20 Rural Health Clinics in the region. The region has dozens of individual emergency response agencies, many of which participate in the North Central Emergency Care Council, which works to support a comprehensive emergency care system.



Hospital	Number of beds	Medicaid discharges (2016)	Total discharges (2016) ³³
Cascade Medical Center	12	5	126
Central Washington Hospital	198	3,129	12,044
Columbia Basin Hospital	69	25	278
Coulee Medical Center	25	228	614
Lake Chelan Community Hospital	25	156	610
Mid Valley Hospital	30	466	1021
North Valley Hospital	67	175	554
Quincy Valley Medical Center	25	4	66
Samaritan Healthcare	49	1,233	2,888
Three Rivers Hospital	25	193	377
Wenatchee Valley Hospital	20	42	298

³² Washington State Institute for Public Policy; Crisis Mental Health Services and Inpatient Psychiatric Care, Dec. 2016; www.wsipp.wa.gov

³³ WA State Department of Health CHARS Payer Census, 2016.

The number of practicing physicians varies widely across the region. In 2016, Chelan County had 360 physicians per 100,000 population, the highest rate in the state³⁴. Neighboring Douglas County had only 34 physicians per 100,000 populations. Similar patterns emerge for primary care physicians. Per 100,000 population, Chelan had 120 primary care providers; Douglas had 25, Grant had 41, and Okanogan had 72. It's worth noting that many health care providers are located near county lines, so residents of one county may cross over to other counties to receive care.

Behavioral health workforce capacity also varies throughout the region. Overall, there are 162 behavioral health providers per 100,000 population, compared with the state average of 266. Okanogan has the highest ratio of behavioral health providers, with 252 per 100,000 population; Douglas has the lowest with 35 per 100,000.³⁵

In addition to our network of regional hospitals, key regional health system partners include:

- Confluence Health, a large health system in the region, operates two hospitals and more than 40 primary care and specialty clinics, including 10 Rural Health Clinics.
- Moses Lake Community Health Center operates FQHCs in three locations, and is dedicated to serving migrant and seasonal farm workers, the uninsured, and others who have difficulty accessing care.
- Columbia Valley Community Health operates 4 FQHCs, providing physical, dental, and behavioral health services.
- Family Health Centers operates FQHCs, largely in Okanogan County. They have 6 medical locations and 5 dental locations.
- Samaritan Healthcare, a multifaceted healthcare organization located in Moses Lake operates a clinic in addition to the hospital.
- Grant Integrated Services manages four community programs including providing mental healthcare, operating a drug and alcohol prevention and recovery center, supportive living for people with disabilities, and an assisted living facility for chronic mentally ill individuals.
- Catholic Family and Child Services provides counseling and behavioral health services in Wenatchee and Moses Lake.
- Okanogan Behavioral Healthcare provides outpatient mental health and substance use treatment services, as well as operating a crisis line and connecting patients to supportive housing.
- Center for Drug and Alcohol Treatment provides inpatient and outpatient substance use treatment services.
- The Confederated Tribes of the Colville Reservation operate a health center in Omak and Nespelem providing medical, dental, and pharmacy services.
- Children's Home Society provides child and family health counseling families with children from birth to 21 years old who receive Medicaid, including Wraparound with Intensive Services (WISe) for children with behavioral health needs and their families. They also focus on children in foster care.

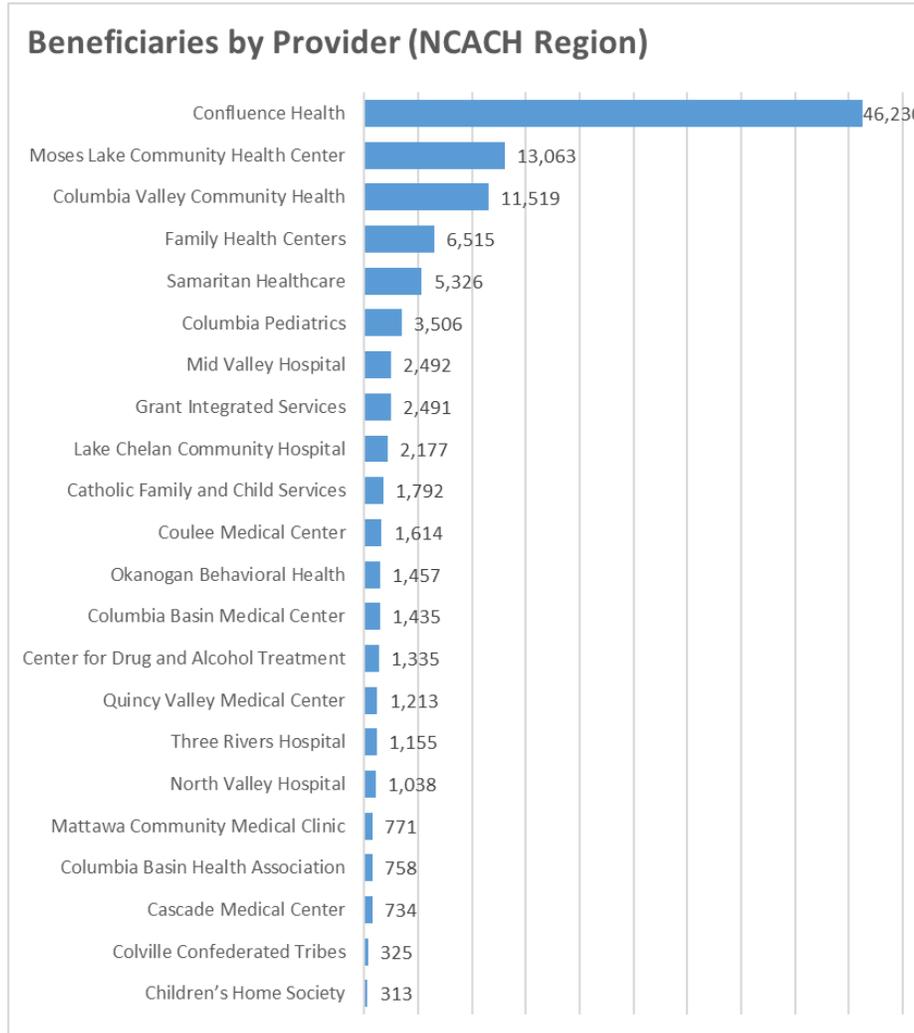
³⁴ UW Center for Health Workforce Studies, Washington State's physician workforce in 2016.

³⁵ Chelan-Douglas Health District, 2016 Community Health Needs Assessment, Appendix A:

http://www.cdhd.wa.gov/Health%20Data/Docs/2016_Chelan-Douglas_Health_District_CHNA.pdf

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These health system providers are all engaged through our Whole Person Care Collaborative (WPCC), and the following chart provides an overview of how many Medicaid beneficiaries these providers served in 2016.



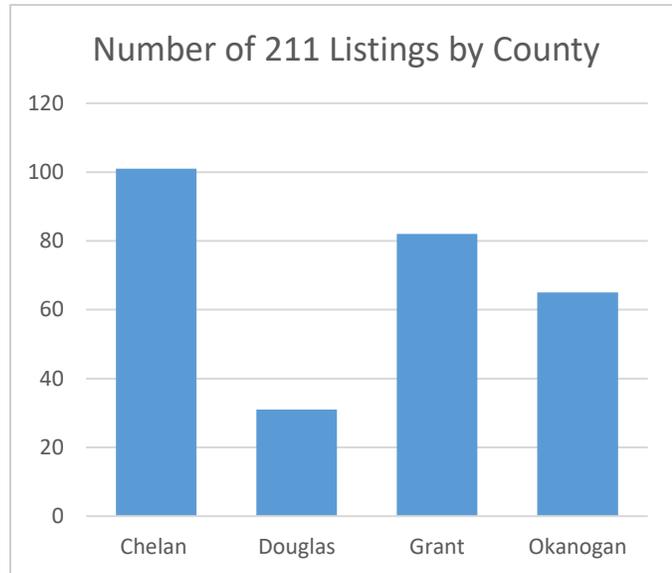
Source: Health Care Authority, based on a special data request from NCACH. These counts are based on professional claims data excluding emergency department related procedures.

Regional Community-based Services Capacity

The region has a number of organizations providing services to support housing and food stability, social services, and employment. Services tend to be located in large population centers, such as Wenatchee or Moses Lake, which may make access to services problematic for residents in more remote areas of the region. Little is known about linkages, collaboration, data exchange, and referrals among community-based service providers, or between community-based organizations and health system providers. Different service providers and sectors have wide variation in resources and available data. As project planning and implementation continues, particularly for the Care Coordination Project, NCACH will explore opportunities to enhance connections between service providers in the region and identify regional capacity, needs, and gaps. Connecting with Washington Information Network's 2-1-1 (WIN 211), which maintains a database of community resources, and our social service providers will be critical as we aim to better understand our network and ways to strengthen existing linkages and build new ones.

There are 243 community-based organizations, healthcare providers, public agencies, and institutions listed in the 211 provider directory for our region. Some of these agencies serve more than one county (e.g., Aging and Adult Care of Central Washington).

These include DSHS community service offices (located in Wenatchee, Moses Lake, and Omak), three local health jurisdictions (LHJs), multiple organizations that provide a variety of social services, such as United Way and Catholic Family & Youth Services, more than a dozen food banks and food assistance organizations, a syringe exchange program in Okanogan County, three district courts, and education institutions (e.g., Wenatchee Valley College and WSU extensions). There are limited transportation resources in the community, though all four counties do operate buses or other forms of public transportation³⁶.



Source: 211 Provider Listing and Taxonomy List (requested from WIN211 for NCACH region).

Housing instability is rising in many areas of the region; as increases in housing costs outpace median incomes and vacancies lower, affordable housing in many areas is limited³⁷. Housing and rental assistance is available from housing authorities in each county, though access to support does not always meet demand (e.g., the Housing Authority of Okanogan County has closed its waiting list for Section 8 Housing Vouchers). Several other organizations in the region provide permanent and transitional housing support, such as Chelan Douglas Community Action. In addition, local jurisdictions are working on initiatives to address homelessness. For example, the City of Wenatchee developed a coordinated entry system to help homeless individuals quickly and easily locate and connect with social services that best meet their needs.

Medicaid Population's Connection to Care

Access to care has been identified as a priority in multiple assessments and community surveys, including the CHNA³⁸. The CHNA identified insufficient numbers of providers, travel distance to health care providers, and lack of providers willing to accept Medicaid and Medicare (especially among dentists) as key barriers to accessing care. Qualis Health reports that all MCOs in Washington State showed decreases in adult access from the 2015 to 2016 reporting years, and that the state rate is now more than 5 percent lower than the national average of Medicaid plans³⁹.

³⁶ Washington Information Network 211.

³⁷ WA Dept. of Commerce, Affordable Housing Needs: <http://www.commerce.wa.gov/housing-needs-assessment/>

³⁸ NCACH Community Health Needs Assessment: http://www.cdhd.wa.gov/Health%20Data/Docs/2016_Chelan-Douglas_Health_District_CHNA.pdf

³⁹ Qualis Health (December 2016). 2016 Regional Analysis Report, Washington Apple Health, Washington Health Care Authority: <https://www.hca.wa.gov/assets/program/eqr-regional-analysis-report-2016.pdf>

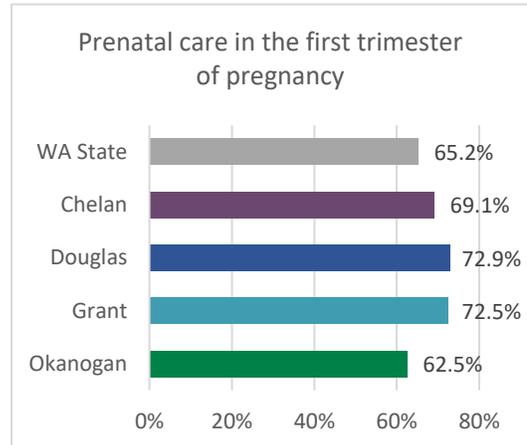
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Access to and utilization of primary care among Medicaid enrollees varies throughout the region. Rates for primary care visits among children ages 1-19 were generally at or above the state average, though Okanogan County consistently had lower rates. Okanogan County is below the state average for access to primary care for children ages 12-24 months and 2-6 years. Rates of adults' use of ambulatory or preventive care are also typically at or above the state average. Among adults, women are far more likely than men to have had an ambulatory or preventive care visit in the last year (88% for women vs. 73% for men).

Engagement in first trimester prenatal care by Medicaid enrollees is higher than the state average for Chelan, Douglas, and Grant counties; however, Okanogan County is below the state average⁴⁰. Rates of chlamydia screening among women ages 16-24 are below the state average (47% compared to 51%, respectively), with Okanogan County having the lowest rate in the region (40%).

NCACH has some of the lowest rates of emergency department (ED) utilization in the state, at 40 visits per 1,000 member months (MM), compared with the state average of 54 visits per 1,000 MM. This measure includes ED visits related to mental health or substance use. Racial and ethnic variations exist for ED utilization. American Indian/ Alaskan Native and Black Medicaid enrollees have much higher rates (61 and 60 per 1,000 MM, respectively). Non-Hispanic members have higher rates of ED use than Hispanic members (51 vs. 32)⁴¹.

NCACH's rates of follow-up after hospitalizations for mental illness are higher than the state average (88.9% vs. 79.8% for 30-day follow-up), and they are among the highest rates in the state. Similarly, NCACH rates of follow-up with Medicaid members after an ED visit for alcohol or drug dependence are well above the state average (44.4% vs. 29.4%), as are rates of follow-up after an ED visit for mental illness (80.6% vs. 72%)⁴².



Source: HCA Pregnancy and Birth data:
<https://www.hca.wa.gov/about-hca/reproductive-health>

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

NCACH faces many challenges that are common for rural communities: high poverty rates, limited employment opportunities, lower median incomes, shortages of care providers, rapid demographic shifts, areas of geographic isolation, and high rates of residents covered by Medicaid. Residents of rural areas typically travel two to three times further than urban residents to access health care services. These greater distances can be a barrier to receiving care. Weather can further compound transportation issues, especially for residents in mountainous or high elevation areas. The NCACH region

⁴⁰ HCA Pregnancy and Birth data: <https://www.hca.wa.gov/about-hca/reproductive-health>

⁴¹ Healthier Washington Dashboard. *Population Explorer* tab. Based on October 2015-September 2016 measurement period.

⁴² DSHS Research and Data Analysis Division, "Measure Decomposition" file.

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is home to large Hispanic and Native American/Alaskan Native populations, both of which experience disparities in social and health outcomes, and may face language or cultural barriers in accessing care.

Workforce capacity is a significant challenge for the region. Three of the four counties in the region are designated as Medically Underserved Areas (Douglas, Grant, and Okanogan). The entire region is designated as a geographic Health Professional Shortage Area (HPSA) for primary care, mental health, and dental care⁴³. Large areas of the region also have population-based HPSA designations for migrant workers, low-income individuals, and Native Americans. Health care employers have experienced difficulty in filling vacancies for positions for registered nurses, clinical social workers, and mental health counselors⁴⁴. Based on population/primary care provider ratios, workforce shortages are most prevalent in Grant and Okanogan Counties. The Medicaid Demonstration projects provide a crucial opportunity for NCACH partners to address workforce capacity issues, through regional collaboration and planning to implement strategies such as telehealth to build workforce capacity.

Access to behavioral health care is another challenge. There are no designated psychiatric inpatient beds in the region, despite the fact that mental and behavioral health diagnoses are among the top reasons for hospitalization. The region's rates of mental health treatment penetration (40.5%) and substance use disorder treatment penetration (22.2%) are below the state average for these indicators (42.9% and 26.7%, respectively)⁴⁵. This suggests that there are Medicaid members with treatment needs who may not have adequate access to care.

Access to affordable housing is an emerging challenge for the region. NCACH has 184 HUD assisted units per 10,000, compared with the state average of 303 HUD assisted units per 10,000⁴⁶. Access to stable housing is an important driver of health outcomes. This will be a crucial issue for the region to address as it implements transformation projects.

⁴³ WA State Department of Health, Health Professional Shortage Areas: <https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth/DataandOtherResources/HealthProfessionalShortageAreas>

⁴⁴ Washington State Health Workforce Sentinel Network: <http://www.wtb.wa.gov/HealthSentinel/findings.asp>

⁴⁵ HCA AIM, ACH Toolkit Historical Data file.

⁴⁶ NCACH Community Health Needs Assessment: http://www.cdhd.wa.gov/Health%20Data/Docs/2016_Chelan-Douglas_Health_District_CHNA.pdf

ACH Theory of Action and Alignment Strategy

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

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

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

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

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

¹ *Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017. Accessible at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwif437393*

- Describe the process the ACH followed to consider and select projects as part of a portfolio approach.
 - What were the criteria for selecting projects?
 - Describe how the ACH applied its whole-population vision for health system transformation to inform its project selection and planning.
 - Which interventions, resources, and infrastructure will be shared throughout the project portfolio, and how will they be shared?
- Describe how, through these projects, the ACH plans to improve region-wide health outcomes.
- Describe how, through these projects, the ACH plans to improve the region-wide quality, efficiency, and effectiveness of care processes.
- Describe how, through these projects, the ACH plans to advance health equity in its community.

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- Describe how, through these projects, the ACH plans to demonstrate a role and business model as an integral, sustainable part of the regional health system.
- Discuss how the ACH addressed any gaps and/or areas of improvement, identified in its Phase II Certification, related to aligning ACH projects to existing resources and initiatives within the region.
- Submit logic model(s), driver diagrams, tables, and/or theory of action illustrations. The attachments should visually communicate the region-wide strategy and the relationships, linkages, and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects, and outcomes (*submit as ACH Theory of Action and Alignment Strategy – Attachment A*).

ACH Response

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

- Describe the ACH’s vision for health system transformation in its region; include a vision statement and a discussion of how the vision addresses community needs, and the priorities of the whole population.
- Define the ACH’s strategies to support regional health and healthcare needs and priorities.

The vision of the North Central Accountable Community of Health (NCACH) is for every person in our region to achieve optimal health and experience the best health care possible. We strive for all community members to be empowered with the resources needed to obtain excellent physical, mental, and social well-being. We are working toward this vision by leading a collaborative approach to transform the system of care from one that is fragmented to one that is connected and sustainable. We rely on four guiding principles:

1. Ensure patients receive culturally appropriate services that address the whole person at multiple entry and exit points in the health care and social service system.
2. Promote an innovative system of care in which community-based organizations and health care providers integrate and communicate to address patient needs.
3. Plan for sustainability of the transformed system beyond the Demonstration including the network of providers and social service agencies.
4. Use population health data to identify, target, and reduce health disparities through purposeful deployment of project resources.

NCACH realizes that our transformation work must extend beyond medical care, and our vision ensures there is greater alignment with medical providers and social services providers. NCACH will require every medical provider who participates in the Demonstration to articulate their engagement with community-based organizations and ensure they influence social determinants of health (SDH) in our region.

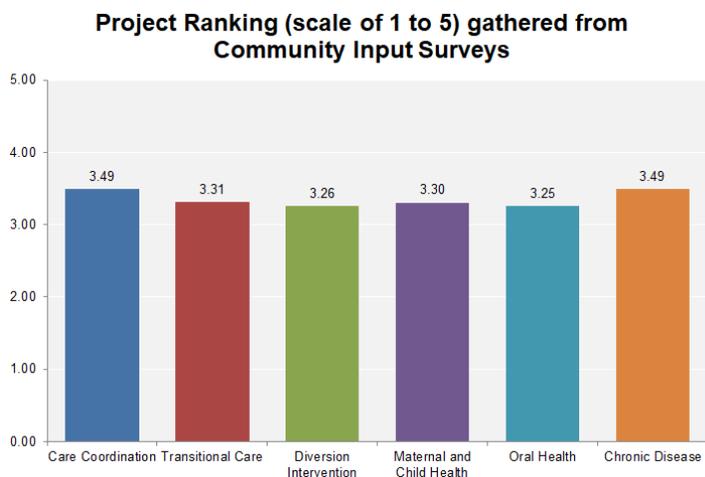
In the process of crafting the NCACH vision statement and selecting the six Demonstration projects, NCACH first focused on the established health priorities of the region. NCACH choose to utilize the region’s Community Health Needs Assessment (CHNA) in identifying those priorities. The CHNA involved a robust process of reviewing health data and gathering community input over a six-month period (May 2016 – December 2016), and it was completed by dedicated staff and community

volunteers across the North Central region. This document clearly outlines community member and stakeholder priorities and was one of the cornerstone documents the Board utilized in making final project selections in May 2017. As we explored the evidence-based approaches within each project area, NCACH has continued to regularly connect with local stakeholder groups (e.g., Chelan-Douglas Opioid Workgroup, North Central Emergency Care Council) to understand their priorities and ensure we are aligning the approaches in the Demonstration toolkit with the current work that is occurring in our local communities. Examples of this are a medication-assisted treatment project in operation at the Chelan County Jail and a Community Paramedicine program starting in Chelan County. NCACH staff attends monthly or bi-monthly meetings of these groups and provides summary updates at NCACH workgroup meetings and through the Executive Director report at open NCACH Governing Board meetings.

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

- What were the criteria for selecting projects?
- Describe how the ACH applied its whole-population vision for health system
- Transformation to inform its project selection and planning.
- Which interventions, resources, and infrastructure will be shared throughout the project portfolio, and how will they be shared?

NCACH’s multi-faceted approach ensured project selection aligned with regional needs. Rather than trying to recreate an already robust process for community engagement and needs identification, the Governing Board analyzed the region’s December 2016 CHNA completed by hospitals and public health jurisdictions in the North Central region. The process to complete this assessment included an analysis of data from 10 health and community databases in addition to gathering local input at six community meetings across the region. North Central region’s top priorities from the CHNA include mental healthcare access, access to primary care, high school graduation rates, obesity, affordable housing, drug and alcohol abuse, access to healthy foods, and diabetes.



NCACH staff and Governing Board used this information and applied it to the Demonstration project selection process. NCACH held six widely advertised community forums (March-April of 2017) at locations throughout the region and electronically distributed surveys with recorded presentations during April of 2017 to 550 stakeholders including Medicaid beneficiaries, providers, and other community partners. Data from the CHNA was shared with NCACH community partners, and each partner

had an opportunity to provide input on what projects they felt were needed in the community, based on a one to five point scale (see chart above). The Governing Board then spent a full day at the end of April 2017 reviewing the community input and CHNA data.

The Governing Board examined projects using five criteria:

1. The region’s health status (including health disparities);
2. How the projects align with the regional priorities of its members;
3. What the data said were the biggest health disparities;
4. How the projects would align across the Demonstration; and,
5. How the demonstration aligned with the current initiatives occurring in our community

Based on this input, the Governing Board formally voted to select Care Coordination, Transitional Care, Diversion Interventions, and Chronic Disease in addition to the two mandatory projects during the May 2017 Board meeting.

As NCACH staff and Board are developing the project implementation plans, NCACH emphasizes to its partners, including clinical providers and community-based organizations, that we must implement interventions and infrastructure investments that are mutually reinforcing and regional in scope. Through the selected projects, NCACH plans to improve the systems of care for providers and partners who provide direct services to patients. Therefore, these improvements will address the entire population in our region and not only the small percentage of Medicaid patients these partners serve. Specific to shared resources across the project portfolio, behavioral health-medical integration, investment in adoption of evidence-based care models enabled and incentivized by value-based payment (VBP), and implementation of the Pathways HUB in the Care Coordination Project will not only address Projects 2A and 2B, but also Projects 3D (Chronic Disease), 2C and 2D (Transitional Care/Diversion Interventions) through more effective care coordination, and 3A (Opioids) through adoption of clinical guidelines on opioid prescribing and pain management. Infrastructure investments across the region, including a regional 24/7 nurse call line and enhanced use of telehealth, will help all providers decrease Emergency Department (ED) visits and increase access to behavioral healthcare settings in rural communities. NCACH will ensure that every project element chosen and the investments we make in them are interconnected and mutually reinforcing to the overall goals of Healthier Washington. These connections are described in more detail in our project plan application.

Describe the following:

- Describe how, through these projects, the ACH plans to improve region-wide health outcomes.
- Describe how, through these projects, the ACH plans to improve the region-wide quality, efficiency, and effectiveness of care processes.
- Describe how, through these projects, the ACH plans to advance health equity in its community.

To improve region-wide health, we must improve systems and not just payment structures for Medicaid services. Therefore, NCACH staff and Board emphasize interventions and infrastructure investments that are mutually reinforcing and regional in scope. Because clinical providers do not operate clinics that serve only Medicaid patients, improvements to the overall health care system will improve care for all patients. For example, NCACH partners have emphasized data sharing among electronic health records (EHRs) as a key to integration of care. Improving interoperability will have a significant impact on every patient that interacts with a medical facility (Medicaid, Medicare, and commercial insurance). Increasing EHR interoperability will also support other regional initiatives including the Pathways Care Coordination HUB, region-wide 24/7 nurse call line, and other systems helping medical providers connect patients with social service providers who address social

determinants of health (SDH). NCACH will utilize the Pathways Care Coordination HUB to better link medical providers with social service providers, while also tracking shortfalls in the system due to funding issues or lack of services. These changes, and the fact that NCACH is building a strong framework to engage both medical and social service providers (through our CHIs, Workgroups, and WPCC), will promote stronger connections to social service providers and integration of SDH into clinical workflow processes.

Other project efforts will also lead to region-wide improvements. For example, changing the opioid prescribing practices of providers will benefit all patients in a clinic. Opioid education in the community will be directed at all community members, not just Medicaid beneficiaries. And if NCACH enhances community paramedicine programs through our Diversion Interventions Project, those programs will better support care for any patient that Emergency Medical Service (EMS) professionals come into contact with.

To ensure each project will result in a region-wide impact on health, NCACH will make changes that are not only in alignment with the Demonstration, but also in alignment with the contracting and quality metrics of all payers (Medicaid, Medicare, and commercial insurance). Aligning payment sources will ensure providers focus on the quality metrics they have to track for every patient in their organization, not just Medicaid. To initiate this process and sustain it, NCACH must engage payers in the Demonstration.

NCACH has accomplished this by making managed care organizations (MCOs) an integral part of NCACH's formation from the beginning. MCOs hold a voting seat on the NCACH Board, and every MCO has a representative on each of our workgroups. MCOs are active participants in all of NCACH's local Coalitions for Health Improvement (CHIs). In October 2017, NCACH staff initiated monthly meetings with the three MCOs who have contracts in every county of our region starting January 1st, 2018 (under FIMC) to directly address topics such as shared savings and VBP. To ensure that we maintain consistency with Medicare and commercial insurance, NCACH works with providers through the Whole Person Care Collaborative (WPCC) to identify which metrics need focus in our region, so providers are able to gain financial incentives through all payment methods.

In terms of health equity, our region is paying attention to racial and ethnic demographics, which vary by county. While the region has lower rates of Black, Asian, and Native Hawaiian/Pacific Islander enrollees (compared to the state average), the region has higher rates of Medicaid enrollees who identify as American Indian/Alaskan Native, White, and Other. In addition, more Medicaid enrollees in the region identify as Hispanic compared to the state average (47% and 21%, respectively)⁴⁷. In light of these demographics, NCACH and its partners will need to ensure interventions that improve patient care are culturally relevant. Through our selected projects, NCACH is focusing on health equity by identifying disparities in health risks and health outcomes through analysis of data during our project planning phase. NCACH deliberately analyzed health equity issues during our project selection; specific data on health disparities is outlined in all six of our project plan applications. Additional data analysis will help to further refine NCACH target populations in 2018 for our six selected projects, and ensure we focus on health equity when selecting how we implement, scale, and sustain our efforts across broader populations in the region. Since progress toward health equity is assessed by measuring how health disparities change over time, NCACH will employ the Robert Wood Johnson Foundation's "Key Steps to Advancing Health Equity" in identifying, addressing, and

⁴⁷ HCA RHNI Starter Kit, *Demographics-Medicaid* tab. Based on HCA Medicaid enrollment and claims data for the 2015 calendar year.

evaluating and monitoring health disparities⁴⁸.

As target populations are refined, NCACH will also engage our three local CHIs during project implementation planning (December 2017 – June 2018) to ensure we are able to have a local perspective on what providers see as the causes of health disparities in their communities. This information will be shared with project workgroup members who will incorporate these details into the project implementation plan due in 2018.

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

Through NCACH’s role as convener and influencer, we activate Medicaid beneficiaries, health and social service providers, payers, and other community members to join in building a healthier region together. The work of NCACH has provided a unique platform for medical providers, payers, and social service providers to address patient health collaboratively. As we move forward in the Demonstration, NCACH will use this role to help partners develop collaborative business models that span across the continuum of care and develop innovative payment models that address the whole person, including reinvestment of dollars through shared savings. Payment models are an essential element in every organization’s business model to ensure our providers can continue to deliver high quality low cost care in the region. NCACH believes that our partners will continue to see this convening function as a vital role after the Demonstration, and NCACH will continue to act in its current role or will find the appropriate agency to convene our community partners in the work of Healthier Washington beyond the Demonstration.

NCACH has structured its business model to follow the above process. NCACH’s business model is designed to provide internal staffing to convene our partners in planning, implementing, and monitoring projects and processes that will achieve the goals of the Demonstration project. Staff remain focused on ensuring the deliverables of the Demonstration are met. NCACH continues to distribute funding to our partners to develop our partner’s internal capacity and assist them in process improvement efforts that can be sustainable under value based payments. NCACH will continue to assess over the course of the next 5 if our convening function will continue to bring value to our partners and community beyond the Demonstration. If there is value to continue NCACH’s role as a convening agency, we will work with our partners to identify initial and long term funding for operating the ACH beyond the Demonstration.

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

As we continue to refine approaches within each project, NCACH staff have made it a priority to continue connecting with local stakeholder groups (e.g., Chelan-Douglas Opioid Workgroup, North Central Emergency Care Council) to understand the priorities of those sectors and ensure we are aligning the approaches in the Demonstration toolkit with the current work that is occurring in our local communities. Examples include a medication-assisted treatment project currently occurring at the Chelan County Jail, a Community Paramedicine program starting in Chelan County, and a proposal to adopt a regional EHR at the North Central Hospital Council, a meeting of all hospital providers in the NCACH region.

⁴⁸ *What is Health Equity? And What Difference Does a Definition Make?* (May 2017). Robert Wood Johnson Foundation and University of California San Francisco.

Governance and Organizational Structure:

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

- Describe how the ACH's governance provides oversight for the following five required domains:
 - **Financial**, including decisions about the allocation methodology, the roles and responsibilities of each partnering providers, and budget development
 - **Clinical**, including appropriate expertise and strategies for monitoring clinical outcomes and care delivery redesign and incorporating clinical leadership, including large, small, urban, and rural providers
 - **Community**, including an emphasis on health equity and a process to engage the community and consumers
 - **Data**, including the processes and resources to support data-driven decision-making and formative evaluation
 - **Program management and strategy development**, including organizational capacity and administrative support for regional coordination and communication
- If applicable, provide a summary of any significant changes or developments related to the governance structure (e.g., composition, committee structures, decision-making approach) and decision-making processes since Phase II Certification, including a rationale for changes.
- Discuss how the ACH addressed areas of improvement identified in its Phase II Certification related to its governance structure and decision-making processes.
- Describe the process for ensuring oversight of partnering provider participation and performance, including how the ACH will address low-performing partnering providers or partnering providers who cease to participate with the ACH.
- Submit a visual/chart of the governance structure (*submit as Governance – Attachment A*).

ACH Response

Describe how the ACH's governance provides oversight for the following five required domains:

- **Financial**, including decisions about the allocation methodology, the roles and responsibilities of each partnering providers, and budget development
- **Clinical**, including appropriate expertise and strategies for monitoring clinical outcomes and care delivery redesign and incorporating clinical leadership, including large, small, urban, and rural providers
- **Community**, including an emphasis on health equity and a process to engage the community and consumers
- **Data**, including the processes and resources to support data-driven decision-making and formative evaluation
- **Program management and strategy development**, including organizational capacity and administrative support for regional coordination and communication

Financial: To ensure the Board meets its fiduciary responsibility, all budgetary items are approved by the North Central Accountable Community of Health (NCACH) Board annually and as needed to approve non-budgeted expenses. The Treasurer reviews all financials and provides an update to Board members during monthly Board meetings. This fiduciary responsibility directly applies to the allocation methodology of project pool funds, and NCACH Board has final approval of any funds allocated to partners directly from the NCACH or through the Financial Executor. Broader input on funding allocation outside of the Board is facilitated through NCACH workgroups. Workgroups, comprised of Board members and other community partners, are tasked with developing a process to

allocate funding associated with the projects and partners each workgroup manages. That process will then be presented to the NCACH Board for final review and approval.

Although NCACH continues to refine the specific points of accountability and process for funds flow as we move toward implementation, the Whole Person Care Collaborative (WPCC) Stage 1 funding document is a key example of our current process. The WPCC, a collaborative including primary care and behavioral health providers, developed a process for how its members can engage and receive funding through the Demonstration. This process was refined in the WPCC and presented to the Board for final approval. The Board approved Stage 1 of this document at the October 2nd, 2017 Board meeting and provided recommendations to the WPCC to refine the additional stages of the document that will be approved at later Board meetings. Since workgroup members will also have a vested financial interest in the decisions made, members of all workgroups are expected to comply with the conflict of interest policy adopted by the NCACH Board.

Clinical: Clinical capacity is supported through the WPCC. The WPCC is a workgroup of the Board and all decisions that are made within the WPCC are developed into recommendations that are then considered by the Board for approval. This WPCC includes primary care and behavioral health outpatient providers across the North Central area, including rural providers who manage Critical Access Hospitals, rural and urban Federally Qualified Health Centers (FQHCs), community and clinical behavioral health providers, and large “urban” hospital systems (20 total organizations). The WPCC has engaged more than 90% of the physical health providers in the region and every behavioral health provider that is currently part of the Behavioral Health Organization (BHO) system. Current members have collectively likely touched every Medicaid covered life in NCACH. Workgroup members represent individuals at different levels of each of the above organizations ranging from direct service providers (i.e. Medical Doctors) to organizational leadership (i.e. Chief Executive Officers). This range of workgroup members allows the WPCC to develop improvement processes in patient care that are feasible to complete at the provider level and has strong leadership support. A sample of the diverse clinical expertise of the WPCC membership includes the following:

1. Primary Care Doctor who see patients in rural clinics
2. Federally Qualified Health Center (FQCH) CEO
3. FQHC Behavioral Health Department Director
4. Critical Access Hospital CEO
5. Community Behavioral Healthcare Organization Clinical Manager/Director
6. Substance Use Disorder Inpatient Treatment Facility Clinical Manager and Director
7. Managed Care Organization Representatives
8. Pediatric Transforming Clinical Practice Initiative & Qualis Health Coaches

NCACH has staffed the WPCC with a Director of Whole Person Care (Peter Morgan) who is a retired Group Health executive with direct experience implementing Patient-Centered Medical Homes (PCMH) in a large health care setting. As well, NCACH has contracted with the Centre for Collaboration, Motivation and Innovation (CCMI), a nationally recognized leader in change management, to initiate a “Learning Community” for providers in the WPCC. The key objective of the learning community is to provide a venue for partnering providers to learn from each other’s successes and obstacles in implementing the evidence-based approaches in the Demonstration toolkit. This includes ensuring that changes implemented in their clinics are sustainable after the Demonstration. CCMI has a national reputation and experience in running large, diverse learning collaboratives. Clinical outcome measures in NCACH will be monitored through the WPCC with the

help of our contractors from CCMI and CSI Solutions, Inc. The WPCC and CCMI will develop and implement continuous improvement (CI) processes based on best practices for clinical and health systems improvement, bringing in expertise from contractors and partners where needed. This framework draws on learning series involving Plan-Do-Study-Act (PDSA) cycles outlined by the Institute for Healthcare Improvement. As part of the initial Memorandums of Understanding, each participating provider will have to agree to share with the Learning Community members data points identified as key to improving progress in the NCACH. This will be done through a customized web portal developed by CSI Solutions, Inc. (Healthcare Communities) that would serve multiple functions, including document sharing, tracking of process/outcome measures through reporting and surveys, and tracking of clinical measures through a dashboard.

Community Engagement: The Coalitions for Health Improvement (CHIs), broad-based local community coalitions intended to engage a wide variety of partners in the mission and work of the NCACH, have become vibrant and active vehicles for community engagement. Each CHI has a voting seat on the Board and each CHI has an average of 30 community members attending monthly meetings. At the September and October 2017 meetings of each CHI, members reviewed Demonstration project data and provided input on anticipated target populations for the project plan application. This information was and will continue to be shared with workgroups as they fine-tune evidence-based approaches for each selected project area.

NCACH is in the process of enhancing contracts with each Local Health Jurisdiction (LHJ) within the three CHI regions. This will boost their ability to identify and formalize CHI membership and provide staff support to ensure bi-directional feedback between the CHIs, workgroups, and Board, while also placing a greater emphasis on obtaining authentic consumer engagement in our local communities. Each contractor needs to demonstrate direct outreach two times a year to groups with >50% of their members consisting of Medicaid beneficiaries (six total in the region). This information will be collected and presented to each workgroup. Workgroups will be required to demonstrate how they have incorporated Medicaid beneficiary input from the CHIs in their project planning. To date, NCACH has also engaged in outreach ensuring data collected from beneficiaries includes those with the greatest health disparities. Examples of this outreach include:

- Attending the Columbia Valley Community Health Back to School Night (>50% Hispanic Medicaid clients);
- Engaging the staff and the population they serve in the CHIs through email communications and meetings with the Office of Superintendent of Public Instruction's (OSPI) Migrant Health Education Supervisor in August of 2017; and,
- Attending the Confederated Tribes of the Colville Reservations Tribal Powwow on September 15th, to learn more about tribal culture and health

Data: NCACH hired a staff member at the end of July 2017 to build our internal data capacity. In addition, NCACH has a contract with the Center for Outcomes Research and Education (CORE), a not-for-profit health policy research center committed to improving community health that has been involved in several projects across the state to date. They are directly supporting ACH strategic and analytic needs, giving us additional capacity for accessing and analyzing data. Our approach is to analyze and summarize available data, including descriptive data (prevalence and rate disparities for specific Medicaid sub-populations and for specific conditions/risk factors) as well as available outcome data (performance metrics from dashboard and comparisons to state averages and national benchmarks). This data has been shared at meetings of the three CHIs to identify preliminary target

populations. Each workgroup took CHI feedback to refine both the target population and evidence-based approaches at their October 2017 meetings. This will continue to be an iterative process, given that these discussions often surface the need for additional or more detailed data (e.g., specific demographic or geographic breakouts). As we move forward with project planning and into project implementation, all of our workgroups will review and consider data needs including specific targets, metrics, and quality improvement plans. Data validation and interpretation as we receive performance data from HCA and our local partners will help us determine whether we are adequately moving pay-for-performance (P4P) measures and hitting the metric targets. NCACH will evaluate the need to adjust implementation plans as we implement and scale our health improvement efforts during the Demonstration. In terms of data governance specific to Health Information Technology/Health Information Exchange (HIT/HIE) and data integration, our staff will participate in cross-ACH and state HIT/HIE efforts. We also plan on convening our own regional HIT/HIE Workgroup in quarter 1 of 2018 (see *Governance and Organizational Structure Attachment B*) to tackle information exchange and data sharing needs that will support the goals of our projects, especially with respect to bi-directional integration, care coordination, and transitional care. The charter for the NCACH HIT/HIE Workgroup was approved at the November 6, 2017 NCACH Board meeting.

Program Management and Strategy Development: Program management and strategic development is provided by the Executive Director and the Board and supported by direct NCACH staff. The Board is responsible for the overall alignment and direction of the NCACH. As needs arise, the Board creates a standing committee to review the strategic needs of the organization and provide recommendations back to the Board. Each project is supported by an NCACH workgroup that will meet monthly throughout the Demonstration and manage the deliverables in the project. Each project is also supported by 0.5 FTE NCACH project management staff who will work with applicable contractors as needed. The current workgroups are:

- Whole Person Care Collaborative (WPCC) supporting projects 2A and 3D;
- Regional Opioid Workgroup supporting project 3A;
- Transitional Care and Diversion Intervention Workgroup supporting projects 2C and 2D; and,
- Pathways Community HUB Subcommittee of the Board supporting project 2B.

The CHIs will be leveraged as described above to ensure community input is continuously incorporated in the management and strategic development of our Demonstration efforts. CHI input will be provided to relevant workgroups and to Board members, and those groups will need to demonstrate how input provided by the CHIs have directly influenced their decisions and recommendations.

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

Since Phase II Certification, NCACH took a very deliberate process to develop and initiate the Transitional Care and Diversion Intervention Workgroup and the Regional Opioid Workgroup. Board members reviewed initial charters on September 11 and October 2, 2017 and developed a list of key sectors between October 2 and 12, 2017 that needed to be represented in each of the workgroups. NCACH staff connected directly with the regional councils representing each sector in October (e.g. Law Enforcement Meeting October 4, 2017, North Central Regional Hospital Council, and North Central Emergency Care Council) to discuss qualified candidates that would represent their organizations on the workgroup. Initial workgroup meetings were held in the week of October 23 –

27, 2017. To better align the efforts of our workgroups, CHIs, and Board, NCACH hired a Program Development Specialist who has expertise in communications and community outreach in November 2017. This role will directly interface with the three already established contracts with the Local Health Jurisdictions to ensure data collected at the local level is rolled up to the workgroups and Board while taking into consideration the entire region's priorities.

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

Since Phase II Certification, two CHI representatives were appointed to the NCACH Board on September 10 (Chelan-Douglas CHI) and October 2 (Okanogan CHI). The remaining CHI (Grant) plans to finalize their search criteria in December to identify their nominee with Board approval anticipated at the January 2018 Board meeting. NCACH is currently looking to fill the only remaining Board seat (business sector) by January 2018 and has made it a focus to obtain that member from Okanogan County to maintain balanced representation from all counties. This will ensure we move into 2018 with all Board seats filled. NCACH also improved the defined sector representation in every level of the NCACH decision-making process. The Board, workgroups, and CHIs have requirements outlined in their charters and bylaws that reference the sector representation and the need to maintain a broad range of sectors in their work. This is assessed annually at a minimum to ensure appropriate recruitment efforts and maintain diversity. To help fill identified gaps, NCACH staff identifies organizations that are not represented on workgroups and schedules key informant interviews to gather input on projects.

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

NCACH anticipates that initial awards and funding will target capacity building needs of partners to complete Demonstration work. The initial funding amount will be determined by the Board and partners will need to sign agreements that assert their intent to be active partners in the Demonstration project prior to receiving any dollars. After that initial funding, funds flow will be based on the organizations' ability to help NCACH report progress and move the pay-for-reporting and pay-for-performance metrics. NCACH partners will be required to report and complete activities within the Board-approved process to be able to earn Demonstration funding. Each project workgroup will develop the reporting process for partnering organizations which will go to the Board for final approval. This process will be developed by quarter 3 of 2018. Staff will evaluate reports and share recommendations with the Board who will provide final approval that all reports have been sufficiently completed. While reporting requirements and timelines are not currently set, we expect reports to be submitted semi-annually, at a minimum. NCACH staff will be assigned to monitor partner performance, and the NCACH will do everything possible to work with partners who are having trouble complying with reporting requirements. This may include connecting those partners with the needed consultants to ensure they can better complete the expectations outlined in the Board approved funding documents. If partners do not complete needed milestones or cease to participate in Demonstration activities, they will not receive additional funding since the required milestones to receive funding will be considered incomplete.

Community and Stakeholder Engagement and Input

Describe the ACH's community and stakeholder engagement and input. In the narrative response,

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address the following:

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

ACH Response

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

- Through what means and how frequently were these opportunities for input made available? (e.g., ACH website posting, ACH listserv, surveys, newspaper, etc.)
- How did the ACH ensure a broad reach and ample response time in its solicitation?
- How did the ACH ensure transparency to show how public input was considered?
- How did the ACH address concerns and questions from community stakeholders?

Coalitions: North Central Accountable Community of Health’s (NCACH) primary opportunity for community and stakeholder engagement is through the three local Coalitions for Health Improvement (CHIs) located in the North Central region. The CHIs main goal is to foster authentic community engagement and create an ongoing pathway for gathering input from diverse groups of community members to shape the work of NCACH. Coalition members advise the Board on issues directly related to NCACH’s mission and activities, including needs assessments and local health data; community health improvement plans and priorities; health improvement initiatives; project planning and selection; and delivery system transformation. Through the Board CHI representatives, input from each CHI is utilized in the decision-making process of the Board at monthly Board meetings, and any decision and direction approved by the Board is shared with every CHI. CHIs currently meet monthly or every other month. To ensure that those individuals who cannot directly attend CHI meetings are able to provide input, NCACH distributes every survey shared with CHI members to the entire NCACH distribution list (~600 stakeholders).

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To ensure a broad reach and adequate response time was provided for major decisions, both through project selection (March 2017 – May 2017) and during preliminary project planning (August 2017 – November 2017), NCACH held public forums, provided community presentations, and attended community events to gather a wide range of community input (see more details in the next question of this section). Each key decision made by the Board (project selection and preliminary information in the project plan) was predicated by six to eight weeks of intensive community outreach prior to final consideration by the Board. This outreach included additional meetings with the CHIs, key informant interviews, and local events across the NCACH region to gather input from community members. The outreach across the region (two presentations in each Chelan, Grant, and Okanogan County for a total of six presentations) and the length of time (six-eight weeks) NCACH spent gathering information from our community members and stakeholders, ensured that a majority of individuals in all four counties were able to learn about the projects, review the necessary data, and provide meaningful input into the project selection and approaches.

To solicit recommendations specific to our preliminary project plans for Board approval, NCACH established workgroups. These workgroups involve a broad range of community partners throughout the region (15 – 30 members on each workgroup) based on defined composition written into their charters that require diverse representation ensuring robust input into the project implementation plans. Current workgroups include:

- Whole Person Care Collaborative (WPCC)
- Regional Opioid Workgroup
- Transitional Care and Diversion Interventions Workgroup
- Pathways HUB Subcommittee of the Board

NCACH workgroups will engage CHIs and partnering providers who are directly completing the work over the next eight to eleven months as we refine the project implementation plans due quarter 3 of 2018.

To ensure all decisions of the Board are shared publicly, meeting minutes are posted on the NCACH website monthly and emails are sent to our listserv one to two times a month. NCACH updates its webpage every month to ensure community members have the most current information including announcements, meetings schedules, and meeting documents. The NCACH Executive Director creates a monthly newsletter (see *Community and Stakeholder Engagement Attachment B*) that provides an overview of activities each NCACH staff is currently working on. In addition, our new NCACH staff responsible for communications will update the NCACH website weekly and send out routine email communications as project planning and implementation moves forward. When major NCACH decisions are made, NCACH works with local media to share the news with the broader community. For example, when the NCACH Board approved project selection in May 2017, we submitted a press release to the local papers and sent a notification to our stakeholder and partner list.

To allow community members to express concerns, the Board opens each meeting with a public comment period. In addition, after the Chelan-Douglas CHI meeting in September 2017 when there was robust community engagement around the Demonstration that couldn't be fully covered in the time allotted, the NCACH team started an FAQ sheet to help provide answers to CHI member questions and distributed it electronically and in person to members of the CHI. Moving forward,

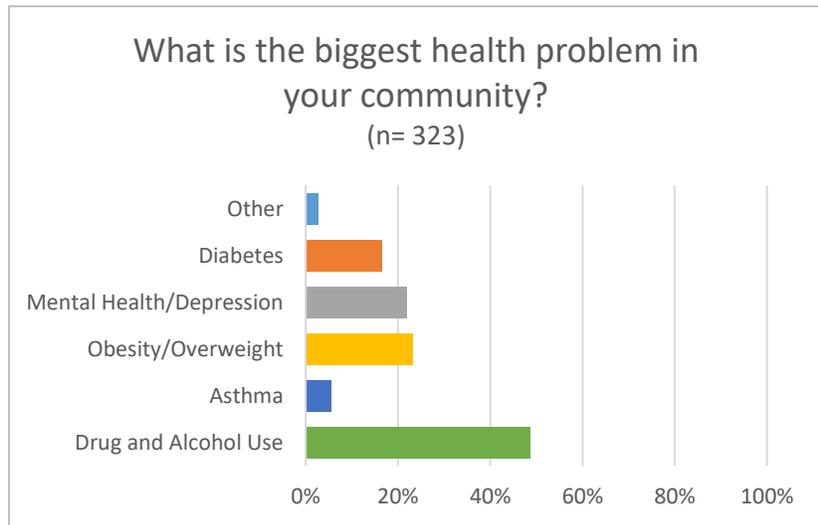
NCACH will ask the CHI members for feedback on the usefulness of the FAQ format to help us determine if we should use a similar method for other areas of the Demonstration. At each CHI meeting, questions and concerns from community members related to selecting target populations have been gathered by NCACH staff to share with workgroups and Board members. More details are included in the next question of this section. Finally, when individual concerns and feedback are raised with NCACH partners, NCACH's Executive Director and Board Chair schedule individual meetings to address partner concerns. If themes occur with multiple partners, this feedback is shared with the Board as part of the Executive Director report given at monthly Board meetings.

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

Project selection: NCACH's multi-faceted approach ensured project selection aligned with regional needs. Rather than trying to recreate an already robust process for community engagement and needs identification, the Board analyzed the region's December 2016 Community Health Needs Assessment (CHNA) completed by hospitals and public health jurisdictions in our region. This assessment of the entire NCACH region involved volunteers and staff who spent six months gathering data from multiple health and community databases and traveling across the region to each county to gather local input. Based on the data and community input, the NCACH region's top priorities were identified as: mental healthcare access, access to primary care, high school graduation rates, obesity, affordable housing, drug and alcohol abuse, access to healthy foods, and diabetes. NCACH then held six widely advertised community forums in March and April 2017 (advertised through newspaper, NCACH webpage and listserv, and community partner listservs) at locations throughout the region and also electronically distributed surveys with recorded presentations to 550 stakeholders including Medicaid beneficiaries, providers, and other community partners. This information was then synthesized into a summary document and reviewed extensively at a full day Board retreat in April 2017. Based on this input, the Board selected Care Coordination, Transitional Care, Diversion Interventions, and Chronic Disease in addition to the two mandatory projects.

Target population: The local CHIs have been the primary groups tasked with identifying the preliminary target populations in the project plan application. NCACH staff compiled and shared population health data with each of the 3 CHI regions (Chelan-Douglas, Grant, and Okanogan) during their meetings in September and October 2017. Based on the data, CHI members discussed what populations they felt NCACH should focus on and suggested additional data needed to refine or validate the preliminary populations. NCACH staff then took that information and shared results with the workgroups and Board who provided additional recommendations and feedback that were incorporated in our project plan applications.

Focus on Chronic Disease Conditions: To ensure NCACH incorporated regional feedback from community members on the project plan application prior to November 16, 2017, NCACH attended three local community events. On August 5, 2017 NCACH staff attended the Columbia Valley Community Health (a local Federally Qualified Health Center) back to school event where more than 50% of attendees were Hispanic. To assist in gathering information at this event, NCACH translated all materials in Spanish and recruited a Spanish speaking volunteer to assist at the event. On September 15, 2017 NCACH attended the Confederated Tribes of the Colville Reservation’s Powwow in Grand Coulee which consisted predominately of tribal members. Finally, on September 30, 2017 NCACH staff attended the North Central Regional Health and Wellness Expo which was representative of the mix of race/ethnicities in our community. Over the three events, a total of 323 responses were collected (see chart). The question asked at each event was, “What is the biggest health problem in your community?” Overwhelmingly, the top choice at each event was drug and alcohol use. At the August 5 and September 30 events, the second choice was a close tie between obesity/overweight and mental health/depression. At the September 15 Powwow the second place choice was diabetes. This information was synthesized in a summary sheet and these responses were shared with each of the workgroups. Their recommendations were presented to the NCACH Board for approval in November 2017. Workgroups will continue to fine-tune evidence-based approaches and final target populations.



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

Through the Coalitions for Health Improvement (CHIs), NCACH will continue to share Demonstration information to create a bi-directional feedback loop between community members and the Board. Each CHI is open to any member of the community interested in the work of the NCACH, and CHI leadership is expected to follow the guidelines of membership outlined within the charter to ensure the membership is diverse. The input gathered at the local CHI meetings will be compiled by each CHI and presented to the Board and/or appropriate workgroups when making further decisions pertaining to the Demonstration. The primary focus for each CHI is to refine the preliminary target populations selected in the project plans and identify the partners in each area (Chelan-Douglas, Grant, and Okanogan) who should be active in the Demonstration. Each CHI will have a representative on the Board, so that information can flow between the CHIs and the Board. Starting in December 2017, each CHI Board representative will have time allocated on the Board meeting schedule to provide an update of the work of their local CHI.

Each of the four NCACH project workgroups will have time allocated on the Board meeting schedule to provide an update of their work. Decisions under consideration by workgroups and the Board will

be shared at CHI meetings through the CHI Board representative so community members have an opportunity to provide feedback on the directions and decisions of NCACH.

To ensure consistent and direct feedback to the Board, NCACH will continue to hold a public comment period at the beginning of every monthly Board meeting. Prior to final submission of the project implementation plan, NCACH will go through another robust public input period (six to eight weeks) where community members will have the opportunity to provide input on implementation plans prior to final approval (September 2018). This will include holding events and public forums allowing community members to provide direct feedback.

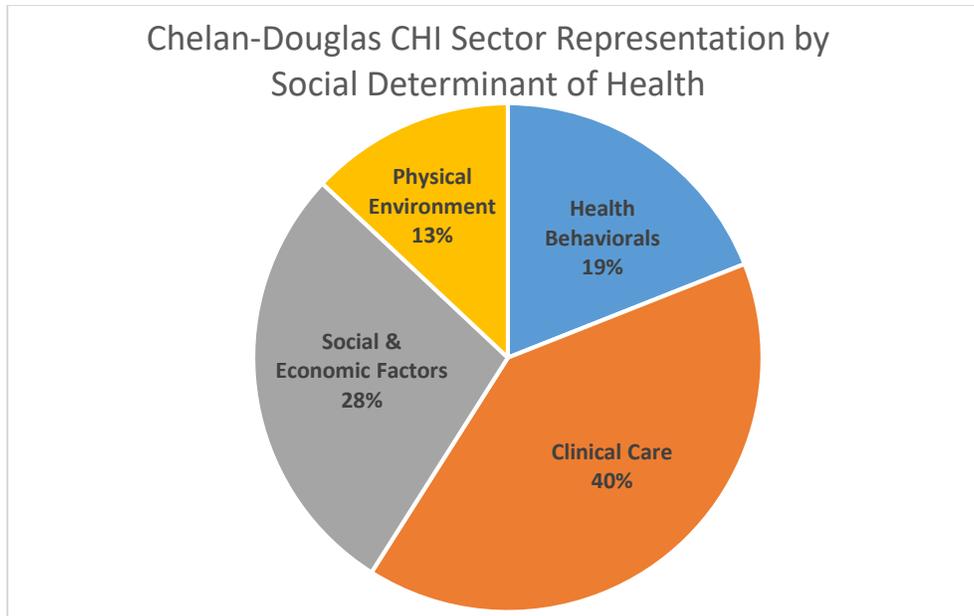
Describe the processes the ACH used, and will continue to use, to engage local county government(s) throughout the Demonstration period.

State and local government continues to have a direct voting seat on the Board and that position is currently filled by State Senator Judy Warnick (13th District). Direct engagement with county officials to date has been primarily focused on NCACH preparing our counties for Fully-Integrated Managed Care (FIMC). Through the FIMC process, NCACH has maintained monthly contact with the Chelan, Douglas, and Grant County commissioners through attendance at the North Central Behavioral Health Organization (BHO) Board meetings. At each meeting, NCACH has a standing agenda item and updates are provided to the county commissioners who sit on that Board. To better educate Okanogan Commissioners on the mid-adopter situation and transition to FIMC, NCACH assisted with bringing together managed care organizations (MCO), HCA, and local providers at regular commissioner meetings on July 25 and September 11, 2017 to discuss Okanogan’s options relating to FIMC and have commissioners hear local providers’ feedback on the topic.

Moving forward, NCACH will continue to work through the Local Health Jurisdictions’ Board of Health to update the county commissioners on the NCACH. As part of the Chelan-Douglas Health District (CDHD) and NCACH hosting agreement, NCACH must provide an update to the CDHD Board on the Demonstration work semi-annually. NCACH will also offer this option to Okanogan and Grant County Boards of Health, yearly. Finally, all county commissioners are also on the NCACH stakeholder listserv and receive email updates monthly inviting them to attend Board meetings and be active participants in their local CHIs.

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

Community-based organizations have increased their engagement in the last six months through the CHIs. More than 50% of CHI members now consist of community-based organizations (see example of Chelan-Douglas CHI sector breakdown in pie chart below). CHIs provide a venue to explore member organizations’ involvement in the Demonstration, and a direct process for feedback to the NCACH Board. To incentivize a direct link between the medical community and social service providers, the Whole Person Care Collaborative (WPCC) has developed a funding and scoring proposal process, which incorporates a section requiring providers to articulate how they will engage and include social service providers in the transformations they make to their clinical practices. We will continue to promote these kinds of incentives and connections between medical providers, MCOs, and social services providers to ensure they shape how and where Medicaid dollars are best spent to reduce health care costs in our community.



Tribal Engagement and Collaboration

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

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

ACH Response

How are tribal and IHCP priorities being identified, either through the ACH or through tribal/IHCP partners? Have those priorities informed project selection and planning?

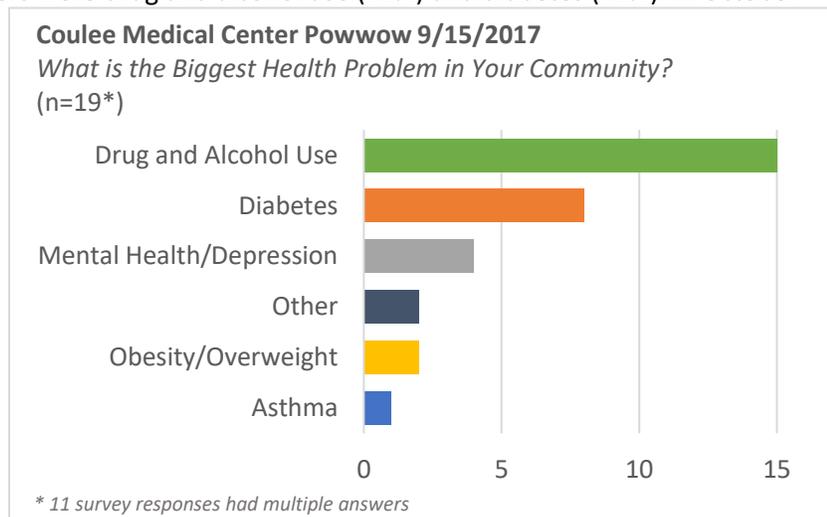
- If applicable, provide examples of at least three key elements of the Project Plan that were informed by tribal input.
- If tribes/IHCPs are not involved in ACH project selection and design, describe how the ACH

is considering the needs of American Indians/Alaska Natives in the ACH region

NCACH has developed a strong relationship with the Confederated Tribes of the Colville Reservation through our tribal representative on the Board, tribal representation in every aspect of our governance structure, and through directly involving Indian Health Services (IHS) in the Whole Person Care Collaborative (WPCC), which is a workgroup including regional primary care and behavioral health outpatient providers.

In July of 2017, NCACH approved a Board member to fill the tribal-designated seat on the Board. NCACH’s tribal Board representative has worked hard to provide education to Board members on health priorities of the Confederated Tribes of the Colville Reservation. Since Phase II Certification, the Board tribal representative arranged a tour of an IHS facility (September 11th, 2017) for Board members and arranged for NCACH to be active partners in the September 15, 2017 Health and Wellness Powwow in Grand Coulee, WA. At the Powwow, NCACH conducted a survey that asked tribal members to choose their biggest health concern (see chart below). Respondents could select the biggest health problems in their community from a variety of options in the survey, and the top two choices by tribal members were drug and alcohol use (72%) and diabetes (42%). In October 2017, the Confederated

Tribes of the Colville Reservation adopted resolutions (see *Tribal Engagement and Collaboration Attachment B*) which describe the Colville Confederated Tribes’ program updates, projects, and directives for Health and Human Services Programs. Since those resolutions were adopted, NCACH staff and our Board tribal



representative have outlined which resolutions are in alignment with the Demonstration work and updated the Board on those resolutions at the November 6, 2017 Board meeting. Specifically, two resolutions adopted by the Affiliated Tribes of Northwest Indians (ATNI) at their 2017 Annual Convention strongly relate to the work of NCACH through the Demonstration:

- Resolution #17 – 59: Support for Adoption of “Center for Disease Control Guideline for Prescribing Opioids for Chronic Pain” by Indian Health Service Facilities and Tribal Health Organizations.
- Resolution #17-60: Support for Legislation Amending Title XIX of the Social Security Act for Adult Inpatient Treatment and grant funding for American Indian/Alaska Native (AI/AN) Youth Addiction Treatment Facilities’ Infrastructure.

These resolutions will be incorporated into the strategic plan of the Confederated Tribes of the Colville Reservation Health and Human Services Department, which is currently in the process of being developed. NCACH believes this plan should be developed in quarter 1 of 2018 and the NCACH tribal Board member will schedule a time with the Board to review the tribal strategic plan at the next available Board meeting after release of the document. At that meeting, the Board will discuss

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how the work of the Demonstration can better support the Confederated Tribes of the Colville Reservation.

Finally, the tribal Board representative and NCACH staff will talk monthly to discuss how we can better identify priorities of the tribal nations, how we can continue to enhance NCACH's relationship with Tribal Health and Human Services Department and Indian Health Services, and how NCACH can best articulate the advancements NCACH has made in tribal relations to HCA through the project plan application. Our regular meetings with the NCACH tribal Board member helped connect staff to the September Powwow and better understand which resolutions of the Confederated Tribes of the Colville Reservation to share with the NCACH Board.

To ensure direct communication is made between NCACH and tribal members, the Board tribal representative meets regularly with the Colville Tribal Health and Human services director pertaining to the Demonstration. NCACH also sends meeting invitations to key staff of the Tribal Health and Human Services, and sends them regular project updates directly. In addition, NCACH's Executive Director directly reached out to The Confederated Tribes of the Colville Reservation's Indian Health Service CEO Colleen Cawston on September 11, 2017 to discuss the connection between their IHS facility and the Demonstration. NCACH's Executive Director also followed up via email on October 9 and 17, 2017 to extend invitations to the IHS to participate in the Whole Person Care Collaborative. On Tuesday October 17, 2017, NCACH Executive Director connected with Colleen Cawston and received a firm commitment of IHS participation in the NCACH.

Beyond the Board, NCACH views individuals in our tribal community as equal partners in the work of the Demonstration. Therefore, we have worked to infuse tribal engagement into every level of our ACH's outreach. At the local community level, tribal members participate in our Coalitions for Health Improvement (CHIs), which are broad-based local community coalitions intended to engage a wide variety of partners in the mission and work of the NCACH. At the September and October 2017 meetings of each CHI, tribal members reviewed Demonstration project data that outlined the Medicaid demographics, local health statistics, and how the NCACH is currently performing on the Demonstration project metrics. This data helped CHI members provide recommendations on the anticipated target populations to include in the project plan application. This information was shared with NCACH workgroups as they considered preliminary evidence-based approaches and preliminary target populations to recommend for Board approval.

Every NCACH workgroup has tribal representatives in its membership, and NCACH works with its tribal Board member to ensure that designated tribal positions on the workgroups are filled. The tribal representative on these workgroups will be able to share specific tribal perspectives and ensure tribal priorities are included in the project implementation plans due in quarter 3 of 2018.

Finally, specific to medical providers, NCACH has enhanced its partnership with the Indian Health Services of the Confederated Tribes of the Colville Reservation. In October 2017, they chose to be active members in the WPCC, making them eligible for funding through the WPCC. Each member of the WPCC, including IHS facilities, will have the opportunity to submit a change plan articulating how systemic process improvements in their clinics will improve patient care. Each change plan allows the flexibility for providers to tailor their clinic's transformation to their own unique needs. NCACH believes this will provide the IHS facilities an opportunity to tailor their change plans to meet the specific needs of the tribal population. If needed, NCACH staff including our Director of Whole Person Care will work with our tribal partners to ensure change plan criteria for the IHS

facilities are in alignment with priorities of the tribes.

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

N/A

Funds Allocation

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

- **Describe how the ACH will manage and oversee the funds flow process for DSRIP funds (Project Incentive funds, Managed Care Integration Incentive funds, and VBP Incentive funds), including how decisions will be made about the distribution of funds earned by the ACH.**
- **Discuss the roles and responsibilities of, and relationships between, the ACH governance body and partnering providers in managing the funds flow process.**

To ensure the Board meets its fiduciary responsibility, all budgetary items are approved by the North Central Accountable Community of Health (NCACH) Board annually and as needed to approve non-budgeted expenses. This fiduciary responsibility directly applies to the allocation methodology of project pool funds, and the NCACH Board has final approval of any funds allocated to partners directly from the ACH or through the Financial Executor. Broader input on funding allocation outside of the Board is facilitated through the NCACH workgroups. Workgroups, comprised of Board members and other partnering providers, are tasked with developing a process to allocate funding associated with the projects and to recommend partners who will receive funding related to the project the workgroup manages. That process is then presented to the NCACH Board for final review and approval. Funding processes approved by the Board must outline the initial funding for each workgroup; the NCACH partners needed to implement projects; and the anticipated funds that the project will need over the course of the Demonstration to scale and sustain projects. Annually, project specific funding will be reviewed by each workgroup and the Board to make necessary adjustments over time. A more detailed budget specific to project funding will be submitted when the full project implementation plans are due in quarter 3 of 2018. The following workgroups will recommend their project specific budgets to the Board and follow the budget process outlined below throughout the course of the Demonstration

Workgroups and budgets:

- Transitional Care and Diversion Intervention Workgroup: Budget for 2C Transitional Care and 2D Diversion Intervention Projects
- Whole Person Care Steering Committee: Budget for 2A Bi-Directional Integration and 3D Diversion Intervention Projects
- Pathways Hub Workgroup: Budget for 2B Community Based Care Coordination Project
- Regional Opioid Workgroup: Budget for 3A Opioid Crisis Project

Budget approval process:

1. NCACH Board develops general budget/funds flow figures, guidelines, and policies for each workgroup to follow for their project specific budgets

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2. Workgroups review the projects assigned to their workgroup and develop a budget/funds flow process (in alignment with the Board guidelines) that will support the project implementation plans the workgroup develops.
3. Governing Board revises as necessary and approves workgroup recommended budgets/funds flow process.
4. Workgroup initiates approved project funds flow process with implementation partners, reviews initial partner plans, and submits initial implementation plans and funding recommendations to Board
5. Board approves initial implementation plans and funding for projects.
6. Workgroup monitors progress of implementation partners and continues to go through steps 4 and 5 throughout the course of the demonstration as projects are scaled and sustained.

NCACH staff will be involved in this through two methods:

1. A global budget will be maintained by the NCACH program manager in conjunction with the Governing Board (Final approval of all budgets are at the Board level). Each month the overall budget for the Demonstration will be shared with the Governing Board by staff and any changes that need to be made by the Board will be reflected on the Budget.
2. Project specific staff (i.e. Regional Opioid Workgroup lead) will work with workgroup members to review projects and develop a recommended implementation plan and budget. Changes to the budget will be rolled into the overall ACH budget managed by the Program Manager and NCACH Governing Board. NCACH project staff will continue to work with the Program Manager over the course of the Demonstration to refine the budget details for approval by both the Governing Board and the workgroups.

The Whole Person Care Collaborative (WPCC) stage one funding document is a key example of this process. The WPCC, a collaborative including primary care and behavioral health providers, developed a process during May – September 2017 outlining how its members can engage and receive funding through the Demonstration. This process was refined in the WPCC and presented to the Board for final approval. Since workgroup members have a vested financial interest in the decisions made, all workgroup members are expected to comply with the conflict of interest policy adopted by the NCACH Board.

Moving into the distribution of funding, partnering providers who receive funding through the Demonstration will sign agreements with the ACH and Financial Executor describing the terms and conditions of earned funds. We expect there to be three types of funding for participating partners: initial capacity building funding to support partners in initiating Demonstration projects, payments for completion of milestones/process measures, and payment for partners' ability to assist NCACH in moving the Demonstration metrics (exact details to be determined in 2018). As stated above, processes for how partnering providers are able to receive funds will be recommended by the established NCACH workgroups that oversee each project, but final approval and release of any funding will be at the discretion of the Board.

Describe the ACH process for ensuring stewardship and transparency of DSRIP funds (Project Design funds, Project Incentive funds, Managed Care Integration Incentive funds, and VBP Incentive funds) over the course of the Demonstration.

NCACH does not treat funds differently based on the direct source of Demonstration funding (e.g., Project Design Funds vs. Value Based Payment (VBP) Incentive funds). Therefore, stewardship and

transparency of every category of funds over the Demonstration will follow the same principles and policies of the NCACH. To ensure stewardship of funds, it is NCACH's firm policy to not fund direct service costs, or other project activities that are not sustainable beyond the Demonstration period. Startup costs will exist in some projects – for example, the initial purchase of information technology infrastructure and software for the Pathways Community HUB - but no such investments will be made until a practical sustainability plan, with commitments from funders, is developed. For clinical transformation efforts funded through the WPCC, one of the requirements for change plans is a clear plan for sustainability. Implementation awards for provider change plans will not be made in the absence of such sustainability plans. Plans must demonstrate how the proposed changes will position the provider organization to provide integrated whole person care under new payment approaches such as value-based payments (VBP) after 2023. The same emphasis on sustainability will occur in planning other projects of the Demonstration and will also include the social service providers NCACH directly funds under the Demonstration. Sustainability is a core value of NCACH in all Demonstration strategies. Transparency of funding will be addressed through open Board meetings. The NCACH Board has the final approval of all Demonstration funds that are distributed by NCACH. No funding decisions will be made outside of open Board meetings, with meeting minutes published on the NCACH webpage and distributed to community partners.

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

To better align Medicaid funding with the work of the Demonstration, NCACH leadership holds monthly meetings with the three managed care organizations (MCOs) who will be operating in every county of our region beginning January 1st, 2018. At these meetings, MCOs and NCACH directly address topics such as shared savings, Value-Based Payment (VBP), and the alignment of selected projects with VBP. NCACH also is working with Sue Dietz from the National Rural Accountable Care Consortium to ensure provider organizations are able to align the work they complete in the Demonstration with the metrics they are held accountable for in Medicare. This will allow providers to receive a greater return-on-investment on every change they make to their practices.

Through the Fully Integrated Managed Care (FIMC) process, NCACH identified a large gap in the number of mental health crisis stabilization beds in the region. Though no formal funding has been allocated, NCACH continues to hold conversations with local providers and state officials (e.g., Board member State Senator Judy Warnick) to advocate for funding in the state budget that could be used to enhance current facilities to accommodate crisis beds in our region. Access to these beds would greatly increase the ability for NCACH to address projects such as Bi-Directional Integration and Diversion Interventions.

Three North Central counties (Chelan, Douglas, and Grant) are currently working towards FIMC starting January 1, 2018. During this process, NCACH has worked closely with the HCA, North Central Washington Behavioral Health Organization (NCWBHO), and the local behavioral health providers to ensure the FIMC process is aligned with the additional work and requirements we expect providers to complete during the Demonstration. This includes a collaborative partnership and weekly communications between NCACH, NCBHO, and HCA. This partnership will help NCWBHO spend down their Medicaid and non-Medicaid reserve and other balances in a way that will assist providers in being successful in the Demonstration.

NCACH's in-kind support will continue throughout the Demonstration and will include support such

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as:

- **Financial:** In partnership with Chelan-Douglas Health District Administrator Barry Kling, and the WPCC, NCACH staff will continue to refine a draft funds flow model to support the process of distributing funds to partners.
- **Community Engagement:** The initial successes of Coalitions for Health Improvement (CHIs) have been attributed to dynamic volunteer leadership established within each of the three CHIs to recruit members, develop meeting materials, and provide strategic direction.
- **Outreach:** To allow for Board meetings in every county of the region, community partners donated meeting spaces at locations such as Samaritan Hospital, Pateros Fire Hall, Okanogan Behavioral Health Care, and Moses Lake Community Health.
- **Health Equity:** To better reach Hispanic Medicaid beneficiaries, NCACH has received in-kind translation services from community partners who are fluent in Spanish and English.
- **Governance:** NCACH Board dedicated time developing our strategic plan at quarterly Board retreats. Beyond the work of the Board, other local leaders have donated time on the VBP Taskforce (John Doyle, Confluence Health), and local opioid workgroups (Steve Clem, Douglas County Prosecutor).

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

N/A

Project Design Funds

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

As the NCACH State Innovation Model (SIM) project has strongly aligned with the Demonstration, current SIM funding has been able to cover a majority of startup costs for NCACH. Moving forward, Project Design funds will be used in Demonstration year 2 - 5 to support project management, community and stakeholder engagement, and data analytics for the six selected projects. NCACH will utilize 65% of Phase II Design funds to support those three aspects of the project through NCACH staff and contractors. NCACH believes that each project can be supported with 0.5 FTE and/or equivalent contractors and has developed a staffing matrix to support that structure. Contractors will be used to provide subject matter expertise around Demonstration specific functions (e.g., provider learning collaborative, data, funds flow). To maintain sound human resource and financial management practices, NCACH contracts with Chelan-Douglas Health District (CDHD) and allots 13% of Design funds for that contract.

NCACH understands that we need to continue enhancing internal and contracted analytical capacity to enable successful project planning and implementation through data collection, analysis, and monitoring. To support this process, NCACH hired staff at the end of July 2017 to build our internal data capacity. Through a contract with Center for Outcomes Research and Education (CORE), a not-for-profit health policy research center committed to improving community health that has been involved in several projects to date that directly support ACH strategic and analytic need, NCACH gained additional resources for accessing and analyzing data. Our approach is to analyze and summarize available data, including descriptive data (prevalence and rate disparities for specific Medicaid sub-populations and for specific conditions/risk factors) as well as available outcome data (performance metrics from dashboard and comparisons to state averages and national benchmarks).

NCACH has also utilized Design funds to contract with the Centre for Collaboration, Motivation and Innovation (CCMI), a nationally recognized leader in change management, to initiate a learning collaborative for providers. The key objective of the learning collaborative is to provide a venue for partnering providers to learn from each other’s successes and obstacles in implementing the evidence-based approaches in the Demonstration toolkit that have been preliminarily selected by the region. This includes addressing how each provider plans to make implemented changes in their clinics sustainable after the Demonstration.

Finally, NCACH has utilized Design funds to enhance current contracts with the Coalitions for Health Improvement (CHIs), which are three local community coalitions that provide input into the Demonstration, to ensure data and Board decisions are shared publicly with community members and that the Board receives community feedback. These enhanced contracts will provide direct staffing to the three CHIs to better organize meetings, gather information for their members, and promote meaningful engagement of Medicaid beneficiaries. Furthermore, to ensure that community input is able to be synthesized into a regional perspective, NCACH hired another Program Development Specialist in November 2017 that will work directly with the CHIs and workgroups to infuse the community input received into all levels of NCACH governance (e.g., Board, workgroups).

NCACH has always held a firm belief that our organization should maximize the amount of Demonstration funds that go to our community partners. Therefore, NCACH estimates that 20% of Design funds will go directly to partnering providers to assist in the implementation of project plans.

Funds Flow Distribution

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

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

NCACH considers all funding that is earned through the Demonstration to be part of the overall NCACH budget allocated to partners assisting with Demonstration goals. Project pool funds, integration incentive funds, and any other funds that pass through the Financial Executor will be considered part of an overall budget that NCACH then allocates according to parameters set by the Board. NCACH does not set different standards for various funding streams. As NCACH finalizes the budgets for project implementation plans due in quarter 3 of 2018, the Board will look at the overall funds available to the region and determine how to allocate funding that will make the largest impact on the Demonstration metrics. Therefore, the following principles apply to all funds:

ACH Organization/Sub-Contractors: Only Design funding will directly go to the NCACH. However, throughout the course of the Demonstration, sub-contractors may be needed to enhance the work of our partners. Any funding allocated from the project pool funds (7% Demonstration year 1 & 2% overall project pool funds) or integration incentive funds that support ACH sub-contractors will go to those contractors through the Financial Executor. An example of a

contractor that will be paid through these funds is the Centre for Collaboration, Motivation, and Innovation (CCMI), which will work with the NCACH Whole Person Care Collaborative (WPCC) members to develop a learning collaborative of primary care and behavioral health provider organizations.

Partnering Provider Organizations: The majority of Demonstration funds (including project incentive funds), will be used to support partnering provider engagement, implementation, and performance (60% project pool funds for engagement and participation & 23% for performance).

- **Provider Engagement:** In 2018, NCACH will begin to distribute funding to our partners to assist in development of the initial capacity of organizations to engage in the Demonstration.
- **Implementation:** After initial funding is distributed, partners will receive money based on their ability to achieve the process measures their organizations are held accountable for in the project implementation plans.
- **Performance:** As the Demonstration moves to pay-for-performance funding, NCACH will develop a methodology to fund partners based on how they are able to move the pay-for-performance metrics. This could be a direct comparison of performance metrics (provider vs. NCACH), utilization of proxy measures, or alternative methodology. NCACH Board and workgroups are still refining this funds allocation methodology and plan to have a Board-adopted methodology by quarter 4 of 2018.

Providers Traditionally Reimbursed by Medicaid: The focus of this work is to improve how primary care and behavioral health outpatient services are integrated to provide better care. Therefore, the bulk of funding (53% of DY1 project pool funds) will go to traditional providers through the WPCC. Through the WPCC, providers will submit change plans and progress reports which will determine the level of funding they will receive throughout the Demonstration. The exact methodology for this funding distribution will be developed in quarter 1 of 2018. The WPCC does not include inpatient hospital facilities; hospital entities may receive funding directly through workgroups of other projects (e.g., Regional Opioid Stakeholders Workgroup, Transitional Care and Diversion Workgroup).

Funding for non-traditionally reimbursed Medicaid providers (15% of DY1 project pool funds) will be broken into two groups:

1. Social service organizations that will be direct partners in the selected Demonstration projects (e.g., correctional facilities, care coordination agencies); and,
2. Social service organizations that are not direct partners in selected projects, but will have an impact on Demonstration outcomes (e.g., housing authority, transportation, other community-based organizations).

Social service agencies who receive funding through Demonstration projects will work through each NCACH workgroup to help define funding allocation methodologies, specific to the projects that the workgroup will then recommend to the Board. NCACH is currently exploring how the Demonstration can help improve social service agencies that impact the health of Medicaid beneficiaries but will not be directly implementing projects from any of the selected project (e.g.,

housing services, transportation). NCACH will form a focus group of social service providers in quarter 1 of 2018. This focus group will explore options on how social service organizations can participate and directly receive funding in the work of the Demonstration. A key principle to communicate to these groups is that any funding should support changes that will be sustainable in the future.

Tribal/ITU: Tribal members are considered direct partners in the Demonstration efforts and currently direct funding (2% of DY1 project pool funding) for our tribal community is associated with the Indian Health Services involvement in the WPCC. We have not yet defined how tribal partners will receive funding through the other projects (Care Coordination, Transitional Care, and Diversion Interventions), but tribal organizations that partner in those specific projects will be considered eligible for funding if they become a direct partner in project implementation. It is important to also note that some agencies that directly provide services to the tribal community but are not tribal entities will receive funding through the Demonstration.

Health System and Community Capacity Building: NCACH anticipates that it will use approximately 15% of Demonstration funding for Domain 1 activities that will directly impact the selected projects. Specifically, NCACH had conversations with local hospitals at the September 2017 Regional Hospital Council meeting about developing a regional electronic health records (EHR) system or HIE/HIT product that could help improve interoperability of all providers in the region. In fact, our Board approved a charter in November 2017 for an HIT/HIE workgroup which will be tasked with regional planning activities that promote a robust IT infrastructure facilitating integration and care coordination goals of our selected projects. NCACH is also reviewing the opportunity to develop a regional approach to Value-Based Payment (VBP) and is planning to form a workgroup (with consultants) in quarter 1 of 2018 to assist providers in developing a regional VBP strategy. Workforce strategies will be heavily focused at the state level, however local investments (e.g., community health worker trainings), may need to be developed at community colleges with initial funds to get the program started. This will be better refined as we develop our project implementation plans during quarter 2 of 2018.

Other Use Category: Finally, NCACH is unable to foresee all Demonstration costs and earnings. Therefore, NCACH will keep a portion of earned funds (22% of DY1 project pool funds) in a “reserve budget allocation” that can be utilized for unexpected costs for projects or any shortfalls that may occur in the future. If there are no shortfalls that are identified through the initial years of the Demonstration, NCACH will evaluate other potential options to utilize this funding allocation. This funding will likely roll into partnering provider engagement and performance funds.

- Using the **Funds Distribution tabs** of the **ACH Project Plan Supplemental Data Workbook**:
 - **Funds Distribution – 1:** Provide the projected percent funding of the Project Incentive funds by use category over the course of the demonstration (DY 1 through DY 5 combined). “Project Management and Administration,” “Provider Engagement, Participation and Implementation,” “Provider Performance and Quality Incentive Payments,” and “Health Systems and Community Capacity Building” are use categories that are fixed in the workbook. ACHs may enter

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additional use categories. For each use category (fixed and additional), ACHs must provide a definition and the projected percentage of Project Incentive funds over the course of the demonstration.

- **Funds Distribution – 2:** Provide the projected percent funding of the Project Incentive funds by/for organization type for DY 1. “ACH Organization/Sub-contractors” and four “Partnering Provider Organizations” types are fixed in the workbook. ACHs must define “Other” organizations if the organization type is used. For each organization type, ACHs must provide a projected percentage of Project Incentive funds for DY 1.
- Attest to whether all counties in the corresponding Regional Service Areas (RSAs) have submitted a binding letter of intent (LOI) to integrate physical and behavioral health managed care.

YES	NO
X	

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

YES	NO
	X

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

DATE (month, year)

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

DATE (month, year)

Chelan, Douglas, & Grant Counties – January 1st, 2018
 Okanogan County – January 1, 2019

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

(The Managed Care Integration Incentives are intended to assist providers and the region with the process of transitioning to integrated managed care. This could include using funds to assist with the uptake of new billing systems or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with managed care business processes. County governments are one example of a potential partnering provider that could

receive earned integration incentives, but integration incentives are dispersed by the financial executor, according to an allocation approach defined by the ACHs. Include use categories defined by the ACH for planned funds distribution).

As stated above, NCACH considers all funding earned through the Demonstration as part of an overall budget to be allocated to contractors and partners who are assisting NCACH in achieving the goals of the Demonstration. Therefore, project pool funds, integration incentive funds, and any other funds that pass through the Financial Executor will be considered part of an overall budget that NCACH spends according to budget parameters and priorities.

Integration incentive funding will be distributed to partners based on the overall funding principle outlined above. Behavioral health providers are directly tied into determining how funding is allocated through their sector representation on the Board; involvement in the Whole Person Care Collaborative (WPCC); and representation on each workgroup. Specific to the WPCC, behavioral health providers will submit independent change plans for their organizations that will help their organizations better adapt to Fully-Integrated Managed Care (FIMC), prepare them for value-based payments (VBP), and complete the integration work needed to better care for their patients. These change plans could include investments to current electronic health records (EHR) systems, consultants to help behavioral health providers move towards VBP with MCOs, or assist in integration of primary care and behavioral health between different organizations. In addition, NCACH will utilize funding to enhance interoperability between EHRs of behavioral health and physical health providers. This will allow for better communication between each provider and ensure true integration can occur between organizations.

County governments are directly tied into determining how funding is allocated through their direct seat on the Board and with representatives on each workgroup. Direct funding for county governments will go to support departments that are directly involved in the Demonstration projects (e.g., courts, regional justice centers). To ensure that elected officials who are not directly involved in the NCACH stay informed in how funding is spent, NCACH staff attend monthly meetings of the Behavioral Health Organization (BHO) to provide updates to elected officials on the NCWBHO Board which includes county commissioners from Chelan, Douglas, and Grant counties. NCACH has worked closely with this group to move those three counties to Fully-Integrated Managed Care by January 1st, 2018. In October 2017, Okanogan County commissioners voted to become mid-adopters on January 1, 2019. Therefore, these discussions will occur in greater detail as we prepare Okanogan County for Fully-Integrated Managed Care.

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

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

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

Domain 1 Strategies

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

Domain 1 activities create a foundation for the successful implementation and sustainability of NCACH's six selected Demonstration projects. Without that foundation, projects will dissolve due to loss of funding, inability to hire workforce to meet the skill requirements of projects, and inability to coordinate and communicate care plans between providers. NCACH is approaching capacity building in the three focus areas of Domain 1 in the following ways:

Value-Based Payments: Sustainability of each project within the Demonstration will be successful if providers are able to align the clinical and community changes in each project with value-based payments. For example, NCACH will develop a sustainable model for paying for the completion of pathways through the Pathways Community HUB model. NCACH is currently discussing with our managed care organization (MCO) partners what pathways Medicaid will pay for and what steps will need to be taken with each MCO to ensure commitments to pay for those pathways. Specific to clinical providers, if contracts move towards value versus volume, providers will have the flexibility to utilize funding to provide quality care. This is most evident in rural health clinic settings. Current regulations at these clinics do not allow organizations to get reimbursed for the work that is completed by pharmacists who review medication as part of the primary care team. Therefore, although value-based payment (VBP) saves money and improves patient care, these clinics must absorb the staffing cost associated with transitioning to VBP. Clinics who cannot afford additional expenses are unable to provide this quality care to their patients. To support this work, NCACH will convene a VBP workgroup in quarter 1 of 2018. The primary role of this workgroup will be to educate providers on what resources are available for them to transition to VBP contracts and develop a regional strategy by quarter 3 of 2018 that will align with the work of the Demonstration.

Workforce Development: Each Demonstration project will require a different set of unique workforce needs. As we change the delivery system to provide integrated, whole person care, we will shift from the need for staffing for a more acute setting to a less intensive outpatient setting. This change will create new employment opportunities such as behavioral health practitioners in primary care or physical health providers in community behavioral health. NCACH plans to work with community colleges and providers in quarter 1 of 2018 to explore programs and training we can bring to our local community and how providers might use current preceptorships in behavioral health and physical health to attract more providers to the NCACH region.

Population Health Management: NCACH believes that interoperability is a key to achieving bi-directional integration. Interoperable systems allow all behavioral health providers, physical health providers, and community-based care coordinators to share information in an efficient manner that will ensure care is not duplicated, and that each provider has the information needed to make good medical decisions for patients. Therefore, NCACH believes it must invest in a system that can connect all provider types to the information they need. NCACH held initial discussions with the North Central Hospital Council in September 2017 to determine the possibility of a regional electronic health records (EHR) system or whether we will need to develop a Health Information Exchange (HIE) platform to connect each provider's different EHR systems.

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

Specific to Domain 1 activities, NCACH is moving forward with three major initiatives and infrastructure investments within those initiatives that will spread across the six selected projects in Domains 2 and 3:

1. **Whole Person Care Collaborative (WPCC):** This collaborative includes primary care and behavioral healthcare providers. Through the WPCC Learning Community, managed by consulting partners from the Centre for Collaboration Innovation, and Motivation (CCMI) and NCACH, we will work with local providers to create a structure of shared best practices, data, and tools that each provider can leverage to improve the care and quality of services across the region. Another major investment that NCACH is reviewing with the WPCC is a region wide 24/7 nurse call line to assist in reducing unnecessary emergency department (ED) visits.
2. **VBP Workgroup:** NCACH will establish a Value-Based Payments (VBP) workgroup in quarter 1 of 2018 to work with financial experts from each provider organization. This workgroup will identify where our region can work together with the Managed Care Organizations (MCOs) to align with the Demonstration projects, assist providers in meeting the quality goals outlined in VBP contracts, and develop a plan to make project work sustainable after the 5 years of funding ends.
3. **HIT/HIE Workgroup:** NCACH is establishing a Health Information Technology/Health Information Exchange (HIT/HIE) workgroup in quarter 1 of 2018 that will determine how our region will align with the statewide HIT/HIE initiative and what regional work can be done to ensure direct interoperability between all providers. This will include reviewing the possibility of a regional EHR system and working with the Pathways HUB software vendor, Care Coordination Systems (CCS), to ensure it can integrate with systems used by medical providers.

Value-based Payment Strategies

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

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

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

NCACH had 18 facilities (78%) in our region complete the Value-Based Payment (VBP) survey. NCACH assisted in the process through the following mechanisms:

1. Updates to complete the survey at the monthly Whole Person Care Collaborative meetings (WPCC);
2. Emails directly to provider organization executives in the region; and,
3. A list provided to HCA of provider contacts for further follow up.

When the deadline was extended, NCACH made an additional push to ensure strong participation from the medical facilities in our region. NCACH's strong partnership with the medical facilities in our community was the primary driver for the strong representation from our region in the VBP survey.

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

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

In NCACH, the largest Medicaid providers (Federally Qualified Health Centers and major hospital systems) have a portion of their reimbursement connected with VBP contracts through the MCOs. However, a majority of our providers (63%) are Critical Access Hospitals and behavioral health organizations that do not have VBP contracts. The survey findings are consistent with the general understanding of how care is delivered in the region. A primary example of this are the Critical Access Hospitals in our region. These organizations provide a necessary function in our communities, but maintain very low patient volumes throughout the year. Therefore, it is difficult in the current system for these providers to absorb risk in VBP contracts for patient care. This group will require additional support to determine how they can move their contracting to be aligned with the VBP goals of the state. NCACH will work with these providers through our regional VBP workgroup to determine what changes they can make to their business model to best align with the new contracting requirements.

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

In NCACH, the survey outlined that three facilities will maintain their current VBP contracts, eight facilities will increase by 10%, three facilities will increase between 10%-24%, two facilities will increase between 25%-50%; and one facility plans to increase more than 50%. For NCACH behavioral health providers, 2018 will be a transition year as they move into Fully-Integrated Managed Care (FIMC). This integration will require MCOs and providers to spend time in the next 12 months to gain an understanding of each organization's processes and services that will help both sectors to develop VBP contracts in future years. Primary care providers who are able to absorb the risk of VBP contracting have a higher likelihood to move to more VBP contracts in 2018, but those who have small Medicaid populations and are less financially stable will have to spend additional time

reviewing contract parameters before they are able to take on risks in VBP arrangements.

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

Reviewing the Value-Based Payment Survey for NCACH, providers indicated that the major barrier to achieving VBP targets is their ability to obtain data in a timely fashion. Specifically, three of the top four barriers focus on the need to have strong data management and interoperability:

1. Lack of availability of timely patient/population cost data to assist with financial management;
2. Lack of interoperable data system;
3. Lack of access to comprehensive data on patient (i.e. demographics, morbidity data); and,
4. Misaligned incentives or contract requirements.

Providers stated that the main drivers that enable them to move towards VBP are focused on aligning strategies and creating trust between the agencies involved in this work. Specifically, providers called out the following enablers towards VBP attainment:

1. Trusted partnership and collaboration with payers;
2. Aligned incentives and/or contract requirements;
3. Sufficient patient volume by payer to take on clinical risk; and,
4. State-based initiatives (e.g., State Innovation Model grant, Healthier Washington; Medicaid Transformation Demonstration).

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

To ensure each project assists NCACH in moving towards statewide Value-Based Payment (VBP) targets, NCACH will make changes that are not only in alignment with the Demonstration, but also in alignment with the contracting and quality metrics of all payment sources (Medicaid, Medicare, and commercial insurance). Aligning payment sources will ensure providers focus on quality metrics tracked for every patient, not just Medicaid beneficiaries. NCACH is planning to form a regional VBP workgroup in quarter 1 of 2018 to help providers in this region come into alignment. If NCACH were to focus on Medicaid alone, we would be doing our providers a disservice by minimizing the quality of care and reimbursement of care to a smaller population.

To ensure project plans are in alignment with VBP, NCACH meets monthly with its MCO partners to discuss how the Demonstration work can align with the performance measures and VBP contracting goals set by the Health Care Authority (HCA) to the MCOs. This venue allows ACH leadership to discuss with the MCOs how the move towards value-based payments can support the specific projects selected by NCACH. NCACH will also work with partners to explore the Healthier Washington's Rural Multi-Payer Payment Model and ensure VBP arrangements can also support our rural Critical Access Hospital partners.

NCACH's Whole Person Care Collaborative (WPCC), a workgroup of primary care and behavioral healthcare providers working with a national consultant in change management (the Centre for Collaboration, Motivation, and Innovation) will host a Learning Action Network (LAN) around VBP.

The VBP LAN will last between 3 and 6 months and will provide an opportunity for providers to learn from each other with a faculty expert guide on VBP. CCMI Faculty will host periodic webcasts featuring new content and sharing what each team is learning. The CCMI portal will also provide educational resources and best practices for NCACH providers to access when implementing VBP in their own clinics.

To maintain alignment with statewide partners, NCACH attends monthly calls of the Washington State Hospital Association (WSHA) to learn about the current projects WSHA is completing across the state and how it can align with the work of NCACH. To ensure alignment with the Rural providers in both Greater Columbia, Better Health Together, and NCACH, NCACH has met (Initial meeting Friday November 3rd) with ACH leads, local providers, and the Northwest Rural Health Network Executive Director to see how we can support our providers who serve Medicaid clients. Finally, NCACH stays current with local provider initiatives by attending meetings of the North Central Regional Hospital Council (held every other month). This meeting includes all hospitals in Chelan, Douglas, Grant, and Okanogan Counties.

To initiate this process, NCACH has made MCOs an integral part of NCACH's formation from the beginning, including holding a voting seat on the ACH Governing Board. Each MCO has a representative on each of our workgroups, and MCOs are active participants in all of NCACH's Coalitions for Health Improvement (CHIs). NCACH leadership holds monthly meetings with the three MCOs operating in our region as of January 1, 2018 to directly address topics such as shared savings and VBP. To ensure that we maintain consistency with Medicare and commercial insurance, NCACH works with providers through the Whole Person Care Collaborative (WPCC) to identify metrics our region needs to focus on in order to enable providers to gain financial incentives through all payment methods.

What will be the ACH's role in supporting providers in the transition to VBP arrangements? What are the preliminary considerations and strategies regarding alignment of VBP strategies in all projects?

NCACH's role is to educate, facilitate provider conversations, and align the work completed in the projects with the direction our region is going with Value-Based Payments (VBP). NCACH understands that contracting itself is proprietary; however, MCOs and providers will benefit if there is a regional focus on what specific services could be reimbursed under this new model. An example of this is the Pathways Coordination HUB which is a community-based care coordination system that helps providers connect their patients with the social services they need to better care for their health. NCACH will discuss how the designated Pathways will be paid for through VBP contracting. NCACH will also work with providers and MCOs to determine how we can collaborate on regional initiatives (e.g., 24/7 nurse call line) that may be shared by all providers.

Workforce Strategies

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

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

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

NCACH will complete an initial review of local workforce data, work with statewide workforce groups, and review the workforce needs of each Demonstration project in quarter 1 of 2018. After review of workforce data, NCACH will develop a regional workforce strategy that can be initiated in our region in quarter 2 and quarter 3 of 2018.

Data: Data will provide a key insight into specific workforce shortages in the region. NCACH has analyzed the Washington State Sentinel Network data. This data outlines the current workforce hiring gaps North Central Washington providers’ experience. For example, NCACH organizations have experienced exceptionally long job vacancy rates in the following occupations: nurses (42%), nursing assistants (25%), medical assistants (21%), and mental health counselors (17%).

In quarter 1 of 2018, NCACH will also review local workforce data points to identify key areas with primary care and mental health shortages. With respect to mental health care access, eight clinics in NCACH have a score of 20 or higher (a score of 25 indicates the highest level of need). Five of the clinics are in Grant County, two are in Okanogan County and one is in Chelan County

Statewide Taskforces/Workgroup: NCACH has worked directly with statewide workforce groups. In October 2017, NCACH initiated discussions with Suzanne Swadener (HCA) and Nova Gattman (Legislative Director, Workforce Training and Education Coordinating Board) to understand the current status of the behavioral health workforce project team recommendations. Through this connection, NCACH has reviewed the Statewide Behavioral Health Workforce project team’s recommendations (<http://www.wtb.wa.gov/Documents/BehavioralHealthWorkforceAnalysis-Phase12016.pdf>). Key elements of the Statewide Behavioral Health Workforce recommendations include a section to promote team-based and integrated (behavioral and physical health) care and to increase diversity in the behavioral health workforce (including health literacy). As NCACH analyzes these recommendations and best practices, we will implement them into the project planning at a local level.

NCACH understands that HCA will convene the ACHs to develop a statewide workforce group in quarter 4 of 2017 and NCACH plans to have representation on that group.

NCACH also connected with Dan Ferguson (Director of the Washington State Allied Health Center of Excellence) in October 2017 to further discuss how community colleges might assist in this work. Mr. Ferguson provides a statewide perspective of how community colleges can work with their local ACHs. He also connected NCACH with the key educational partners in our local communities who will work with NCACH to address how education can assist in narrowing the shortfalls in the

healthcare workforce. NCACH plans to gain a better understanding of how the statewide taskforce can support the regional needs, and will initiate contact with local education stakeholders in quarter 1 and 2 of 2018 to assist in developing a regional workforce strategic plan.

Demonstration Project Workforce Needs: NCACH will use the evidence-based approaches in the six selected projects to identify local workforce gaps needing to be addressed for the projects to be successful. A primary example of this is the Pathways Community HUB. Through the Pathways Community HUB, NCACH will be able to evaluate the current state of care coordination in the area and where additional training is needed for new care coordinators and retraining for existing care coordinators.

NCACH plans to take recommendations developed at the state level, review data locally, determine Demonstration project workforce needs, and develop a more comprehensive workforce strategy in 2018. The initial plan will be to connect more fully with statewide resources in quarter 4 of 2017. After NCACH has a better understanding of what can be leveraged at the state level, in quarter 2 and quarter 3 of 2018, we will work with our local partners in education and healthcare to identify what statewide principles we can implement at a local level. Within the NCACH region, we will leverage a number of local resources to develop this comprehensive plan. Some examples include:

- The Whole Person Care Collaborative (WPCC) - NCACH is working with the Centre for Collaboration, Motivation, and Innovation to create a “Learning Community” structure where local partners can learn what each provider is doing to improve quality of care within their clinics, including addressing local workforce shortages. This collaborative will be launched by quarter 1 of 2018. A primary focus of the WPCC will be to move providers towards Patient Centered Medical Homes (PCMH). This model ensures that providers are moving towards team-based care through empanelment of providers, care teams and case management, and an enhancement of care coordination in the clinic. The move towards PCMH and whole patient care focuses on surrounding the patient with a team of providers from different expertise (including behavioral health providers).
- Charter Colleges and Community Colleges – NCACH will work with them in quarter 2 of 2018 to develop programs and training to address the workforce gaps in the region for: chemical dependency staff, medical assistance staff, community health workers, and nurses. Charter College and Community Colleges will help NCACH develop the training programs for these providers and will include key components of the statewide recommendations (team-based care, diversity, and health literacy)
- The Pathways Coordination HUB – This business opportunity will create an opportunity for training community health workers (CHW) who can help fill the gap that is currently being addressed by more highly skilled professions such as nurses and EMTs. The general guidelines around training community health workers includes ensuring that the CHW who provides the service has a strong understanding of the cultural needs (cultural competency) of its patient population and preferably is a current member of the community they serve.
- The North Central Regional Hospital Council (a council of provider organization executives) provides a venue where NCACH can gain regional consensus from all major medical facilities on the workforce issues they want to address in the region. For example, a number of providers from this council have stated they would like to see the region enhance the use of preceptor programs for behavioral health specialists to encourage recruitment of new graduates into the region. This regional council will be able to help each local organization

develop the needed processes to provide training and recruitment efforts throughout the region. As part of those internal training processes, the North Central Regional Hospital Council can work with its members to include training around cultural competency, health literacy, and team-based care to the staff of their organizations.

- NCACH has had strong representation with the North Central Educational Service District (Serving Chelan, Douglas, Grant, and Okanogan) on the Governing Board. NCACH realizes that this venue will provide NCACH the ability to review what potential programs could increase health literacy within our school aged youth and their parents.

Population Health Management Systems

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

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

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

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

One of NCACH’s key strategies is to target Demonstration funds to support changes in systems and processes that can lay the groundwork for long-term sustainability. Many of Washington State’s Medicaid Demonstration projects are ultimately about improving linkages between systems to promote more effective coordination and holistic care. As we think about capacity building investments to accelerate this kind of system transformation, NCACH plans on investing in Health Information Exchange/Health Information Technology (HIE/HIT). Tackling information exchange and data sharing needs at the outset will support the goals of our six Demonstration projects, especially with respect to Bi-directional Integration, Care Coordination, and Transitional care.

We are well into this work and engaged in extensive technical discussions with the HCA, behavioral health care providers, our administrative service organization (Beacon), and MCOs through our Fully-Integrated Managed Care (FIMC) IT/EMR workgroup from April to December 2017. Outside experts from Xpio, an IT and technical assistance consultant, are providing technical assistance to our behavioral health partners as they continue to prepare for the January 1, 2018 FIMC transition. We will continue to engage these partners through our Early Warning System developed specifically

for NCACH during FIMC implementation, and through our Regional HIT/HIE Workgroup (explained below.)

As we move forward with our Care Coordination Project, a key question will involve the interoperability of IT systems tracking Pathways (e.g. Care Coordination Systems or some other platform) with other population health management systems. For our Transitional Care Project, we may find that local jails would benefit from implementing electronic health record (EHR) systems within their walls. As our Whole Person Care Collaborative (WPCC) members – primary and behavioral health care providers – take the lead on Bi-directional Integration and Chronic Disease Projects, they may decide that adopting a shared EHR platform would facilitate communication and better care coordination. In fact, local healthcare leaders are already exploring this opportunity in our region as a way to facilitate collaboration across our vast and rural region, and to avoid duplication of costly infrastructure.

Decisions have not yet been made, but these are the types of questions we expect all of our project workgroups and the WPCC to consider as they continue project planning. One of the first steps to creating a robust and interoperable HIT/HIE infrastructure is to identify whether providers critical to our projects would benefit from investments in their own EHRs. NCACH staff will ensure that HIT/HIE issues are fully addressed in our project implementation plans. We have the benefit of various resources as we explore these questions and as we lay the groundwork for a coordinated approach to these investments. Our WPCC members will have access to outside experts (e.g., CCMI and Qualis) who will help them address these issues in their change plans. And as local leaders continue to explore shared solutions, we have a great opportunity to build on this momentum and explore whether regional initiatives like the Medicaid Demonstration might assist and support efforts that are already underway.

NCACH staff have already reviewed the state’s HIT strategic roadmap; we plan on collaborating with the state and other ACHs on any shared platforms and investments. For example, there is a desire to make the most out of the statewide online database maintained by the Washington Information Network’s 2-1-1 (WIN 211) and its regional call centers (NCACH is part of Region 7). In terms of data governance specific to HIT/HIE and data integration, our staff will participate in cross-ACH and state HIT/HIE workgroups. Based on Board member recommendations, we also plan on recruiting technical experts and convening our own regional HIT/HIE Workgroup in quarter 1 of 2018, which will provide leadership and insight to inform regional planning and investments in quarter 1 of 2018 related to HIT/HIE. The charter for this workgroup was approved by the Board on November 6, 2017. A focus of the HIE/HIT Workgroup is to assess and catalyze HIT/HIE investments that are sustainable and useful beyond the life of the Medicaid Demonstration. Full assessments should be completed by quarter 4 of 2018 of current HIT/HIE systems that are being utilized by our participating partners and the Hit/HIE workgroup charter outlines the following deliverables that will be completed by the workgroup to assist our partners in moving towards better regional connectivity:

- Identify barriers, gaps, and needs related to data, information technology, information exchange, and interoperability
 - Participate in and review regional HIT/HIE infrastructure assessments in our region and identify opportunities for alignment with Washington State investments
 - Identify health system stakeholder needs for population health, social service, and social determinants of health data

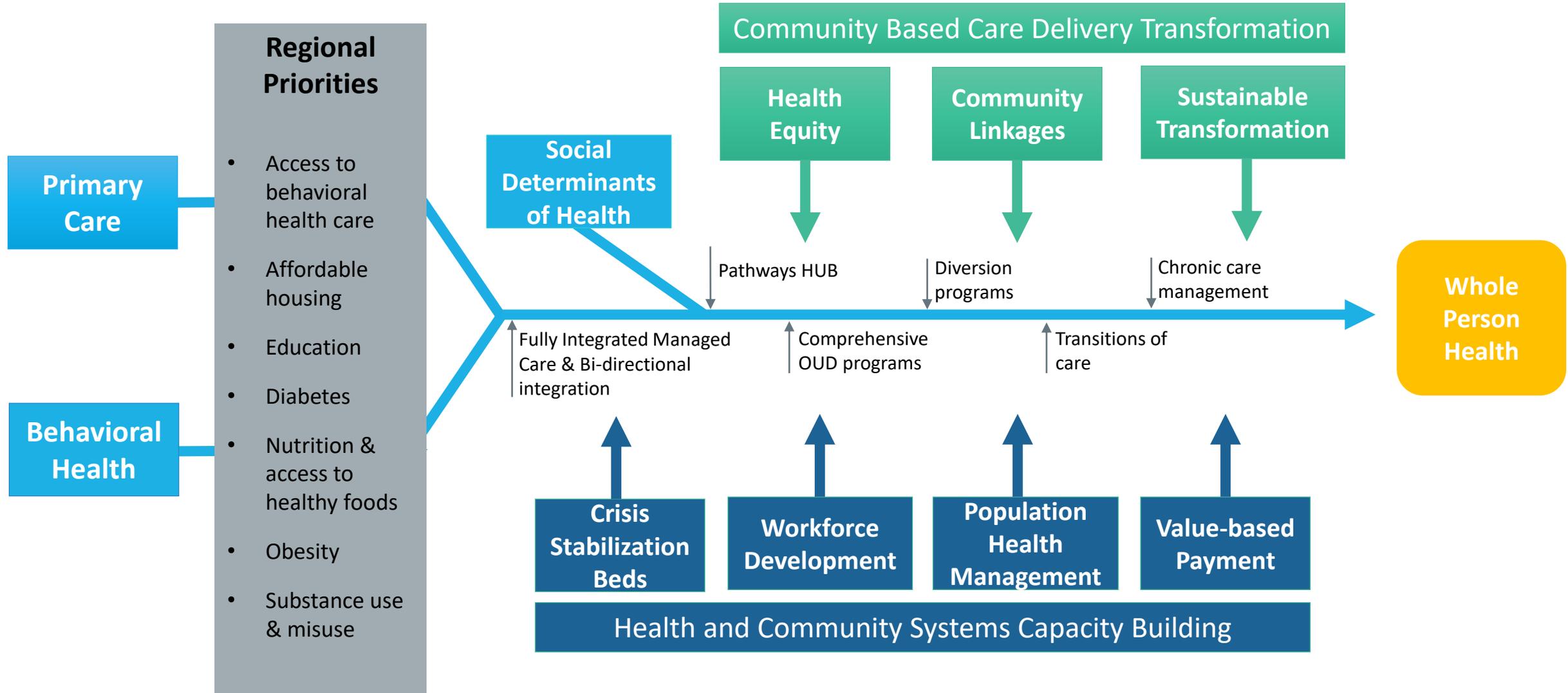
Section I – ACH Level

- Discuss provider requirements to effectively access and use population health data necessary to advance VBP and new care models
- Identify, review, and recommend potential solutions and articulate a regional HIT/HIE strategy that will provide a path for community-based, integrated care.
 - Identify potential Health IT solutions that could be leveraged through ACH projects to support Participating Provider organizations, (e.g. technologies needed to transition to VBP, One Health Port services including the CDR, EDIE/Pre-manage, Pathways, Prescription Drug Monitoring Programs (PDMP), telehealth, etc)
 - Identify feasible strategies and recommend capacity investments (whether leveraging existing technology, or investing in new systems) to improve systems for population health management that will support NCACH's Demonstration projects
 - Identify opportunities and needs for shared acquisition of HIT/HIE and other care coordination tools
 - Prioritize potential NCACH investment opportunities that will support integrated care and community-based care coordination in our region
- Review and provide input into Washington State Health Care Authority (HCA) plans focused on HIT/HIE investments
 - Provide collective feedback and recommendations to HCA with respect to investments and resources they are developing statewide (e.g. OneHealthPort, All Payer Claims Database)
 - Engage in periodic review and provide feedback on HCA's Health IT Operational Plan and Strategic Roadmap, as it evolves.

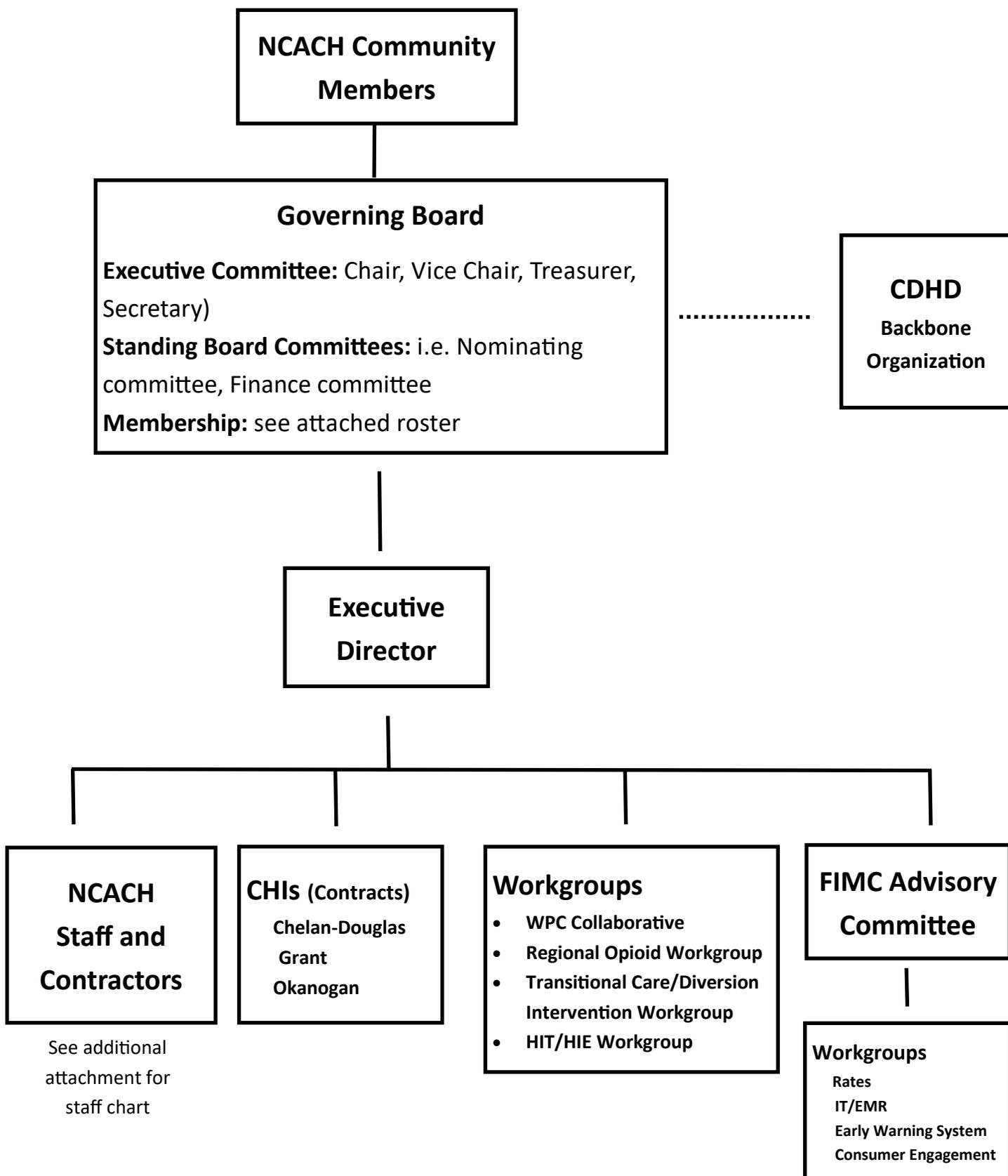
NCACH has already demonstrated our ability to engage technical assistance for our behavioral health providers through our Fully-Integrated Managed Care (FIMC) IT/EHR workgroup. NCACH worked with HCA to have Qualis Health, a current HCA contractor, complete an assessment of IT readiness for our behavioral health providers. This assessment further led to the recommendation for HCA to retain Xpio, an IT and technical assistance consultant, to provide technical assistance to our NCACH behavioral health partners as they prepare for the January 1, 2018 FIMC transition.

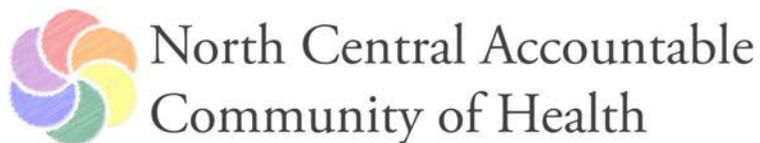
As much as possible, this workgroup will consider and align resources and efforts across multiple levels (e.g., providers, counties, NCACH, HCA). Generally, HIT/HIE Workgroup members will provide strategic advice and input into population health management systems required to implement Demonstration projects in the short-term and to promote continued health improvement and care coordination in the long-run. This involves assessing the availability of, use, and barriers to provider use of technology solutions and providing input and direction to build on and improve our current ACH-region's data infrastructure. This workgroup will also be charged with periodic review of and feedback on the HCA's Health IT Operational Plan and Strategic Roadmap as it evolves.

North Central ACH Path to Whole Person Health



NCACH Governance Structure





Health Information Technology and Health Information Exchange (HIT/HIE) Workgroup Charter

Background

Washington State's Medicaid Transformation Project Demonstration grant was approved by the federal Centers for Medicare & Medicaid Services (CMS) in January 2017. As part of this 5-year contract initiative, nine Accountable Communities of Health (ACHs) across the state are supporting health improvement projects in their region by bringing together leaders with a common interest in improving health and health equity. The North Central ACH region, which includes Chelan, Douglas, Grant and Okanogan counties, has selected 6 health improvement projects to plan and implement.

Planning and implementation of these projects involves infrastructure investments, including investments in information technology and population health management systems that will facilitate bi-directional communication and care coordination (a goal inherent to many of our projects).

Definitions

The following definitions linked to population health management systems are provided to ensure clarity and shared understanding within the workgroup:

- *Health Information Technology (HIT)*: The range of information technologies used to store, share, and analyze health information, including clinical and claims related data. Examples of HIT tools include, but are not limited to, electronic health/medical records, electronic prescribing, telehealth, and clinical data repositories.
- *Health Information Exchanges (HIE)*: The secure access and exchange of health information allowing providers, patients, and other participants to share patient information. Today's HIE context is focused on electronic tools allowing secure and efficient transfer of information to facilitate delivery system and payment transformation, care coordination, and improved health outcomes.
- *Interoperability*: The ability of two or more systems or components to **exchange** information and to **use** the information that has been exchanged. Health information exchange is a prerequisite for interoperability, but it is not sufficient by itself to achieve health information interoperability. The shared information must be useable by all parties involved.

While this workgroup will focus on HIT/HIE issues, it may also consider broader information technology and information exchange issues, especially where social service providers and other partnering providers are contributing to our Demonstration project goals.

Charge

The purpose of the HIT/HIE Workgroup is to provide leadership and insight to inform regional planning and investments related to Health Information Technology and Health Information Exchange. As much as possible, this workgroup will consider and align resources and efforts across multiple levels (i.e. providers, counties, NCACH, and statewide.) Generally, members will provide strategic advice and input into population health management systems required to implement Demonstration projects in the short-term, and to promote continued health improvement and care coordination in the long-run. This involves assessing the availability, use, and barriers to providers' use of technology solutions (identifying needs and gaps), and providing input and direction to build on and improve our current ACH-region's data infrastructure. A goal would be to catalyze HIT/HIE investments that are sustainable and useful beyond the life of the Medicaid Demonstration. This workgroup will re-evaluate its charge and deliverables on an annual basis and dissolve when all deliverables under their purview are met.

Composition

The HIT/HIE workgroup will consist of 10-15 members who have experience and knowledge of health information technology and health information exchange. This may include familiarity with:

- Health care quality and performance data metrics and reporting
- Familiarity with clinical workflows and point of care data needs
- Data sharing and governance
- Health data compliance issues
- Interoperability needs
- Value-based purchasing arrangements

Members will include representatives from Grant, Chelan, Douglas, and Okanogan Counties. The Governing Board will approve members, assuring representation from:

- Decision-makers from member organizations involved in the Whole Person Care Collaborative (WPCC)
- Management information services (MIS) and data officers from various health systems across the region, including primary care, behavioral health, and hospitals.
- Managed Care Organizations (Operating in all 4 NCACH counties after Jan. 1, 2018)
- Other providers involved in Demonstration Projects (e.g. IT staff from criminal justice, housing, and other social service sectors)
- Health Care Authority (HCA) representatives involved in statewide HIT/HIE efforts
- Other Data and health researchers or health policy specialists

Workgroup composition will likely evolve during the course of the Demonstration, as our region moves from planning to implementation.

Meetings

Meetings will be held once per month, with additional meetings scheduled to address emerging issues. Meetings will be held in Chelan, Douglas, Grant, and Okanogan Counties; locations will vary and an effort will be made to hold meetings in each of the Local Health Jurisdictions throughout the year. Whenever possible, meetings will have an option to participate via teleconference or audioconference for those unable to attend in person, although in-person participation is encouraged. NCACH program staff and the Workgroup Chair shall be responsible for setting agendas, facilitating meetings, and ensuring overall coordination with NCACH leadership and other workgroups. Notes for all meetings will be provided to the Workgroup by NCACH staff within two weeks of each meeting. Meeting minutes and materials will be posted on the NCACH website (www.ncach.org).

Member Responsibilities

- Workgroup members are required to comply with NCACH's conflicts of interest policy.
- Attend at least 75% of regular meetings of the Workgroup and actively participate in the work of the Workgroup.
- Sign a Membership Agreement (attachment A)
- Provide input into mechanisms required to meet reporting requirements of the Demonstration
- Serve as a forum for NCACH member organizations to develop a coherent strategy for organizing, governing, analyzing, and deploying health information
- Help advance the use of interoperable health IT and health information exchange across the care continuum in support of regional and statewide health system and payment priorities
- Facilitate information sharing and coordination among NCACH member organizations on data related matters, including data system requirements and standardization, and privacy and security issues
- Coordinate with other NCACH workgroups regarding issues of common interest

Anticipated Deliverables

An early deliverable for the HIT/HIE workgroup will be to develop a work plan with timelines for the following tasks, as well as any other tasks identified by the group.

- Identify barriers, gaps, and needs related to data, information technology, information exchange, and interoperability
 - Participate in and review regional HIT/HIE infrastructure assessments in our region and identify opportunities for alignment with Washington State investments
 - Identify health system stakeholder needs for population health, social service, and social determinants of health data
 - Discuss provider requirements to effectively access and use population health data necessary to advance VBP and new care models
- Identify, review, and recommend potential solutions and articulate a regional HIT/HIE strategy that will provide a path for community-based, integrated care.

- Identify potential Health IT solutions that could be leveraged through ACH projects to support Participating Provider organizations, (e.g. technologies needed to transition to VBP, One Health Port services including the CDR, EDIE/Pre-manage, Pathways, Prescription Drug Monitoring Programs (PDMP), telehealth, etc)
- Identify feasible strategies and recommend capacity investments (whether leveraging existing technology, or investing in new systems) to improve systems for population health management that will support NCACH's Demonstration projects
- Identify opportunities and needs for shared acquisition of HIT/HIE and other care coordination tools
- Prioritize potential NCACH investment opportunities that will support integrated care and community-based care coordination in our region
- Review and provide input into Washington State Health Care Authority (HCA) plans focused on HIT/HIE investments
 - Provide collective feedback and recommendations to HCA with respect to investments and resources they are developing statewide (e.g. OneHealthPort, All Payer Claims Database)
 - Engage in periodic review and provide feedback on HCA's Health IT Operational Plan and Strategic Roadmap, as it evolves.

Authority

The HIT/HIE Workgroup is an advisory body that will inform decision-making by the NCACH Governing Board and ensure regional priorities and local considerations are incorporated in planning and investment decisions. Activities, analysis, and recommendations developed by the Workgroup will be shared with the NCACH Governing Board on a regular basis and are subject to review and approval by the Board.

Evidence of Meaningful Participation by Community Members:

Attachments include the following

Project Selection Process March – April 2017:

In-person presentations were made available to individuals in the 3 Coalition for Health Improvements and the North Central Hospital Council meeting. Each area had a total of 2 presentations in-person where people could attend. A paper survey as well as an online survey monkey was provided for people interested in filling out the feedback form. Presentations were as follows:

- March 6th Wenatchee, WA (Chelan-Douglas CHI)
- March 8th Twisp, WA
- March 21st Brewster, WA (North Central Hospital Council)
- March 23rd Moses Lake, WA (Grant CHI)
- March 24th Omak, WA (Okanogan CHI)
- April 10th Moses Lake, WA (Grant CHI)
- April 13th Wenatchee, WA (Chelan-Douglas CHI, also available by webinar)

Attached: Summary document of outreach presented to the Governing Board.

North Central Accountable Community of Health Coalition for Health Improvement (CHI) Meetings:

- **Chelan-Douglas CHI Workgroup (Wenatchee, WA)**
Chelan Douglas CHI has spent 2 meetings (9.21.17 and 10.12.17) reviewing the data to better select target populations and providing input on the “preliminary target populations” that have been entered in the project plan application.
- **Grant County CHI Workgroup (Moses Lake, WA)**
Grant County CHI held a public webinar (10.10.17) to review the data for the 6 selected demonstration projects to better refine the target population. After that data was shared, an additional meeting (11.01.17) was held to gather additional feedback from local community members including family members of Medicaid beneficiaries
- **Okanogan CHI and Opioid Workgroup (Omak, WA)**
NCACH participates in this regional workgroup to help inform local community members and stakeholders of the Demonstration work and stay in alignment on their work on the Opioid Project. On 9.27.17, the Okanogan County CHI reviewed the data from the 6 selected demonstration projects to better refine the target population. This group includes partnering providers, law enforcement, and Medicaid beneficiaries.

Attached: Examples of feedback and materials provided and collected at meetings:

- *Chelan-Douglas CHI Meeting notes and feedback from Chelan-Douglas CHI meeting*
- *Presentation shared with Okanogan and Grant County CHIs*

Summary of Community Engagement Events in North Central.

- **Columbia Valley Community Health (CVCH) Back to School Fair (Wenatchee, WA) – August 5th, 2017**

An event in which K-12 school-aged children are provided backpacks and school supplies. In 2016, over 2,000 community members attended the event with 829 backpacks distributed. The Back to School Health Fair not only provides the necessary tools to aid in a student's success, but it also serves as platform to inform families and participants about the resources and programs available to them in our community to help them maintain a healthy and safe lifestyle. NCACH had success in surveying over 200 community members at this event and asked "what they thought the greatest health issue in their community is?"

- **The Confederated Tribes of the Colville Reservation POWWOW (Grand Coulee, WA) - September 15th, 2017**

The Confederated Tribes of the Colville Reservation in partnership with Grand Coulee Medical Center hosted a POWWOW and Health fair in Grand Coulee, WA. This event brought both individuals from the Colville Tribe and other local community members to learn more about tribal culture and the health resources they can access in the Grand Coulee area. NCACH surveyed Colville Tribal members and asked "what they thought the greatest health issue in their community is?"

- **North Central Washington Health and Wellness Expo (Moses Lake, WA) – September 30th, 2017**

An event in which greater than 1,000 community members attend. This event has health information for all residents of the North Central region including behavioral health services, Medicaid enrollment information, and other physical healthcare organizations attending and providing needed health information to community members. NCACH surveyed community members and asked "what they thought the greatest health issue in their community is?"

Attached: Summary sheets of each community outreach event shared with the Governing Board

North Central Consumer Engagement Forums

- Two regional Consumer Engagement forums that were held by the Washington State Department of Health. NCACH attended forums to gain a better understand of what concerns consumers had around fully integrated managed care (FIMC) and asked consumers to provide direct feedback on the major health issues they feel need to be addressed through the Demonstration. Dates and locations of the events were as follows:
 - July 13th, 2017 Wenatchee, WA
 - September 22nd, 2017 Moses Lake, WA

Attached: Flyers from both Consumer Engagement events

Medicaid Demonstration Project Selection Feedback Summary

Project Selection Outreach:

To gather continual survey results an online Survey Monkey was created with a recorded webinar presentation to gather feedback from all community partners. This survey was sent out to the 494 members on our partner list. We also encourage local partners to send the survey link to members of their partner lists that may not be part of the NC ACH.

In-Person presentations were made available to individuals in the 3 Coalition for Health Improvements and the North Central Hospital Council meeting. Each area had a total of 2 presentations in person where people could attend. A paper survey as well as a link to the survey monkey was provided for people interested in filling out the feedback form.

Presentations were as follows:

March 6 th	Wenatchee, WA (Chelan-Douglas CHI)
March 8 th	Twisp, WA
March 21 st	Brewster, WA (North Central Hospital Council)
March 23 rd	Moses Lake, WA (Grant CHI)
March 24 th	Omak, WA (Okanogan CHI)
April 10 th	Moses Lake, WA (Grant CHI)
April 13 th	Wenatchee, WA (Chelan-Douglas CHI, also available by webinar)

Feedback Received

The following items were received and available on the following pages.

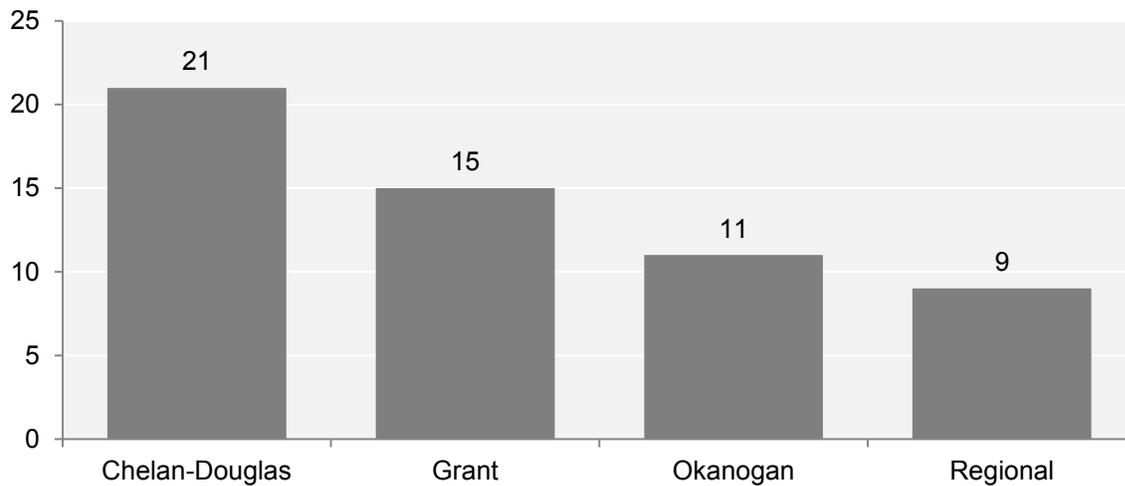
- Medicaid Demonstration Project Survey Summary (n=60)
- North Central Hospital Council endorsement of projects
- Grant County CHI roundtable report out
- Methow Valley Health Care Network response letter

Medicaid Demonstration Project Survey Summary

Number of Surveyed Individuals: 60

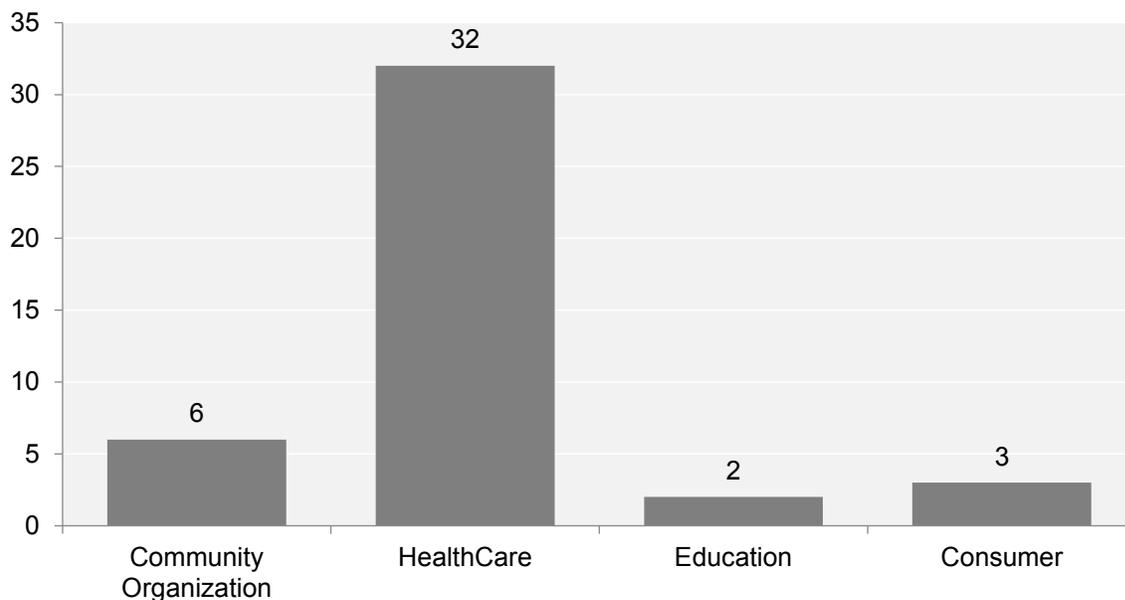
56 respondents (93%) identified what Coalition for Health Improvement they represented. Of responses: 38% where Chelan-Douglas, 27% where Grant, 20% were Okanogan, and 15% identified as regional partners.

Responses by Coalition for Health Improvement (CHI)



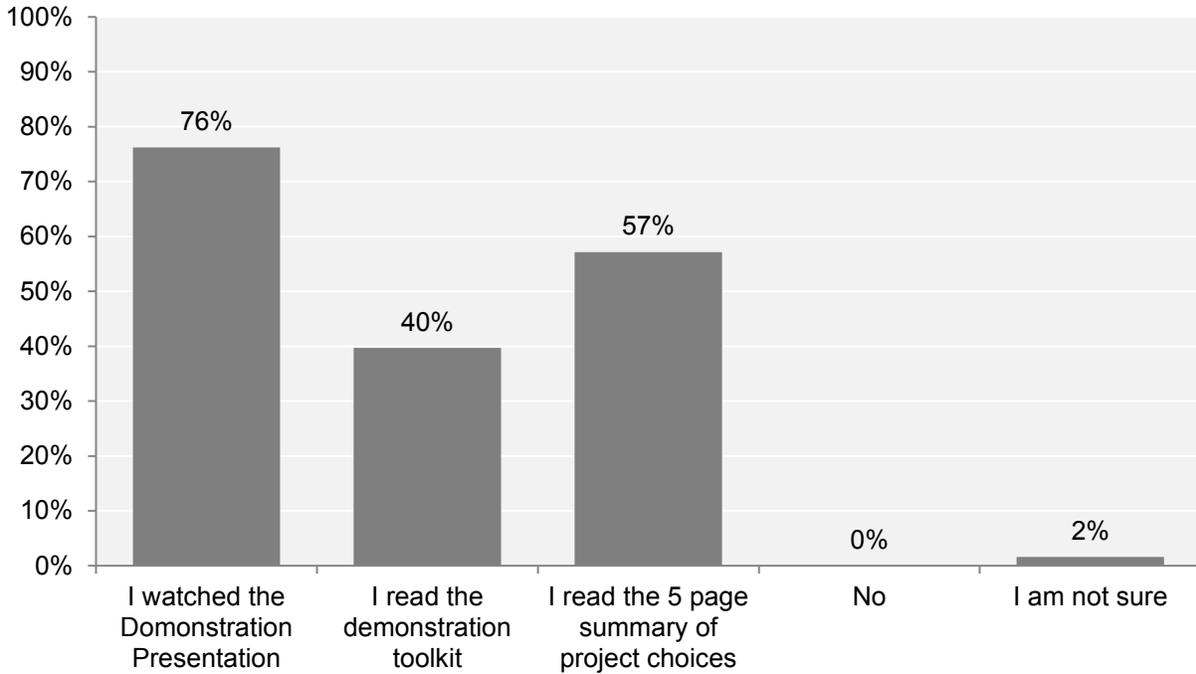
43 respondents (72%) identified what sector they represented. Of responses: 74% where Healthcare, and 26% identified as a representative outside of the Healthcare sector.

Responses by Sector Representation

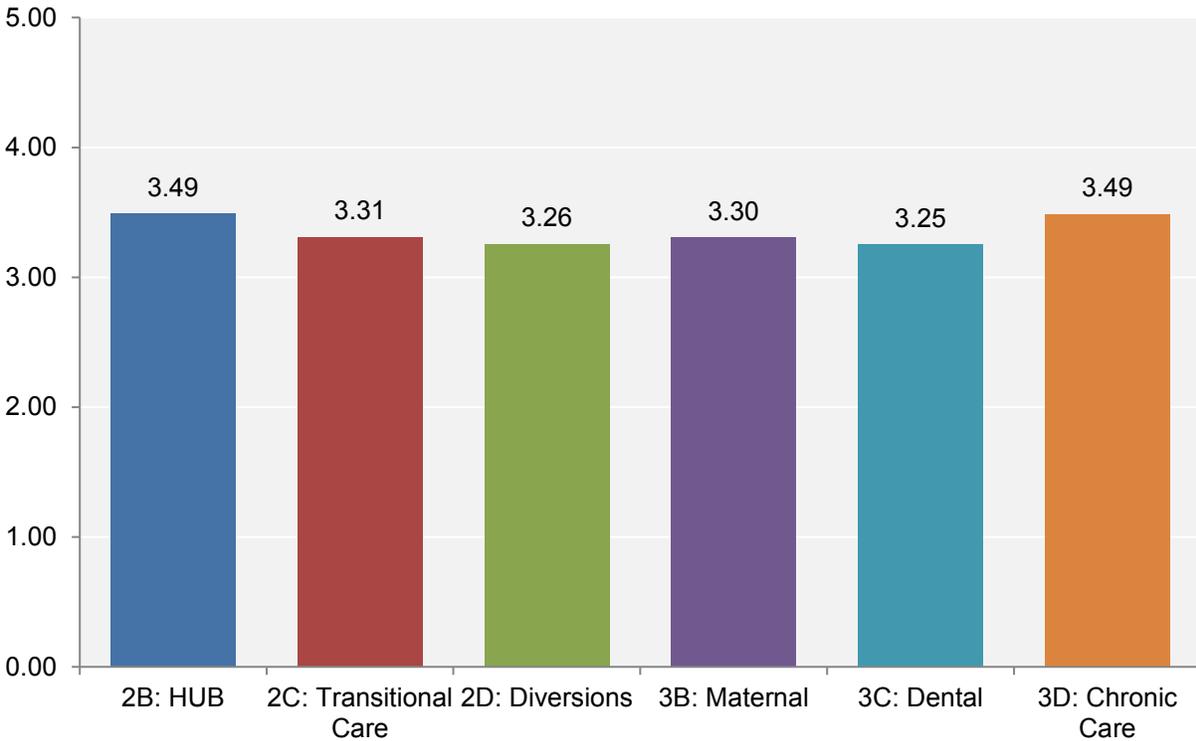


The table below demonstrates the level of basic knowledge respondents had about the Medicaid Demonstration project prior to completing the survey.

**Have you watched the demonstration presentation or read the demonstration toolkit or 5 page summary of project choices?
(n=60)**



Overall Project Score



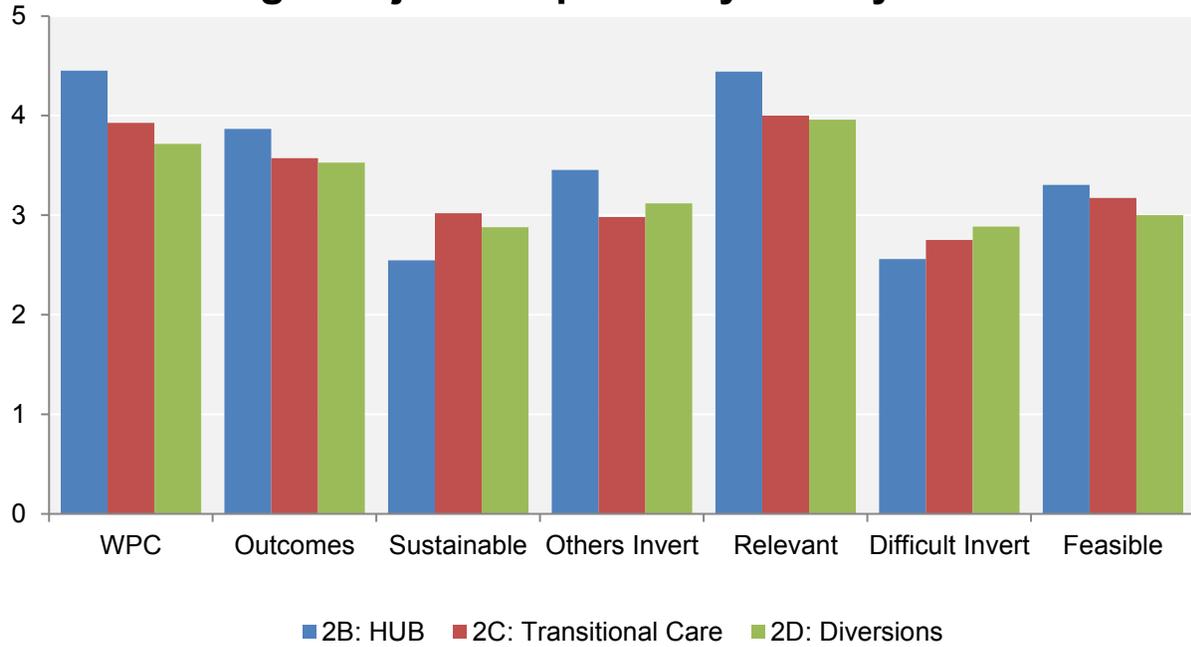
Overall project score is the average of the responses to all seven questions.

The below table is a key to correlate results for the Domain 2 and Domain 3 graphs on page #4 to the survey questions:

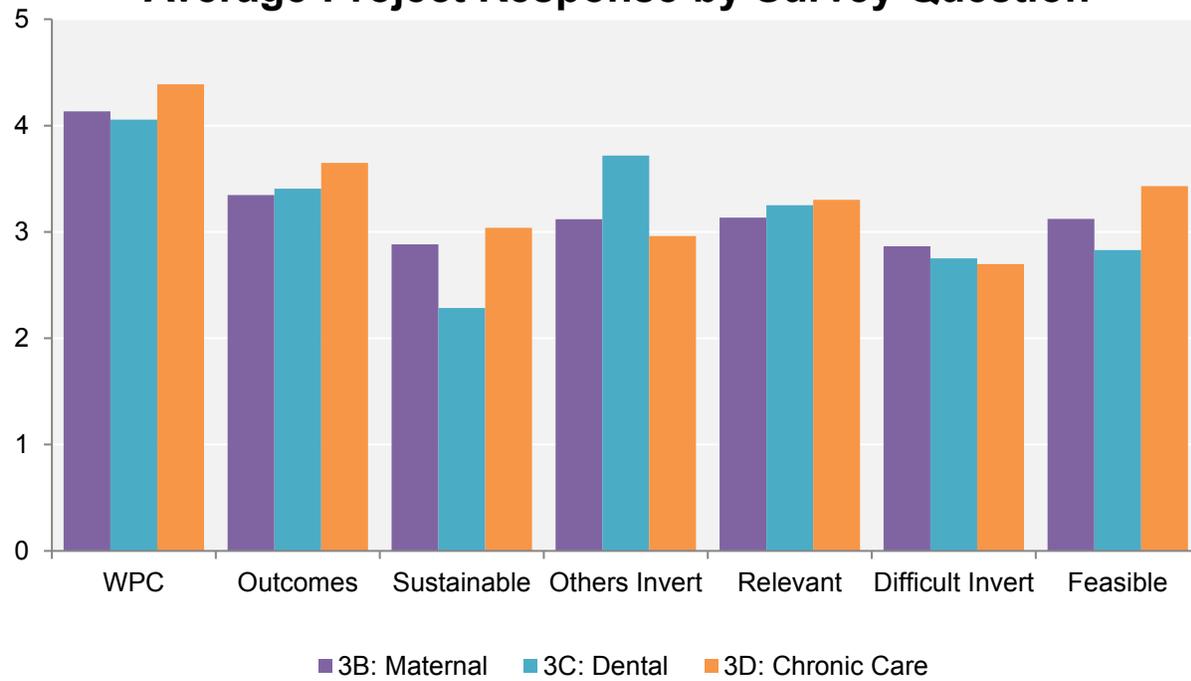
Graph Key	Survey Questions:
WPC	1. How critical is this project to the establishment of Whole Person Care in the region?
Outcomes	2. How likely is it that we will be able to improve outcomes in 4 years of implementation?
Sustainable	3. Would changes be sustainable after Demonstration dollars are gone?
Others Invert*	4. Is this project addressed in part by other projects, making a separate project of this kind less necessary?
Relevant	5. Is this relevant and needed in all 4 counties?
Difficult Invert*	6. How difficult would it be to implement this project on a region-wide basis? (The whole region will be judged and funded on the basis of each project's region-wide success. So a project effective only in a limited area could affect funding negatively for the whole region.)
Feasible	7. How feasible is it to successfully address this problem with the relatively limited funds available through the Demo?

*Response scores were inverted to maintain consistency of 1 to 5 rating score (i.e. 1 least desirable, 5 most desirable)

Domain 2 Average Project Response by Survey Question



Domain 3 Average Project Response by Survey Question



Survey Comment Results Summary:

30% of Survey responses included comments. Main themes of each project are summarized below. Full comments are attached in separate PDF document.

Project 2B: Pathways HUB (n = 29)

- Ability to implement HUB, measure, and meet outcomes required by state in 4 years
- Need to be a dynamic partner in the community and not just a referral source
- Ability to sustain the HUB model after the Demonstration
- Comments are generally positive

Project 2C: Transitional Care (n = 19)

- It could be addressed through programs such as care coordination (i.e. Project 2B Pathways HUB)
- Hard to address due to rural nature of counties
- Already being addressed through current programs

Project 2D: Diversion Intervention (n = 18)

- Could be addressed by other toolkit projects (i.e. Project 2B Pathways HUB)
- It would be a high cost project to implement
- Current financial incentives do not align with project
- Not generally positive about project

Project 3B: Reproductive and Maternal/Child Health (n = 16)

- Focusing on childhood interventions has the biggest impact on health
- Long term ROI hard to demonstrate in 4 years
- It would be very expensive to implement
- Could be addressed by other projects in the Toolkit (i.e. Project 2B Pathways HUB)

Project 3C: Access to Oral Health Services (n = 19)

- Do not have the local dentist willing to accept Medicaid patients
- A lot of agreement this is a big need and very important, but unlikely to achieve.

Project 3D: Chronic Disease Prevention and Control (n = 19)

- Needs coordination and partnerships to be successful
- Complements other projects (i.e. 2A Bi-Directional Integration & Project 2B Pathways HUB)
- Good long term ROI, but concerned that would not be achieved during demonstration.
- Needs to be different than previous chronic disease prevention projects if it is to be successful.

Medicaid Demonstration Project Selection

Q3 Comments on Project 2B: Pathways HUB

Answered: 29 Skipped: 39

#	Responses	Date
1	I understand that in Southwest, there are now care coordinators managing care for the individuals who are the high utilizers. They are in their second year with a much simpler system as far as implementation and it is not yet working well from the provider perspective. While not the same model, that model is less complex. The Hub model may be a better model, but how long has it taken to get it up and running well in the states that are using it? I would guess that it would take a minimum of 2 years, but likely 3 to get it fully operational, and it would be fledgling for the first year. That data (along with what was done to get it up and fully functional) could be valuable in determining the projected timeline, but only if their work force mirrors the workforce in central WA. The workforce issues we face here could substantially delay full implementation of the model when you get to the hiring and training part. When does the Medicaid Transformation Demonstration period begin? Where would the funding come from for the hub after the demonstration project is over? Don't know if one hub is needed in each county...seems like it would be easier to do a smaller area than it would hubs that cover the entire region.	4/17/2017 3:52 PM
2	Great concept!	4/14/2017 3:21 PM
3	The 3 means I don't know. I know a lot about our area, but not some of the other areas in the region.	4/13/2017 12:22 PM
4	211 is a key partner that needs to be at the table in order to meet goals, create healthy outcomes for clients and for sustainability after the demonstration funding is gone. 211 has the infrastructure in place to connect clients to the social determinants of health and to continue to build, update and sustain the regional database of resources. With 211 there is no need to recreate this aspect of the project.	4/13/2017 9:01 AM
5	Care traffic controllers models only work if there are resources to direct traffic too.	4/12/2017 4:34 PM
6	Can't exactly picture what the HUB will look like. Concerned about the viability of the program after initial funding is expended. But I like it (as I picture it anyway)	4/12/2017 2:05 PM
7	My biggest concern is that we invest in technology that will help to "coordinate the coordinators" as opposed to hiring people. A centralized data bank of community resources and shared info about who has interacted with specific patients is what I feel is most important.	4/12/2017 1:46 PM
8	On how difficult it would be to implement - I think this depends largely on who will be taking on the "hub" -- what experience they have and how well connected they already are to the four county area.	4/12/2017 9:47 AM
9	This project should be implemented with careful consideration of how to blend it with the existing care coordination model in our region/state. There has been significant investment in the regional Health Homes program with many lessons learned that can help inform an improved implementation of a second care coordination model. While Health Homes is now realizing a shared savings model based on the Medicare savings from the Duals demonstration project, it has been slow to come to fruition based on slow data reporting and other factors. I highly support this project.	4/11/2017 8:05 PM
10	due to how money/contract would funnel funds through the hub, the sustainability is dependent on the payment reform possible during the demonstration being 'retained' afterwards. If payors see ROI and savings by paying for the services of the HUB coordinators through the HUB, they would need to be ready to continue that methodology after the demonstration period.	4/11/2017 11:10 AM
11	Sustainability is dependent on reimbursement through the development & implementation requires start up (project funds)	4/11/2017 10:47 AM
12	This project is key to NCW success for the goal of the triple aim.	4/10/2017 9:09 AM
13	The NCACH should strongly consider initiating this proven system for addressing social determinants of health.	4/8/2017 9:35 PM
14	If left only to the healthcare sector to accomplish this, it will fail its intent and less likely to be sustainable. Other policy making bodies in the region need to have buy in.	4/8/2017 6:23 AM
15	Many questions about implementation so feedback is limited at this time.	4/7/2017 12:16 PM
16	Pathways presentation at Chelan conference indicated that implementation process takes at least 5 years. Very labor intensive and intensive communication - base process will face difficulty over such a large geographic area with home base services & multiple agencies.	4/7/2017 12:13 PM
17	How difficult is it for a HUB to connect with a variety of BHR's?	4/7/2017 12:09 PM

Medicaid Demonstration Project Selection

18	If done effectively, this project could provide the medical & mental health professionals with needed coordination. Providing both diversion & transitional guidance . If not effective, it would create another layer on medical/mental health team. There is alot of potential with this project to cover the needs of all 4 counties, focusing on specific needs of their residents and available resources.	4/7/2017 12:04 PM
19	Difficulty depends on 1. resources available in each area. 2. Degree of cooperation in communities. If few resources, it is challenging to complete the referral process.	4/7/2017 11:56 AM
20	A single source is smart...4 seems a bit burdensome and might promote inefficiencies with technology, high speed connectivity would be anywhere. Retail facetime unnecessary.	4/7/2017 11:42 AM
21	"Primary Care Case Managers are not nearly as effective as staff providers who know their patients and have strong relationships. PT's need access to a person more than just phone calls & layers of filters. *What stands out as needed & evidence-based is the community health worker, home visits. *Baseline population assessments can be done through collaboration with social service agencies, primary care clinics & school districts. This is more than ""Healthy Youth"" data and census data, more specific that county health assessment data. Aces questionnaire at well child visits, at risk seniors ID's with Medicare Wellness HUB concept needs to have some decentralization of implimentation. Regional and cultural population characteristics have a bearing on who & how care coordination & service delivery is done. So #6 needs to be flexible with room for several regional modes of delivery. The immigration/refugee population will be more challenging to reach. The spiritual community should be tapped into! "	4/7/2017 11:33 AM
22	Barry Kling's comments in the recorded webinar appeared to favor this model of an intervention. To me most important will be to design a system that will show measurable and achievable treatment and outcomes. Where I put a "3", it was my next-best selection to a "don't know." I marked 3s in cases where I'm not clear how important it is for our entire state to improve performance vs. our region v. each of the four counties within NC ACH.	4/6/2017 1:47 PM
23	The idea behind this HUB is brilliant. This implementation and design, as well as hiring highly qualified employees will be key. The idea of the air traffic controller is incredible; it would allow those with specialized care coordinating positions, such as nurse case managers, health homes care coordinators, early headstart home visitors,BH, ECEAP, CPS, DD, APS, Section 8, have a place to go when each position is at the limitations of what the positions can/cannot do. It would free up a nurse case manager to let someone else do housing, or help a 0-3 home visitor refer for a parent of the child s/he is working with. However, what worries me is to be effective and trusted in a community, the person/people running the HUB will need to be Mary Poppins and crew. They will need to really know their communities, be easy to work with across agencies, trusted, and knowledgeable in a variety of ways. My concerns is the HUB would end up an office full of brochures and a glorified receptionist pushing referrals through rather than a dynamic coordination center for the needs of a community.	4/6/2017 1:25 PM
24	Needs more definition between clinical case management and home-based, face to face, care coordination. The MCO's have not bought into the Care Coordination model but continue to try and provide clinical case management. The model needs to include the Predictive Risk Model related to how client access their care instead of clinical measures. These savings are easier to measure than clinical outcomes over a 4 yr period.	4/6/2017 9:27 AM
25	Pathways is solid and flexible enough model. It provides standardization and a data platform that solves key problems.	4/5/2017 2:44 PM
26	THE PATHWAYS HUB WIL BE DIFFICULT TO SHOW roi IN JUST 5 YEARS	4/5/2017 2:24 PM
27	This would be my choice.	4/5/2017 1:50 PM
28	The idea of the Hub would bring (maybe mandate) together agencies and services that are already available. It is important with limited funds to get ALL the players working for the individuals. Agencies need to work in concert and understand what each client needs. smaller numbers may be served, but if it is more holistic it will be better. And NOT creating new efforts and jobs and housing, but using the current experts is much more efficient.	4/5/2017 12:47 PM
29	Due to our ruralness - it may be difficult to coordinate programs. Transportation is a challenge that may not have been fully addressed yet. Many in our community don't have access to transportation nor internet/phones to coordinate these needs.	4/5/2017 11:49 AM

Medicaid Demonstration Project Selection

Q5 Comments on Project 2C: Transitional Care

Answered: 19 Skipped: 49

#	Responses	Date
1	Need to have a good understanding of how the systems work in order to address challenges. For example, there is funding for transition services for individuals who are incarcerated, but there are so many barriers to how the jail works that it is next to impossible to work with someone prior to their transition out of jail. However, in theory it is a great idea. BTW the link to the APIC information in the document does not work.	4/17/2017 4:04 PM
2	3= I don't know	4/13/2017 12:22 PM
3	in both this group and the last, the question about difficulty in implementing the project makes the answers 1-5 kind of hard to judge what is meant. I put in 5s because i think it would be very difficult.	4/12/2017 3:37 PM
4	We are very rural in our region and don't have real access to Interventions or Acute Care Transfers. Mental health office is open only a couple of days per week.	4/12/2017 2:07 PM
5	I think that the potential for saving money is significant but because of that, there may be varying degrees of interest in this project.	4/12/2017 1:49 PM
6	Transitional Care is already a priority (specifically in hospital and nursing homes) in the Health Homes program which demonstrates the ability to address the issue in part by other projects such as Pathways HUB.	4/11/2017 8:10 PM
7	this has care coordination at its core. And the pathways hub has the structure to implement this as a pathway.	4/11/2017 11:12 AM
8	Sustainability is dependent on reimbursement through the development & implementation requires start up (project funds)	4/11/2017 10:47 AM
9	I believe there are already systems in place that address this. Using the Pathway HUB will improve those systems.	4/10/2017 9:11 AM
10	Transitions of care could be strengthened by NCACH sanctioned multi-sector agreements demonstrating commitment and accountability to measurable actions supporting transitions of care.	4/8/2017 6:27 AM
11	This effort could be accomplished by a strong hub that focused on both physical & mental health needs. Personal experiences had me to believe that transitional services from intensive services into the community are poor for elderly clients and certainly not reflective of whole patient care or the specific needs of elderly population. The need behind transitional care should be addressed, but could be done with an effective HUB rather than a stand alone project.	4/7/2017 12:05 PM
12	I don't know much about transitional care.	4/7/2017 11:42 AM
13	The problem population does not get discharged to nursing home, home health, or even follow through with following up on outpatient care. They just go "home" so case managers (CHW's) need to go to where they are, their home, etc. Behavioral health services would help.	4/7/2017 11:34 AM
14	Can some of these outcomes and measures be included as part of project 2B?	4/6/2017 1:54 PM
15	For the most part, the changes in health care have focused on transitional care, and it's one of the peices working better than some of the other transformations. IT could still use work, but is being addressed by clinics, hospitals, and insurances.	4/6/2017 1:27 PM
16	The use of Transitional care RN's is expensive and not necessary. Care Coordinators with specific training and ability to provide home-based visits has proven more effective. Health Homes is a good example.	4/6/2017 9:30 AM
17	NOT SURE WE COULD SHOW THE TYPE OF ROI THE STAE IS LOOKING FOR WITH JUST THIS PROJECT	4/5/2017 2:26 PM
18	The four county area might be challenged by trying to implement this plan. While transition is important there are not always places available for that to happen. I am not as familiar with this area.	4/5/2017 12:49 PM
19	The coordination of these types of needs may be difficult if the services and programs are too distant (rural)	4/5/2017 11:50 AM

Medicaid Demonstration Project Selection

Q7 Comments on Project 2D: Diversion Interventions

Answered: 18 Skipped: 50

#	Responses	Date
1	I think diversion interventions can save the system a lot of money, but it is not clear how that would work in terms of sustaining the project when there is not project funding...funding for diversion activities (all of which are not Medicaid reimbursable to do it right) has to be built into the system, and it is not clear if it would be possible under the CMS regulations. I think again, work force issues are a consistent challenge across all the project options.	4/17/2017 4:08 PM
2	Our location within the region is multi city, multi county, multi jurisdictional and has many moving parts. Lincoln County, Grant County, Okanogan County Sheriff's, Colville Tribal Police, Homeland Security (Dam), Electric City, Grand Coulee, and Coulee Dam Police Depts - just to name some - oh and Washington State Patrol.	4/12/2017 2:16 PM
3	As with transitions, entities that do well financially in the status quo will be less inclined to embrace changes that will reduce their reimbursement.	4/12/2017 1:52 PM
4	Seems to need more approaches listed. Not completely sure what Community Paramedicine entails, but I think social service agencies could be instrumental here	4/12/2017 11:53 AM
5	Similar to Care Transition, Diversion Interventions (ER Diversion) are happening in existing programs and therefore should easily be incorporated into another project.	4/11/2017 8:13 PM
6	This is also a key care coordination and non-traditional referral pathway that can be significantly addressed and measured through the pathways HUB system. Once again, the workforce of the pathways HUB system needs to be grown and a means to pay them agreed upon. And that funding stream, which is itself a diversion of \$ spent in high cost services over to care coordination resources(which should be lower \$).	4/11/2017 11:15 AM
7	This is a heavy lift	4/11/2017 10:47 AM
8	See comments in previous project.	4/10/2017 9:12 AM
9	This low hanging fruit is probably already addressed to a large degree. This and much more would likely be addressed by the pathways model.	4/8/2017 9:42 PM
10	Attention must be given to address the current underlying perverse financial incentives that drive the system. Otherwise, system will not engage meaningfully.	4/8/2017 6:30 AM
11	#4 OBHC & juvenile court system are already engaged in diversion program in our county. I don't know how successful this is.	4/7/2017 12:14 PM
12	The rationale for this project is almost identical to the Transitional Care project definition (NC ACH PPT Demonstration Decisions). Diverting the community from services through the use of EMS is a way to reduce costs, but does not necessarily help the community member or address underlying causes for requests for help.	4/7/2017 12:06 PM
13	In response to the last question, I can see the argument for selecting fewer options to increase the likelihood of a targeted plan for sustainability to occur after the demo ends.	4/6/2017 4:41 PM
14	To have a coordinated effort in this direction is needed. IT's possible the HUB would do this agenda too?	4/6/2017 1:29 PM
15	This will be an expensive and difficult project, best done on a community basis instead of regionally. I do not have enough knowledge of this to have good input.	4/6/2017 9:32 AM
16	COST OF ER DIVERSION WITH PARAMEDICINE COULD BE UNLIMITED WITH A BIG IMPACT IN OVERUSE OF THE ER. IT SHOULD EASILY SHOW AN ROI AND WOULD ALSO dovetail WITH ANOTHER PROJECT OF POST HOSPITAL FOLLOW UP BY PARAMEDICINE THAT COULD BE ROLLED OUT IN CONJUNCTION OR AFTER THIS PROJECT IS SHOWING SUCCESS	4/5/2017 2:28 PM
17	If there was enough money, this project might be doable, but what are the risks of regular relapse. Again the number of individuals served might be small to do it right.	4/5/2017 12:51 PM
18	These may be added to other projects at a much lower cost as an add-on than a stand alone project.	4/5/2017 11:53 AM

Medicaid Demonstration Project Selection

Q9 Comments on Project 3B: Maternal and Child Health

Answered: 16 Skipped: 52

#	Responses	Date
1	Longer term return, but I think you will see a spike in the problems and costs if resources for women's reproductive health are cut by Congress if you don't do something in this area. In that case a static outcome might actually reflect a higher degree of success than you otherwise might think.	4/17/2017 4:12 PM
2	Nurse Family Partnership is very expensive and unless the "requirements" were less stringent, it may not be feasible at this time. Home visit programs could be done and outcomes achieved without the hoops that one needs to go through to provide NFP	4/14/2017 3:28 PM
3	I don't have enough knowledge in this area to honestly answer the questions.	4/13/2017 12:24 PM
4	Wellness and population health begins at birth. Healthy Mother's Healthy Families	4/12/2017 4:36 PM
5	While the long term savings from a program such as this are possible, the savings would likely be minimal in the demonstration project period.	4/11/2017 8:15 PM
6	This is very much a front end early intervention with long term ROI. It can easily piggy back on the pathways HUB care coordination program as a specific pathway.	4/11/2017 11:17 AM
7	Research shows this has the biggest impact on maternal & child health.	4/10/2017 9:13 AM
8	Probably represents a relatively small portion of health cost. This would largely be addressed by the pathways model.	4/8/2017 9:47 PM
9	Engagement of child care providers, Head Start, preschools, schools led by primary car providers and supported by WPC wrap-around services to families will be needed.	4/8/2017 6:33 AM
10	The effects of poor family planning & teen pregnancy, poor prenatal care, lack of parental engagement and lack of prevention & health maintenance create lifelong negative impacts on health & well-being . We should focus on helping the current generation of teens & young adults produce the next generation of healthier adults.	4/7/2017 12:06 PM
11	There is no better investment than zero to 5 years old. Building the brain architecture (neural synapse), early learning, mental, physical and relationships is the very best return on investment. A win in this optional will have an impact on the other optionals and will give these children a chance to escape poverty, incarceration, drag on social services & physically, mentally and spiritual whole success for their entire life.	4/7/2017 11:44 AM
12	Part of outreach needs to be sensitive to the concerns of undocumented individuals and families. This is a key group in addressing and educating parents about adverse childhood experiences and partnering with them to mitigate these risks, which are social determinants of health. It would also help address the teen pregnancy prevention for young mothers, sequelae of post partum depression if unchecked/untreated.	4/7/2017 11:36 AM
13	I believe home visiting programs are effective, but if chosen, measures such as vaccine adherence, better birth outcomes, and other short term measures would be needed. There are home visiting programs in existence, and it would likely be better to coordinate those existing programs than to add more.	4/6/2017 1:31 PM
14	A pathways HUB could include this piece nicely.	4/6/2017 9:33 AM
15	this area of health care is extremely important, but I am not sure how it would be implemented over the whole area.	4/5/2017 12:53 PM
16	The ruralness of our area would make something like this almost impossible.	4/5/2017 11:54 AM

Medicaid Demonstration Project Selection

Q11 Comments on Project 3C: Access to Oral Health Services

Answered: 19 Skipped: 49

#	Responses	Date
1	It would seem that dental services would be feasible, as Medicaid at least will pay for services for children, so if screening could be implemented in a cost effective way that can be integrated with health (can a pediatrician be taught a quick screening process that can be incorporated with the well child check-ups?) it would seem to be more sustainable over the long term.	4/17/2017 4:15 PM
2	While adult oral health is a huge concern, private providers accepting Medicaid adults is an ongoing problem.	4/14/2017 3:30 PM
3	3= I don't know	4/13/2017 12:24 PM
4	I am not sure what providers are currently available to provide the resources to the project.	4/12/2017 4:37 PM
5	The region struggles with a sufficient number of dental professionals willing to work with underserved populations.	4/12/2017 1:55 PM
6	I think it would take longer than the demonstration period to show savings with this program. Building the provider capacity to fit the need would take most if not all the allowed time.	4/11/2017 8:18 PM
7	Oral health can also be a pathway in the HUB model. But this is a high \$ resource and slow to grow provider base that will be difficult to show 4 year return. Dental capacity is a concern.	4/11/2017 11:18 AM
8	Need dentists	4/11/2017 10:52 AM
9	Relevant and important, but ability to effect change and to achieve sustainability are not clear to me.	4/8/2017 9:48 PM
10	With continuation of ACA expansion funding, there is a good chance this can be achieved.	4/8/2017 6:35 AM
11	#6 Very difficult	4/7/2017 12:12 PM
12	"#2 - Depends on strategy Poor dental care & dental maintenance lead to many other conditions. But without changes in dental insurance, it would be hard to implement and sustain. Would be good to have some dental input on NC ACH. Even if this is not the selected project, the dental professionals may have good ideas on regional efforts/needs. "	4/7/2017 12:07 PM
13	I can see this being a priority for kids based on community fundraisers/donations. It shouldn't be funded by government agencies.	4/7/2017 11:44 AM
14	Need to recruit more family dentists, mobile dental services, sliding scale for non-covered services. Basic dental assessment/screening in primary care pediatrics (long term outcome). Adults - catch it early, prevent chronic inflammation and chronic disease.	4/7/2017 11:36 AM
15	It's unlikely the demonstration dollars can "fix" oral health. There are several efforts currently out there, but the sustainability of the demonstration project for oral health is dismal.	4/6/2017 1:34 PM
16	Dollars best spent on high risk medical populations to see most savings along with a prevention program through primary care.	4/6/2017 9:35 AM
17	GREAT PROJECT BUT THAT COULD BE ROLLED OUT TO AL PCP CLINICS ADN INSTITUTED WITH RELATIVE LOW COST BUT NOT SURE HWO WELL IT WOULD SHOW ROI IN JUST 4 YEARS	4/5/2017 2:30 PM
18	I do believe that oral health care is critical to the medicaid population and would help with over all health. Again, not sure how many people can be helped across the entire area.	4/5/2017 12:55 PM
19	We have absolutely no dental office in our community that take Medicaid. It is a huge issue for us, but I believe it can be added to other projects as an add-on at a lower cost.	4/5/2017 11:55 AM

Medicaid Demonstration Project Selection

Q13 Comments on Project 3D: Chronic Disease Prevention and Control

Answered: 19 Skipped: 49

#	Responses	Date
1	This is a huge undertaking--it will take generations to educate people to take charge of their own health. As people are socialized health care costs should decrease, but it is a long term venture. The health care systems have begun implementing this, but considerable public education is going to be required over the long term. That doesn't mean it isn't a good idea to foster productive interactions between informed patients who take an active part in their care, and providers with resources and expertise.	4/17/2017 4:20 PM
2	Not my area of expertise	4/13/2017 12:25 PM
3	The Department of Health and 211 are key partners for chronic disease prevention. Both agencies have been partnering statewide since 2103 to expand self management resources and awareness of resources through community outreach. The expansion of the statewide 211 database of services has opened an opportunity for community health outreach workers to expand information and resources into more rural areas. Through the use of the new DOH CHART software program that connects to the 211 database of services, community health outreach workers will have more immediate access to resource information to make referrals for clients.	4/13/2017 9:17 AM
4	I think that this is a project with almost universal support. It also has the potential to reduce the cost of healthcare through reduced specialty and inpatient costs. This will result in the State viewing this project as a success.	4/12/2017 1:57 PM
5	Coordination of the existing chronic disease programs across agencies in our region, improvements on patient incentives for participation and the initiation of a bi-directional communication system could result in a successful project.	4/11/2017 8:22 PM
6	This is one of the most widely pursued opportunities for improvement in health care. But it continues to be a silo approach in need of relationship based, patient specific, locally trusted, care coordination. The structures and measures of the pathways HUB model create the most relevant workforce (CHW's or ?) to build the Behavior changing/influencing engine needed to affect change.	4/11/2017 11:22 AM
7	Chronic diseases are preventable and controllable. Improving our health systems and community involvement is much needed.	4/10/2017 9:17 AM
8	Dovetails with Patient Centered Medical Home efforts.	4/8/2017 10:06 PM
9	Success in this project is a must, as it has the highest probability to generate system savings that can be applied to sustaining other efforts.	4/8/2017 6:37 AM
10	Our primary care delivery system is not really designed to support the CCM effectively, especially in regards to prevention. Unless the system itself is redesigned (HUB, Home Visiting Models), we will just get the same result we've been getting.	4/7/2017 12:08 PM
11	Community Choice & WSU Extension have a diabetes prevention program at this time.	4/7/2017 12:02 PM
12	My feeling is that messaging marketing should mostly be communicated at young age (middle school up) in schools, in churches, etc. (sporting events). I don't believe older demographics should be the targets for messages.	4/7/2017 11:45 AM
13	How do we get folks to allow community health workers in their homes? I suspect a local, established, trusted team of individuals is necessary, preferred to "outsiders".	4/7/2017 11:37 AM
14	so so many programs are tried via current medical outlets. So many have low participation or adherence. I truly believe coordinating these current efforts and offering trainings to social service and medical staff would be much more effective than throwing yet another diabetes, SAIL, foot care, etc into communities.	4/6/2017 1:37 PM
15	Would need to be measured by a predictive risk model and not clinical model to see outcomes in 4 yrs.	4/6/2017 9:37 AM
16	AGAION THE 4 YEAR WINDOW OF SHOWING IMPROVED OUTCOMES AND ROI IS VERY DIFFICULT	4/5/2017 2:31 PM
17	This would also be my choice	4/5/2017 1:54 PM
18	shine a light on SUD as a chronic disease.	4/5/2017 12:13 PM
19	This combined with Project 2A makes the most sense to me as a Community Health Worker. It is doable and trackable. Those two combined make this a viable project.	4/5/2017 11:56 AM

Email Verifying North Central Hospital Council Project Endorsement

From: Kevin Abel [mailto:kabel@lcch.net]
Sent: Thursday, March 30, 2017 8:43 AM
To: Linda Parlette <Linda.Parlette@cdhd.wa.gov>
Subject: RE: NCWACH Project Options

Hi Linda,

I agree we have what we need to make our decision and the detailed information can go to the board members.

I heard back from some that were not at the meeting and we are at a point where we have consensus on Chronic Disease Prevention and Control and Community Based Care Coordination Pathways HUB as the two optional projects for our region from the hospital standpoint. We still need the input from other community groups but it is a start.

Kevin Abel
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Grant County Summary of CHI answers from April 10th.

Pathways HUB

Concerns	Excites
Data sharing-patient consent (Health Info Exchange)	Relationship with the person
Pathway resources lacking (mental health access to care)	Connecting people to resources
Operationally how it will work	Key to other projects; essential service
Educating CHW's; recruiting good CHW's → not making training too rigorous	Partnership with 211
Making appointments- delays in starting CC	Address social determinants of health
Caseload restrictions?	Measurement-tracking success and failures, lack of resources to be tracked
Who will make referral to HUB?	Focusing on specific population, i.e. ER utilizers
Health homes role?	
Who is the HUB?	

Chronic disease

Concerns	Excites
We do not have people in community that currently do this follow up/tracking	You can measure some of the successes in certain clinical settings
Poor compliance with chronic disease patients	Possible home monitoring would be beneficial since limited transportation in this area
Lack of transportation in rural area	This would have to work/would work well with the Pathways HUB
Once you diagnose a chronic disease, how do you know there will be follow up?	This would be getting ahead of the curve, finding root cause, different than current clinical model
4 years is a short time to measure chronic disease improvement	This will hopefully keep the diagnosis from developing/getting worse
The provider will need a team, who will provide the team to make this possible?	This will provide relief for providers seeing same patients with same issues over and over
How will data be shared?	Hopefully reduce repeat ER users

MCH/Oral Health

Concerns	Excites
Will primary care take on oral health?	Outcomes of home visits
Resources?	Prevention focus, early intervention
See results, but perhaps not savings	Both address transportation issue
What has worked well in other communities?	Support for whole family/outreach for whole family (MCH)
Increased needs in rural areas; mobile unit prepared?	Mobile visits (dental)
Dentist at the table	Addresses children (most vulnerable group)
Who will (MCH) it be open to?	Will collaborate with HUB
Home visits must be culturally relevant	Oral health crosses over with MCH, chronic disease
Cost over time	
You would need care coordination/care coordinator	

ED Diversion/Transitional Care

Concerns	Excites
Very circular, what is the difference?	Types of services are not as big of a concern
Diversion will take a lot more resources/investments to address	Diversion sounds more appealing for work
Still addresses people with acute situations, want to reach them prior to preventative services.	Overlaps with HUB
Cannot do this without care coordination	Transitional interventions would be best to achieve outcome → payment on admission
Resources available in community for this?	Long term care → other initiatives
Not successful without HUB	Focus on opioid work
	Addresses areas of high cost of medical care
	Potential for high cost savings
	It is a more proactive approach

Most groups agreed that in order for each option to succeed, the Pathways HUB would need to be implemented.

Methow Valley Response to Survey
Community Based Care Coordination & Diversion Intervention

Background

The Methow Valley Health Care Network has identified **Community Based Care Coordination** and **Diversion Intervention** as significant health care gaps in our region, with Diversion Intervention being of highest priority for implementation. We believe that a more integrated health care approach is needed to address these specific issues hence an initial partnership has been established with the following valley health care providers: 1) Aero Methow Rescue Service; 2) Lookout Coalition; 3) Frontier Home Health & Hospice; 4) Family Health Centers, Twisp; and 5) Three Rivers Hospital (plans are to extend the network to a broader range of local providers). In addition, the network has recently submitted a revised grant application to the *Rural Health Network Development Planning Program*, (HRSA-16-017) to obtain support to develop a detailed plan to address these specific needs. For the Methow Valley community the planning grant outlines in detail the following: valley history, demographics of target populations, relevant community services, unmet needs, barriers and challenges, project objectives including performance metrics, and roles and responsibilities of network partners. This planning grant funding is for a 12 month period (initiation June 2017 if funded) but will only support the development of a strategic plan; whereas, plan implementation will occur in 2018. The planning grant is directly focused on the need for community based coordination to alleviate loss of local services and better access to care by enhancing emergency medical services with an overarching goal of improving the quality of essential health care services. Although this planning grant was developed specifically to address the needs of the Methow Valley, we believe it is highly relevant to the North Central Accountability Community of Health. *(If you would like a copy of the grant contact Cindy Button)*

Comments to survey questions (1-7), ranking score range- 1 (not at all), 5 (very much)

1. We believe that it is critical to establish “Whole Person Care” in the Methow Valley and the region. To accomplish this, well integrated community networks are vital. The overarching “unmet need” can be summed up as, a lack of health care gap management to fully address chronic, mental and behavioral health needs. Health care needs can be broad in scope where patients may be dealing with a range of short- and long-term health issues. These patients may also be struggling with numerous confounding factors such as poor compliance with medicines, lack of family support, lack of primary care, difficult living conditions among other factors that further compromise their overall health status. Hence, effective strategies need to be developed to address “Whole Person Care”. **Ranking (5)**
2. Once care coordination and diversion interventions are established, and assuming the appropriate performance metrics are developed and used, then health outcome improvements will be realized (in less than 4 years). We believe this is particularly true in the Methow Valley since we’ve already made progress via our Network. **Ranking (5)**
3. A critical component of both care coordination and diversion intervention is network communication. We envision limited resource allocation will be needed to maintain efficient care coordination and ongoing efforts focused on community paramedicine with available resources should enable sustainability with limited additional cost. **Ranking (4)**
4. At this point in time we do not believe that the goals of the HUB and diversion intervention would be addressed by other projects. The HUB as a care coordination strategy in an important health care integrating tool. For example, when we consider diversion intervention, care coordination is a critical component needed for successful integration. Depending upon the scope of the care coordination efforts (local vs. regional

Methow Valley Response to Survey
Community Based Care Coordination & Diversion Intervention

focus) it may or may not be appropriate to integrate into other projects. However, from our perspective we wish to stress the need for a local HUB strategy, since we believe it will best facilitate addressing the unmet needs of our community. **Ranking (2)**

5. We believe it is critical for the Methow Valley and potentially Okanogan County (**Ranking 5**). It may likewise be equally critical to all counties in the region since they share similar issues with regards to rural health care needs; however, we lack adequate information to fully assess. **Ranking (3)**
6. The care coordination could readily be integrated region wide. However, we believe that local coordination is critical since there are unique differences within various communities. For example, in Okanogan County Methow Valley demographics are quite different than those in Omak or Eastern Okanogan County; hence, local coordination is important. However, it is envisioned that the entire region would benefit from care coordination and diversion intervention but how that would look may vary from community to community. **Ranking (3)**
7. The demo project will establish the proof of principle, and once appropriate metrics are developed and measured long-term and broader feasibility can better be assessed. Since each community is unique the results from the demo project will need to be tailored to other communities within the whole region. **Ranking (4)**

DRAFT

Chelan Douglas Coalition for Health Improvement 10.12.17 Meeting Materials

Chelan-Douglas CHI Meeting Documents	Page
NCACH Governing Board Update	2
Chelan-Douglas CHI Steering Committee Description (<i>Volunteers needed</i>)	2
Medicaid Demonstration Projects 9.21.17	3
Meeting Small Group Breakout Discussion	4
9.21.17 Question and Answer Section	5

NCACH Governing Board Update:

1. Approval of 2 workgroup charters
 - a. Transitional Care & Diversion Intervention Workgroup
 - b. Regional Opioid Workgroup
2. Contract with CCMI (Consultant) to work with Whole Person Care Collaborative approved
3. Contract to work with Care Coordination Services for the Pathways Hub approved
4. NCACH passed Phase II Certification from Washington State Health Care Authority
5. The Integrated Managed Care Workgroup submitted early warning measures for implementation on January 1st, 2017 that was approved by the Board

Steering Committee Description:

Description:

Chelan-Douglas CHI Steering Committee members are dedicated Coalition members who are responsible for planning meetings, agendas, and relevant material for Coalition meetings. Working with the Coalition's support staff, steering committee members will ensure that the Coalition achieves its objectives and ensure that bi-directional communication between the NCACH Governing board and Coalition are maintained.

Steering Committee Responsibilities:

(Steering committee members commit to the follow)

1. Meet prior to Coalition meetings to ensure meeting objectives, agendas, and relevant material are planned out.
2. As directed by the Governing Board, lead the CHI in creating workgroups to assist in the implementation of Demonstration project initiatives.
3. Actively educate community partners about the work of the NCACH and let them know how members can engage in NCACH projects.
4. Ensure the Coalition maintains a diverse representation from the various sectors that impact the health of our community.

Selected Medicaid Demonstration Projects

Bi-Directional Integration	
Objective	Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers.
General target population (as defined by HCA)	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions , including mental illness and/or substance use disorder (SUD).
Community-Based Care Coordination (aka HUB)	
Objective	Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
General target population (as defined by HCA)	Medicaid beneficiaries (adults and children) with <ul style="list-style-type: none"> • one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke) • mental illness/depressive disorders • moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization)
Transitional Care	
Objective	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
General target population (as defined by HCA)	Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including <ul style="list-style-type: none"> • beneficiaries discharged from acute care and inpatient care to home or to supportive housing (including beneficiaries with serious mental illness (SMI)) • client returning to the community from prison or jail
Diversion Interventions	
Objective	Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.
General target population (as defined by HCA)	<ul style="list-style-type: none"> • Medicaid beneficiaries presenting at the ED for non-acute conditions • Medicaid beneficiaries who access the EMS system for a non-emergent condition • Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement
Addressing the Opioid Use Public Health Crisis	
Objective	Support the achievement of the state’s goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.
General target population (as defined by HCA)	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.
Chronic Disease Prevention and Control	
Objective	Integrate health system and community approaches to improve chronic disease management and control.
General target population (as defined by HCA)	Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

9.21.17 Small Group Breakout Session:

Discussion Questions

As our project workgroups work on recommending evidence-based approaches and priority populations...

- **What potential populations do you recommend they target?**
 - People in Chemical Dependency
 - Jail Population
 - Diabetes
 - Chronic Homelessness
 - Hispanic Population
 - CPS Moms
- **What populations/issues should they look further into?**
 - Homeless ED Visits
 - Homeless Substance Abuse
 - Homeless Mental Health
 - Inmates released from DOC take part in MAT program, planning/implementation & strategy begin significantly before release. There is currently not a transition coordinator.
 - Hispanic access to social programs/insurance
 - Hispanic navigation of the education system
- **e.g. gender, race/ethnicity, age, specific health conditions**
 - Hispanic Population
 - School Age Children
 - Higher Aces Score
 - Immigration concerns
 - People in Chemical Dependency age 17-30
- **What questions and data gaps should they dig into?**
 - Would like more detail on anti-depressant management, Jail population, Diabetes and ACES scores.
- **Any other takeaways you want us to relay to workgroups?**
 - Use radio, TV, Social Media and Faith Based organizations to communicate with the Hispanic population.
 - Barriers: Lack of data sharing, need for inventory of services
 - Have surveys at doctor's offices for patients to open up about mental health/behavioral health needs.
 - Have behavioral health in schools (Omak has a pilot program)

Q&A – Chelan Douglas CHI

September 21, 2017

Q: What does “antidepressant medication management” mean in the demonstration measures?

A: Antidepressant Medication Management is defined as follows: “The percentage of Medicaid enrollees 18 years of age and older newly diagnosed with major depression and newly treated with antidepressant medication, who remained on an antidepressant medication treatment.” The *Acute* measure looks at those remaining on an antidepressant medication for at least 84 days or 12 weeks, while the *Continuation* measure looks at those remaining on an antidepressant medication for at least 180 days or 6 months.

Q: Was the opioid use data that was presented for the general population in our counties?

A: No, the opioid use data in the presentation was specific to Medicaid members in our 4-county NCACH region. Specifically, the graphs are based on Fiscal Year 2016 claims data from the Health Care Authority for the Medicaid only population with full medical eligibility (excluding dual Medicare eligibles, third party liability and partial medical eligibility.)

Data Requests from CHI members

- Would like to see demographic breakout, including specific diseases, for Outpatient ED utilization measure, since this measure appears in all 6 of our region’s selected projects

Medicaid Demonstration Project Planning Update

Okanogan Coalition for Health Improvement
9/27/2017 Meeting

Goals

- Presentation goals
 - Review 6 selected Demonstration projects
 - Revisit data on healthcare and social needs in our region
 - Discuss potential priority populations for Medicaid Demonstration projects
 - Share your concerns and recommendations
- What will happen with your feedback?
 - Will be shared with regional project workgroups and Governing Board
 - Will inform projects, including selected approach and priority populations

Projects and general target populations

Bi-Directional Integration	
Objective	Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers. Will support bringing together the financing and delivery of physical and behavioral health services, through MCOs, for people enrolled in Medicaid.
General target population (as defined by HCA)	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).

Projects and general target populations

Community-Based Care Coordination (aka HUB)

Objective	Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
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Projects and general target populations

Transitional Care

Objective	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
General target population (as defined by HCA)	Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care, or client returning to the community from prison or jail.

Projects and general target populations

Diversion Interventions

Objective	Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.
General target population (as defined by HCA)	Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Projects and general target populations

Addressing the Opioid Use Public Health Crisis

Objective	Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.
General target population (as defined by HCA)	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.

Projects and general target populations

Chronic Disease Prevention and Control	
Objective	Integrate health system and community approaches to improve chronic disease management and control.
General target population (as defined by HCA)	Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

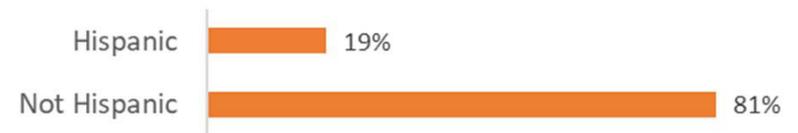
Overall Population Demographics

Okanogan County (N=41,860)

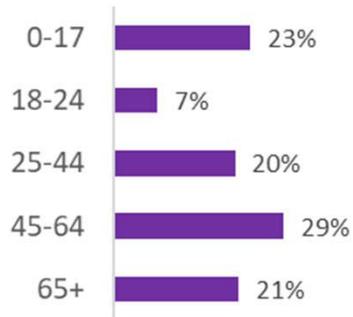
Gender



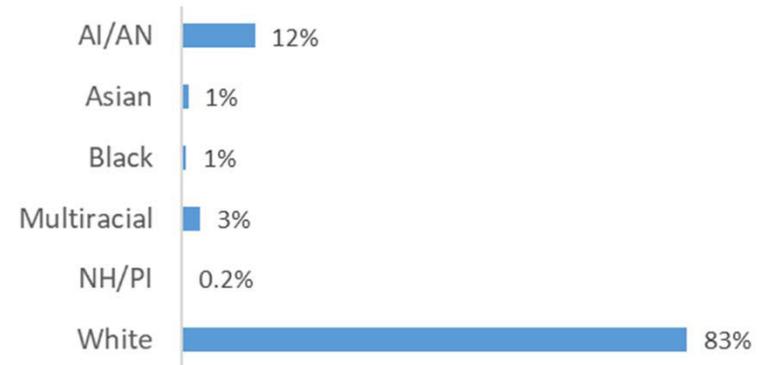
Ethnicity



Age



Race



Source: Office of Financial Management (Measurement period = 2015)

Medicaid Population Demographics

Okanogan County (N=17,035)

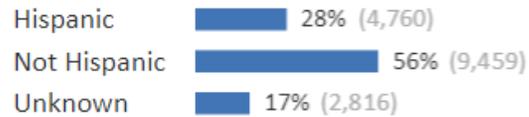
Age Group



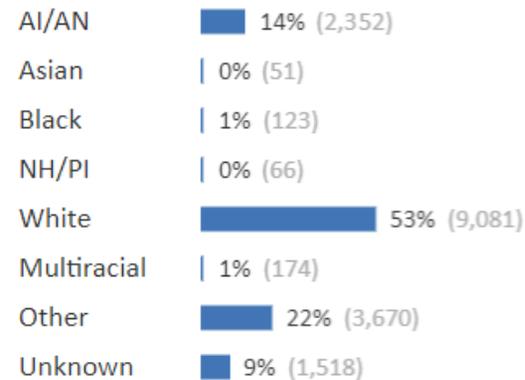
Gender



Ethnicity



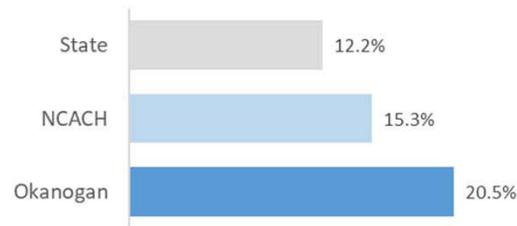
Race



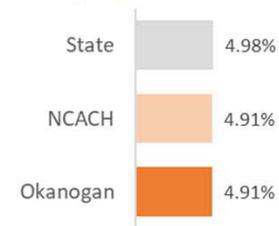
Source: Healthier Washington Dashboard (Measurement period = 10/1/2015 – 9/30/2016)

Social & Environmental Determinants of Health

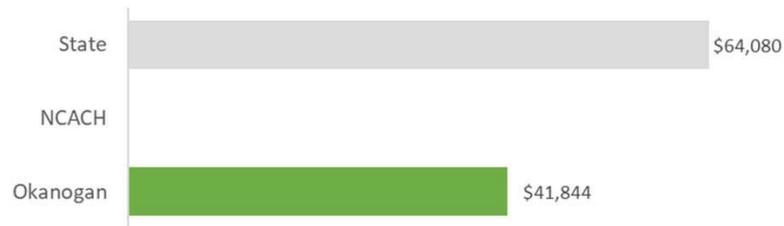
Percent of People Living in Poverty



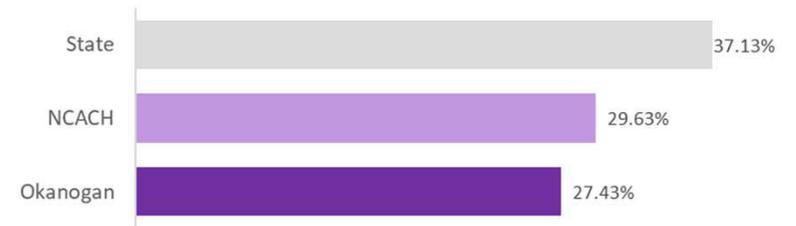
Unemployment Rate



Estimated Median Household Income



Unaffordable Housing



Source: Health Care Authority Starter Kit, drawn from U.S. Census Bureau, Employment Security Department and Washington Tracking Network

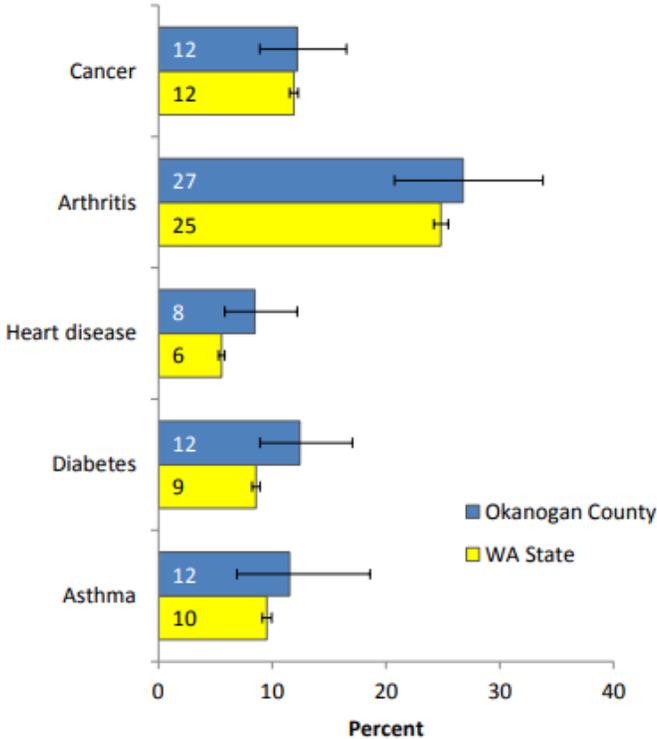
Top Ten Most Common Causes of Acute Hospitalizations Among Medicaid Recipients

Rank	Cause of Acute Hospitalization	Count	%	State Rank
1	Injury and Poisoning	266	12.1	2 (9.4%)
2	Mental and Behavioral Disorders	171	7.8	1 (18.2%)
3	Diseases of Heart	135	6.1	4 (5.7%)
4	Respiratory Infections	132	6.0	9 (3.6%)
5	Diseases of the Musculoskeletal System and Connective Tissue	115	5.2	5 (4.5%)
6	Substance Use Disorder	105	4.8	6 (4.6%)
7	Septicemia	105	4.8	3 (7.4%)
8	Cancer/Malignancies	102	4.6	8 (3.6%)
9	Diabetes	94	4.3	
10	Diseases of Liver, Biliary Tract, and Pancreas	84	3.8	7 (3.7%)

Data for North Central ACH, Excluding Pregnancy and Child Delivery Related Hospitalizations (Jan 1, 2015 - Oct 31, 2015)
 Source: Health Care Authority Starter Kit, determined by primary diagnosis field in HCA ProviderOne Medicaid Data System

Adult (18+) Chronic Diseases

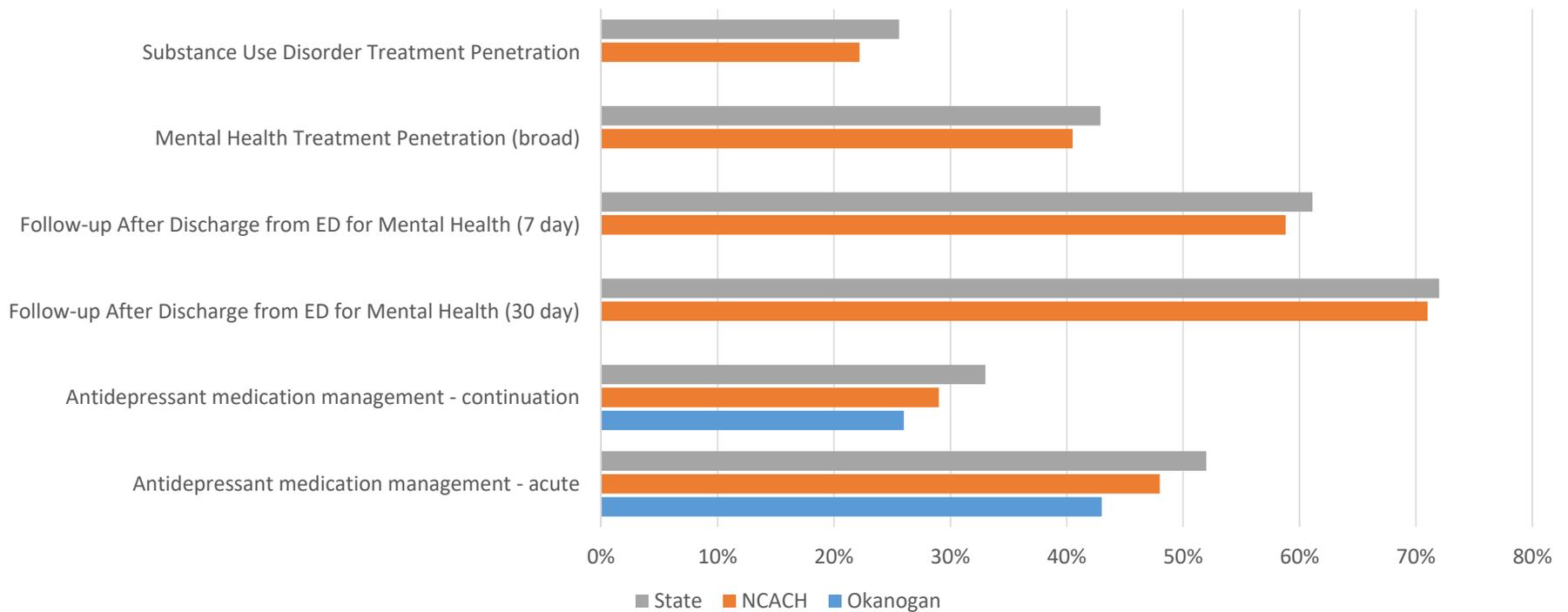
Okanogan County



Source: Washington Dept. of Health Chronic Disease Profiles (2017), drawing from Washington Behavioral Risk Factor Surveillance System 2013-2015

Behavioral Health

Behavioral Health Measures Where NCACH Below State Average



Data for North Central ACH from Health Care Authority – based on demonstration measures

Risk Factors for Arrests

5-6 times more likely to exhibit one of these risk factors

- Substance abuse (not including alcohol)
- SUD treatment need
- Co-occurring mental illness/substance use disorder

Risk Factors for Homelessness

3-4 times more likely to exhibit one of these risk factors

- SUD treatment need
- Co-occurring mental illness/substance use disorder
- Substance abuse (not including alcohol)
- Psychiatric (bipolar)

Risk Factors for ED Utilization

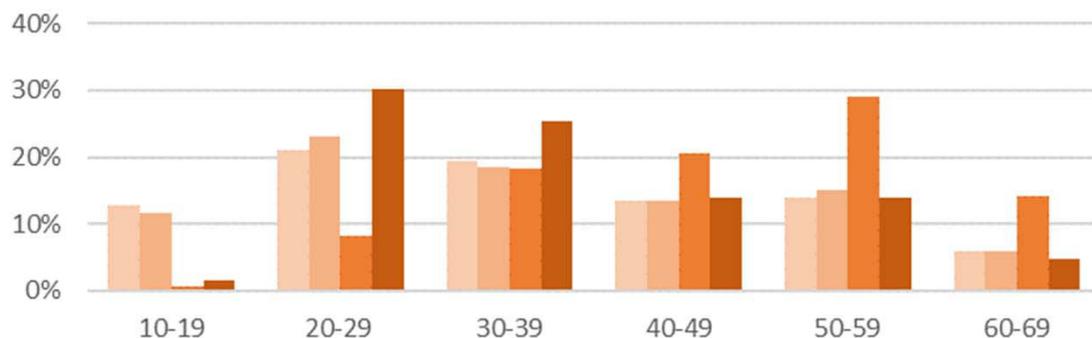
5-7 times more likely to exhibit one of these risk factors, if have 3+ ED visits

- Type 1 diabetes
- Pulmonary
- Cardiovascular
- Renal
- Liver disease
- Co-occurring mental illness/substance use disorder
- Substance abuse (low)

Opioid Use

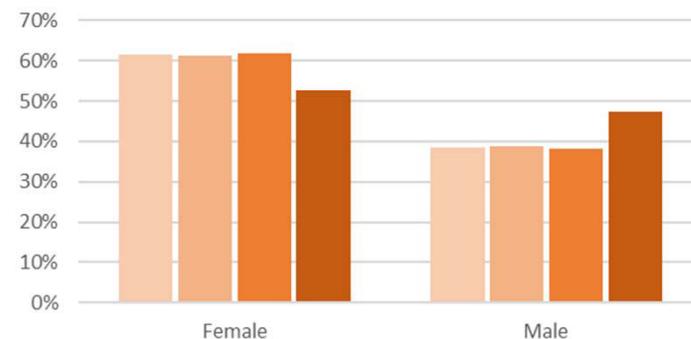
Opioid Use by Age (NCACH Region)

- % Opioid Users with no Cancer Diagnosis history (N = 9,764)
- % Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
- % Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
- % Diagnosis History of Opioid Abuse/Dependence (N = 1,359)



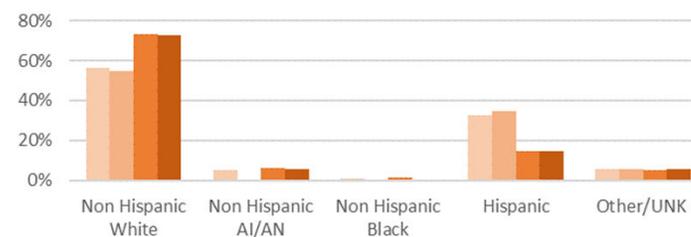
Opioid Use by Gender (NCACH Region)

- % Opioid Users with no Cancer Diagnosis history (N = 9,764)
- % Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
- % Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
- % Diagnosis History of Opioid Abuse/Dependence (N = 1,359)



Opioid Use by Race/Ethnicity (NCACH Region)

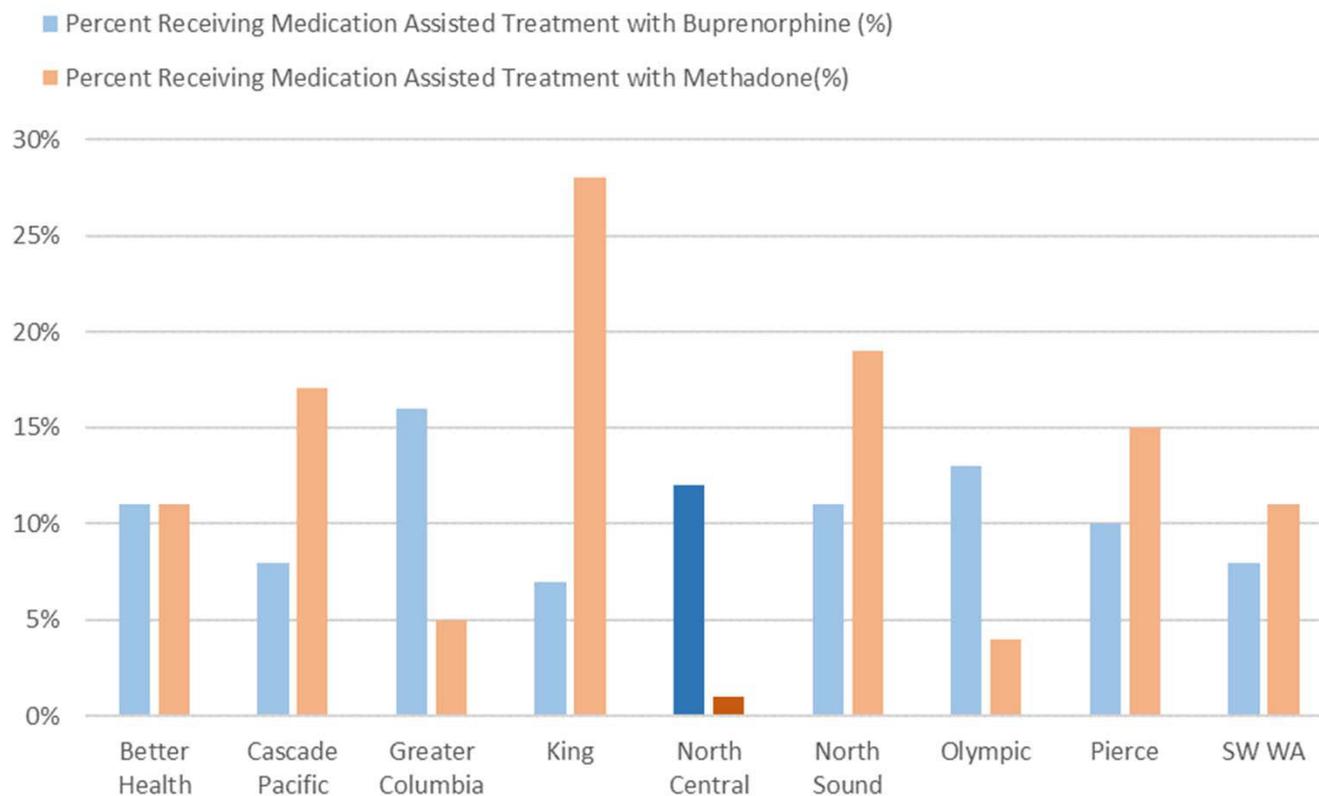
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- % Diagnosis History of Opioid Abuse/Dependence (N = 1,359)



Source: Health Care Authority drawn from fiscal year 2016 claims data and ICD coding

Opioid Treatment

Medication Assisted Treatment Across ACHs



Source: Health Care Authority

Project Performance Measures

- Antidepressant Medication Management*
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization
- Medication Management for People with Asthma (5 – 64 Years)*
- Mental Health Treatment Penetration (Broad Version)
- Outpatient ED Visits per 1000 Member Months
- Plan All-Cause Readmission Rate (30 Days)
- Substance Use Disorder Treatment Penetration
- Percent Homeless (Narrow definition)
- Percent Arrested
- Medication Assisted Therapy (MAT): With Buprenorphine or Methadone*
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Substance Use Disorder Treatment Penetration (opioid)
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)*

High- Performance Measures

Metric	2A: Integration	2B: Pathways	2C: Transitional	2D: Diversion	3A: Opioid	3D: Chronic	Demonstration Projects
Outpatient Emergency Department Visits per 1000 Member Months	1	1	1	1	1	1	6
Inpatient Hospital Utilization	1	1	1		1	1	5
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	1	1	1				3
Follow-up After Hospitalization for Mental Illness	1	1	1				3
Percent Homeless (Narrow Definition)		1	1	1			3
Plan All-Cause Readmission Rate (30 Days)	1	1	1				3
Substance Use Disorder Treatment Penetration	1	1					2
Mental Health Treatment Penetration (Broad Version)	1	1					2
Child and Adolescents' Access to Primary Care Practitioners	1					1	2
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	1					1	2
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1					1	2
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1					1	2
Medication Management for People with Asthma (5-64 years)	1					1	2

Discussion Questions

As our project workgroups work on recommending evidence-based approaches and priority populations...

- What potential populations do you recommend they target?
- What populations/issues should they look further into?
 - e.g. gender, race/ethnicity, age, specific health conditions
- What questions and data gaps should they dig into?
- Any other takeaways you want us to relay to workgroups?

Medicaid Demonstration Project Planning Update

Grant Coalition for Health Improvement
10/10/2017 Meeting

Goals

- Presentation goals
 - Review 6 selected Demonstration projects
 - Revisit data on healthcare and social needs in our region
 - Think about potential priority populations for Medicaid Demonstration projects
 - Share any concerns and recommendations
- What will happen with your feedback?
 - Will be shared with regional project workgroups and Governing Board
 - Will inform projects, including selected approach and priority populations

Projects and general target populations

Bi-Directional Integration	
Objective	Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers. Will support bringing together the financing and delivery of physical and behavioral health services, through MCOs, for people enrolled in Medicaid.
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Projects and general target populations

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Projects and general target populations

Diversion Interventions

Objective

Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

General target population (as defined by HCA)

Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Projects and general target populations

Addressing the Opioid Use Public Health Crisis

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Projects and general target populations

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Overall Population Demographics

Grant County (N=93,930)

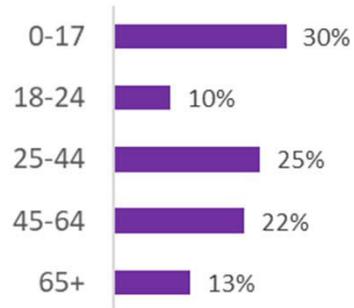
Gender



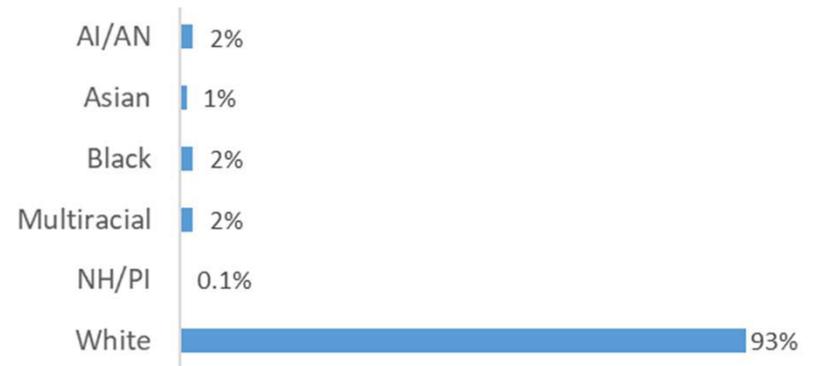
Ethnicity



Age



Race



Source: Office of Financial Management (Measurement period = 2015)

Medicaid Population Demographics

Grant County (N=37,345)

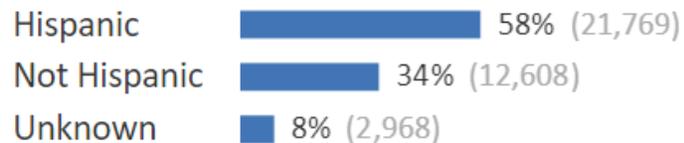
Age Group



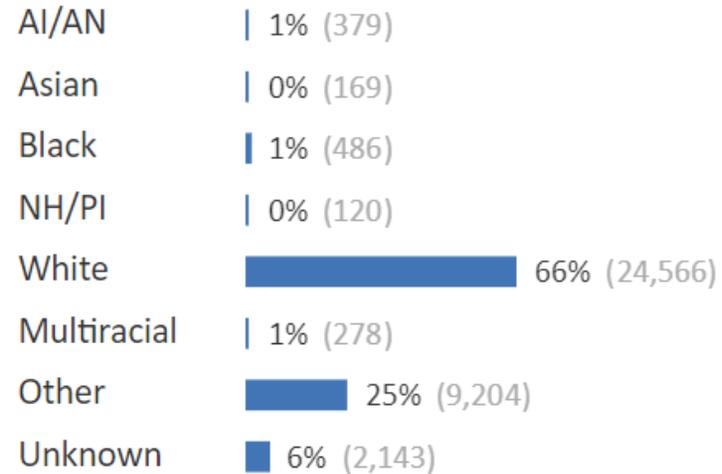
Gender



Ethnicity



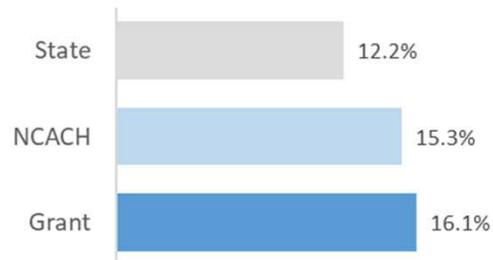
Race



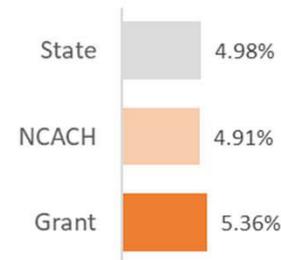
Source: Healthier Washington Dashboard (Measurement period = 10/1/2015 – 9/30/2016)

Social & Environmental Determinants of Health

Percent of People Living in Poverty



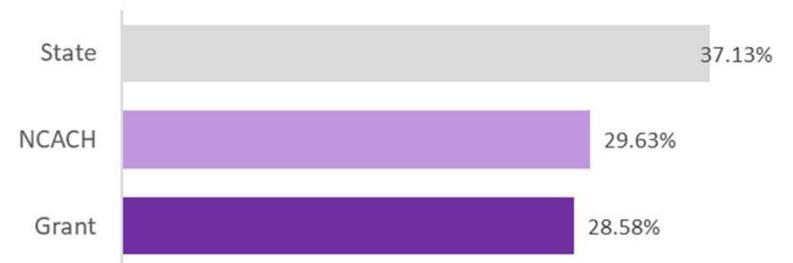
Unemployment Rate



Estimated Median Household Income



Unaffordable Housing



Source: Health Care Authority Starter Kit, drawn from U.S. Census Bureau, Employment Security Department and Washington Tracking Network

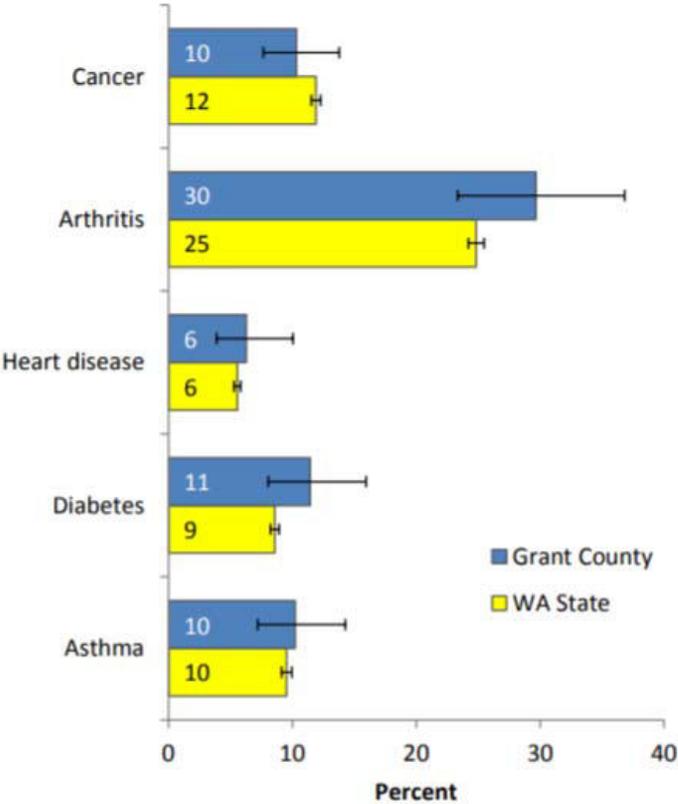
Top Ten Most Common Causes of Acute Hospitalizations Among Medicaid Recipients

Rank	Cause of Acute Hospitalization	Count	%	State Rank
1	Injury and Poisoning	266	12.1	2 (9.4%)
2	Mental and Behavioral Disorders	171	7.8	1 (18.2%)
3	Diseases of Heart	135	6.1	4 (5.7%)
4	Respiratory Infections	132	6.0	9 (3.6%)
5	Diseases of the Musculoskeletal System and Connective Tissue	115	5.2	5 (4.5%)
6	Substance Use Disorder	105	4.8	6 (4.6%)
7	Septicemia	105	4.8	3 (7.4%)
8	Cancer/Malignancies	102	4.6	8 (3.6%)
9	Diabetes	94	4.3	
10	Diseases of Liver, Biliary Tract, and Pancreas	84	3.8	7 (3.7%)

Data for North Central ACH, Excluding Pregnancy and Child Delivery Related Hospitalizations (Jan 1, 2015 - Oct 31, 2015)
 Source: Health Care Authority Starter Kit, determined by primary diagnosis field in HCA ProviderOne Medicaid Data System

Adult (18+) Chronic Diseases

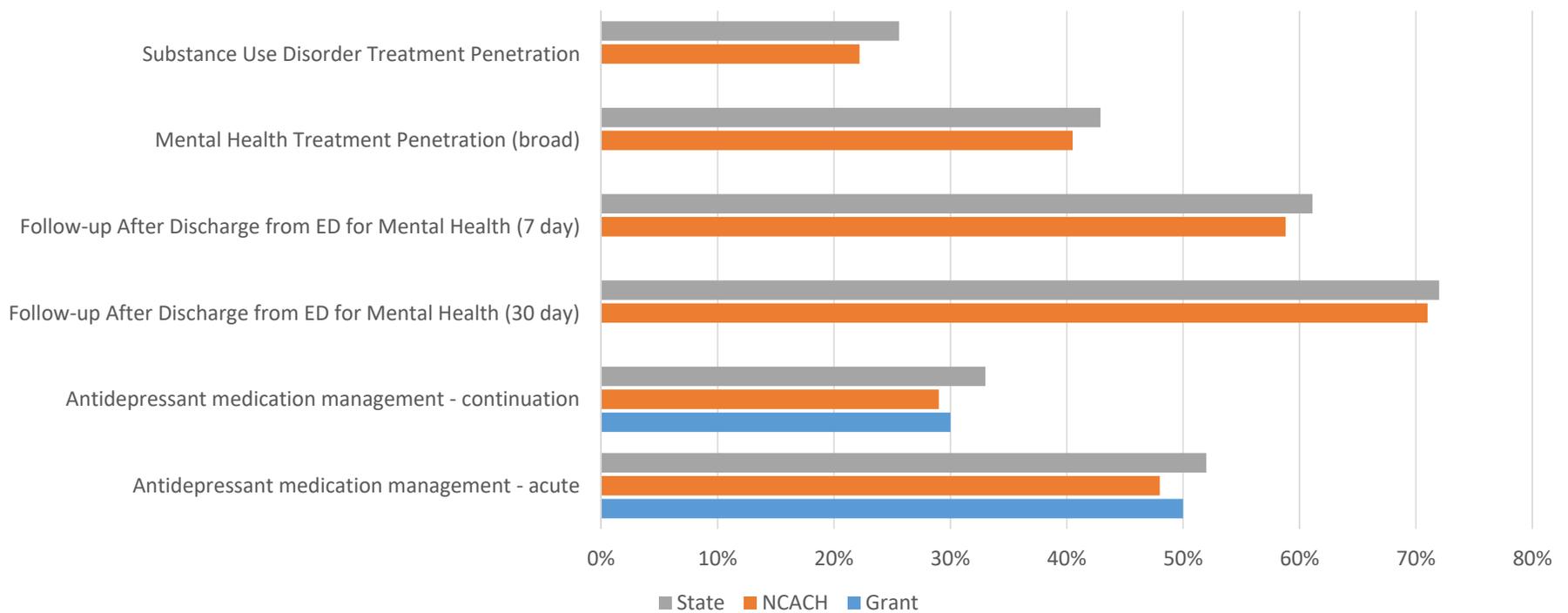
Grant County



Source: Washington Dept. of Health Chronic Disease Profiles (2017), drawing from Washington Behavioral Risk Factor Surveillance System 2013-2015

Behavioral Health

Behavioral Health Measures Where NCACH Below State Average



Data for North Central ACH from Health Care Authority – based on demonstration measures

Risk Factors for Arrests

5-6 times more likely to exhibit one of these risk factors

- Substance abuse (not including alcohol)
- SUD treatment need
- Co-occurring mental illness/substance use disorder

Risk Factors for Homelessness

3-4 times more likely to exhibit one of these risk factors

- SUD treatment need
- Co-occurring mental illness/substance use disorder
- Substance abuse (not including alcohol)
- Psychiatric (bipolar)

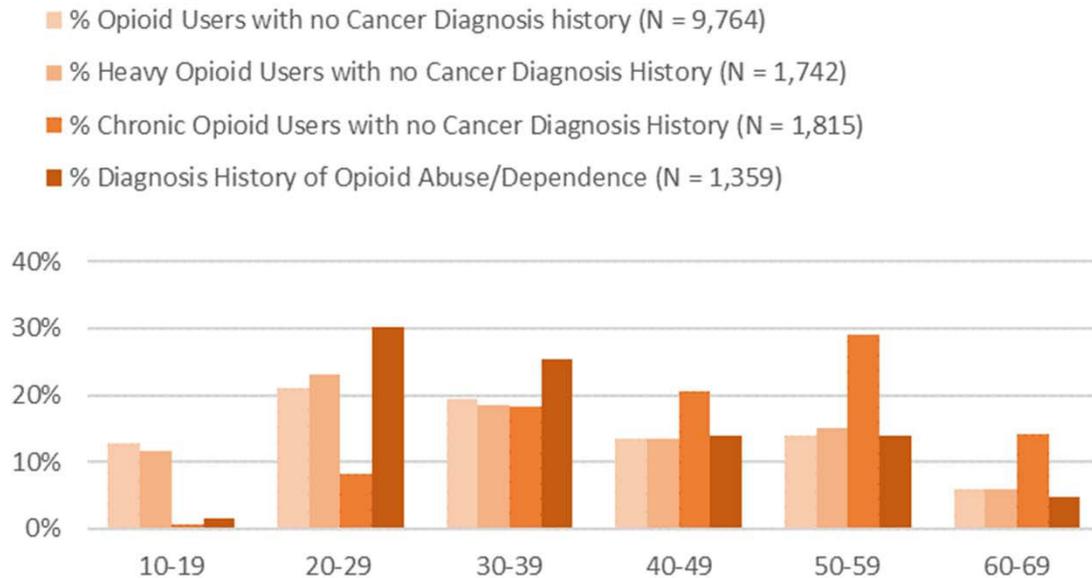
Risk Factors for ED Utilization

5-7 times more likely to exhibit one of these risk factors, if have 3+ ED visits

- Type 1 diabetes
- Pulmonary
- Cardiovascular
- Renal
- Liver disease
- Co-occurring mental illness/substance use disorder
- Substance abuse (low)

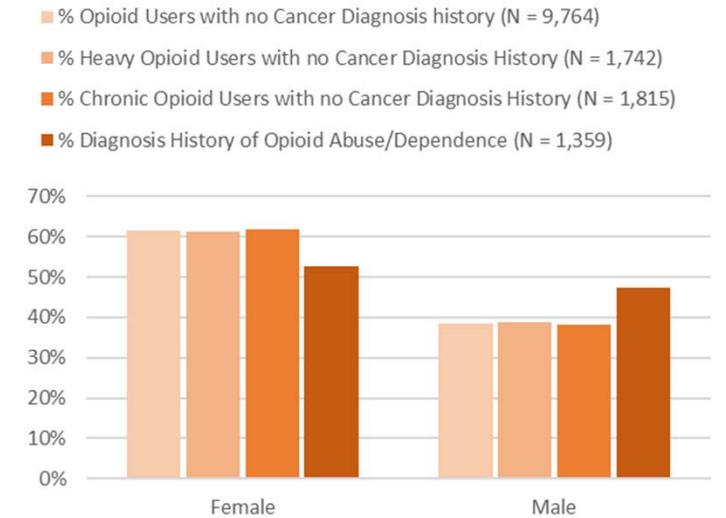
Opioid Use

Opioid Use by Age (NCACH Region)

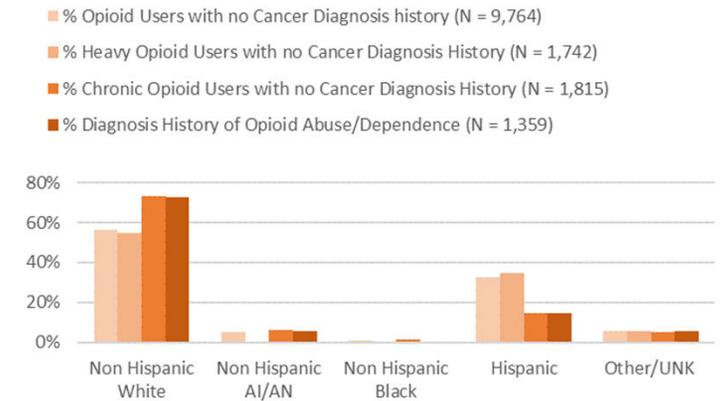


Source: Health Care Authority drawn from fiscal year 2016 claims data and ICD coding Medicaid only population with full medical eligibility

Opioid Use by Gender (NCACH Region)

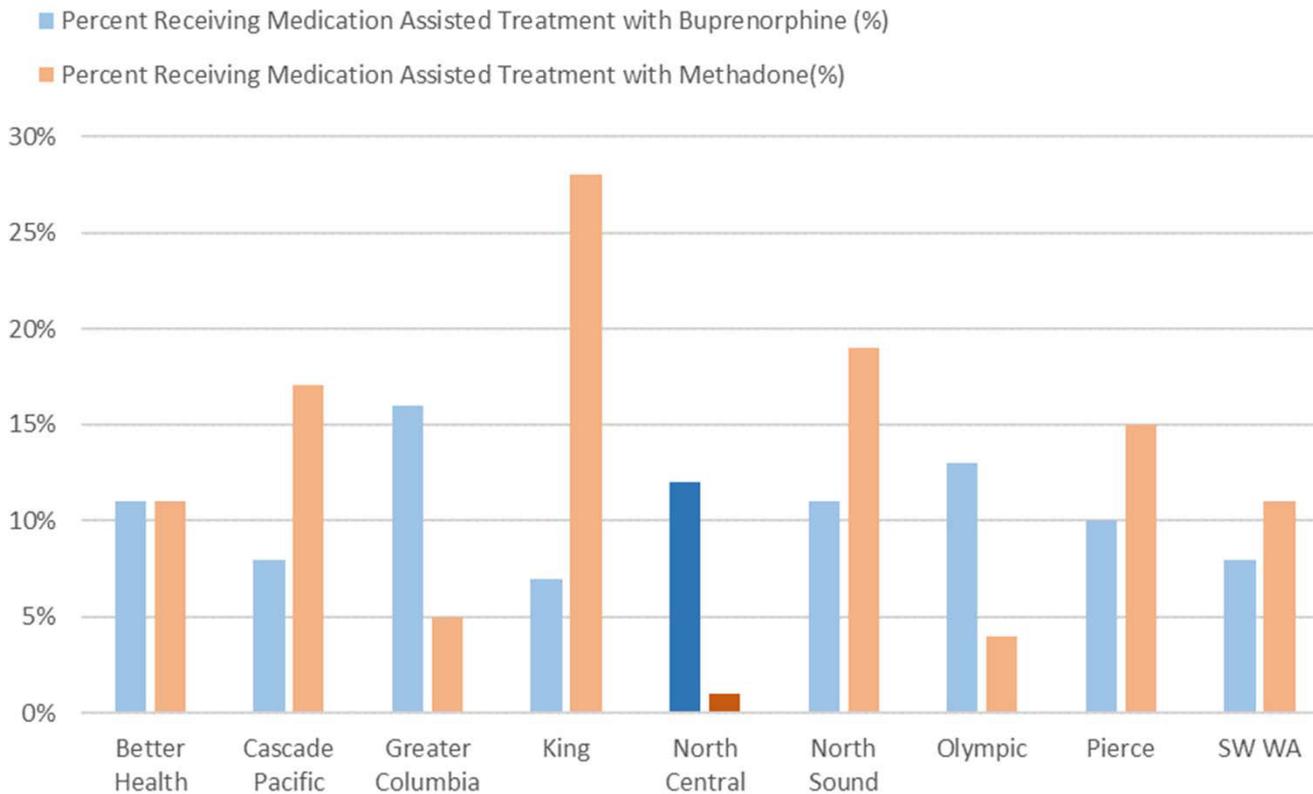


Opioid Use by Race/Ethnicity (NCACH Region)



Opioid Treatment

Medication Assisted Treatment Across ACHs



Source: Health Care Authority

Project Performance Measures

- Antidepressant Medication Management*
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization
- Medication Management for People with Asthma (5 – 64 Years)*
- Mental Health Treatment Penetration (Broad Version)
- Outpatient ED Visits per 1000 Member Months
- Plan All-Cause Readmission Rate (30 Days)
- Substance Use Disorder Treatment Penetration
- Percent Homeless (Narrow definition)
- Percent Arrested
- Medication Assisted Therapy (MAT): With Buprenorphine or Methadone*
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Substance Use Disorder Treatment Penetration (opioid)
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)*

Demonstration Measures across 6 projects – red indicates measures where ACH is below state average (indicates where we are lowest performing ACH)
Measurement periods vary across measures (2015, FY 2016, or Oct 2015-Sep 2016)*

High- Performance Measures

Metric	2A: Integration	2B: Pathways	2C: Transitional	2D: Diversion	3A: Opioid	3D: Chronic	Demonstration Projects
Outpatient Emergency Department Visits per 1000 Member Months	1	1	1	1	1	1	6
Inpatient Hospital Utilization	1	1	1		1	1	5
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	1	1	1				3
Follow-up After Hospitalization for Mental Illness	1	1	1				3
Percent Homeless (Narrow Definition)		1	1	1			3
Plan All-Cause Readmission Rate (30 Days)	1	1	1				3
Substance Use Disorder Treatment Penetration	1	1					2
Mental Health Treatment Penetration (Broad Version)	1	1					2
Child and Adolescents' Access to Primary Care Practitioners	1					1	2
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	1					1	2
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1					1	2
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1					1	2
Medication Management for People with Asthma (5-64 years)	1					1	2

Discussion Questions

As our project workgroups work on recommending evidence-based approaches and priority populations...

- What potential populations do you recommend they target?
- What populations/issues should they look further into?
 - e.g. gender, race/ethnicity, age, specific health conditions
- What questions and data gaps should they dig into?
- Any other takeaways you want us to relay to workgroups?

Event: CVCH Back to School Health Fair

Date: August 5th, 2017

Location: Wenatchee

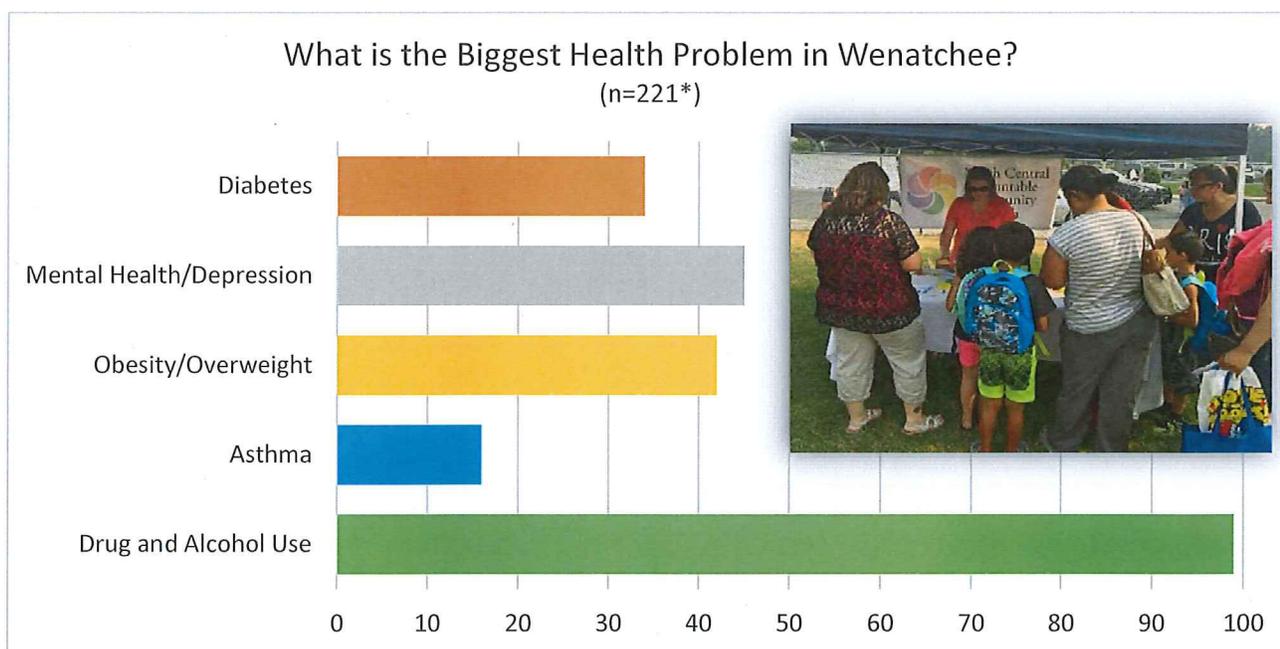
Event Description: An event in which K-12 school-aged children are provided backpacks and school supplies. In 2016, over 2,000 community members attended the event with 829 backpacks distributed. While we do not have the official numbers yet, there appeared to be similar participation in 2017. The Back to School Health Fair not only provides the necessary tools to aid in a student’s success, but it also serves as platform to inform families and participants about the resources and programs available to them in our community to help them maintain a healthy and safe lifestyle. NCACH had success in surveying over 200 community members at this event.



Question: What is the biggest health problem in Wenatchee?

Answer	English	Spanish	Multiple English	Multiple Spanish	Total
Drug and Alcohol Use	54	36	4	5	99
Asthma	6	9	0	1	16
Obesity/Overweight	20	13	5	4	42
Mental Health/Depression	34	7	3	1	45
Diabetes	6	21	4	3	34
Other	2	1	0	0	3
Total Number of Surveys Completed	122	87	6	6	221

Other Answers: Healthcare Systems



*note: 12 survey responses had multiple answers

COMMUNITY ENGAGEMENT

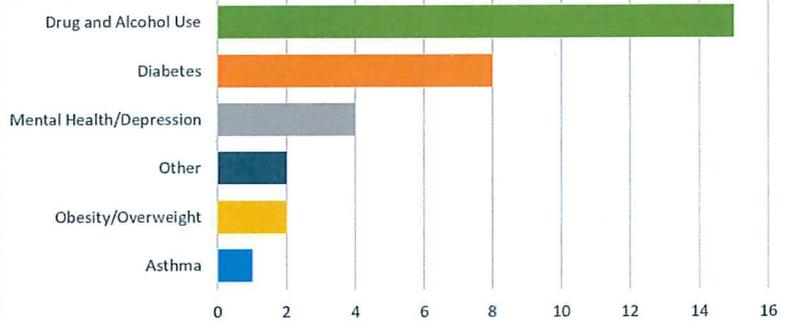
Linda Evans Parlette, Teresa Davis, Caroline Tillier and John Schapman, attended the Coulee Medical Center Annual Gathering of Wellness Powwow. They again asked the question “What is the biggest health problem in your community?” This was a great event and we all enjoyed learning more about the tribal community.



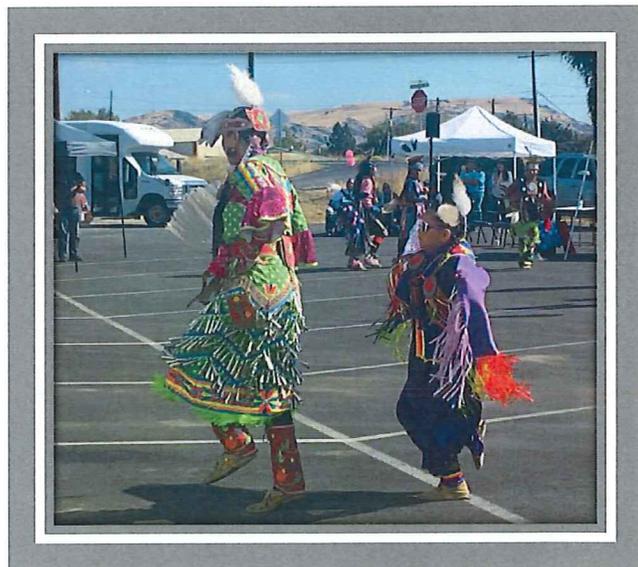
NACH Board member Molly Morris was honored at the Powwow by Molina Healthcare as a community champion. Molly was nominated by Deb Miller from Community Choice. Molly is pictured above with Caroline Tillier and Teresa Davis from NCACH

Coulee Medical Center Powwow 9/15/2017

What is the Biggest Health Problem in Your Community?
(n=19*)

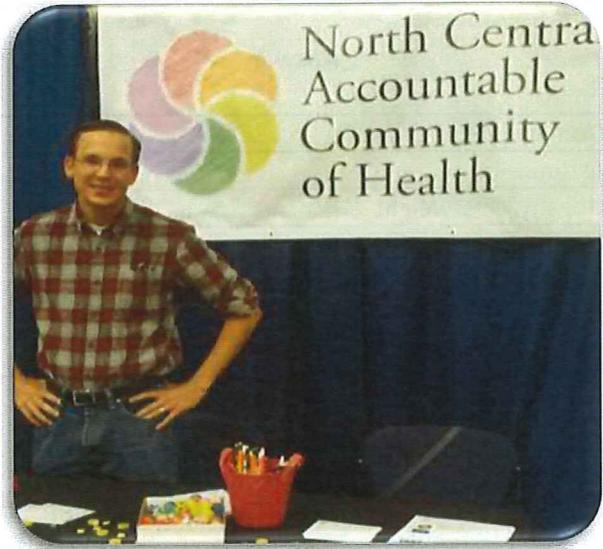


* 11 survey responses had multiple answers



Event: North Central WA Health & Wellness Expo
 Date: September 30th, 2017
 Location: Moses Lake

Event Description: The Central Washington Health & Wellness Expo is a one day event, in September focusing on educating the public on best health & wellness practices. Professionals from the industry and area businesses set up booths and educational seminars that will help educate the public on several subjects including the new health exchange, pediatric care, senior care, and the products and services of numerous businesses in Central Washington. The public is welcomed and encouraged to attend! Entrance is free, and there are lots of activities for the whole family!



Question: What is the biggest health problem in your community?

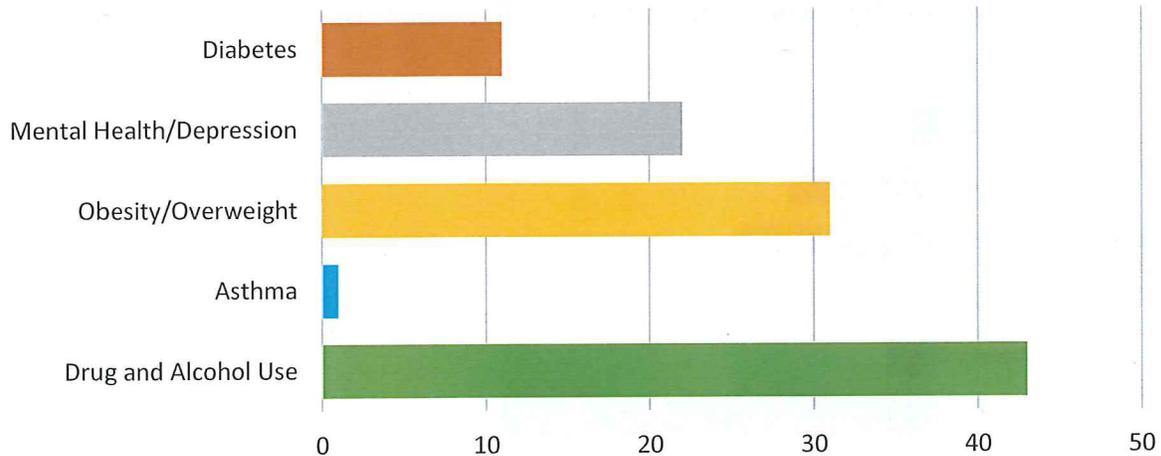
Answer	Single Answer	Multiple Answers	Total
Drug and Alcohol Use	23	20	43
Asthma	1	0	1
Obesity/Overweight	16	15	31
Mental Health/Depression	8	14	22
Diabetes	4	7	11
Other	3	1	4
Total Number of Surveys Completed	55	26	81



Other Answers: Homeless, Water, Teen Pregnancy, None

NCW Health & Wellness Expo 9/30/2017

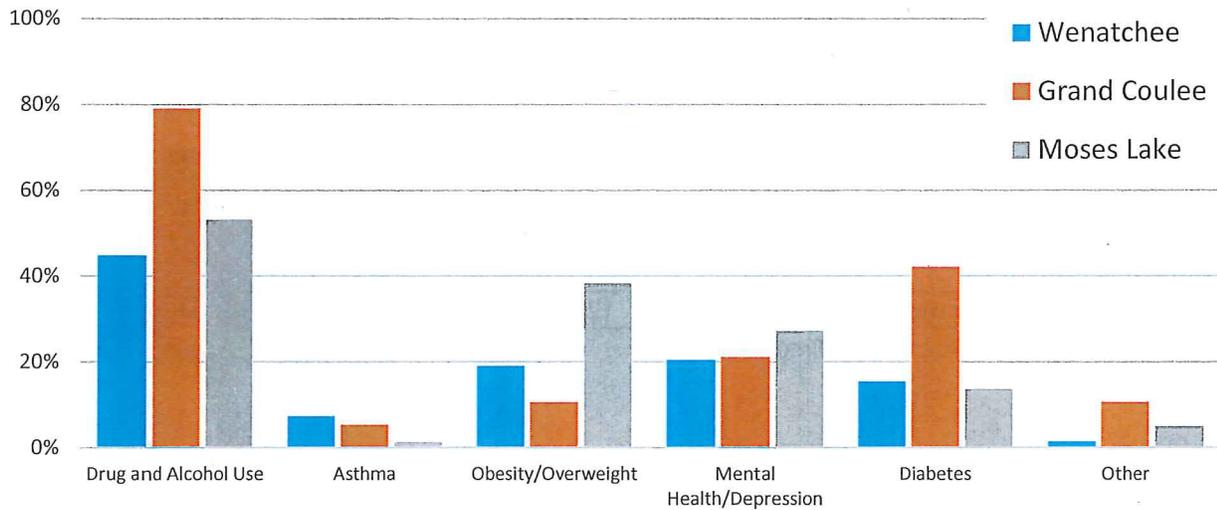
What is the Biggest Health Problem in Your Community?
 (n=81*)



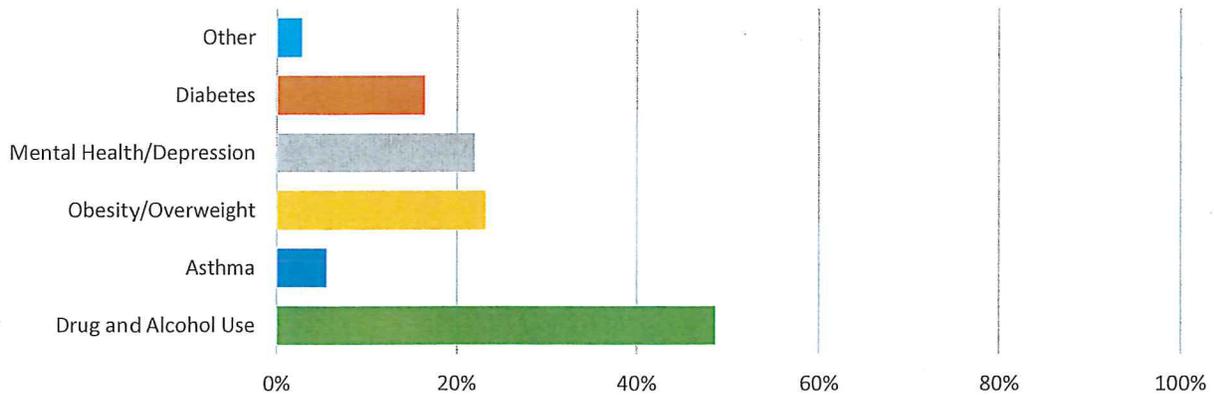
*note: 26 survey responses had multiple answers

Answer	Wenatchee		Grand Coulee		Moses Lake		Total	
	n	%	n	%	n	%	n	%
Drug and Alcohol Use	99	44.8%	15	78.9%	43	53.1%	157	48.6%
Asthma	16	7.2%	1	5.3%	1	1.2%	18	5.6%
Obesity/Overweight	42	19.0%	2	10.5%	31	38.3%	75	23.2%
Mental Health/Depression	45	20.4%	4	21.1%	22	27.2%	71	22.0%
Diabetes	34	15.4%	8	42.1%	11	13.6%	53	16.4%
Other	3	1.4%	2	10.5%	4	4.9%	9	2.8%
Total Number of Surveys Completed	221	100.0%	19	100.0%	81	100.0%	323	100.0%

What is the biggest health problem in your community?
(n= 323)



What is the biggest health problem in your community?
(n= 323)



Behavioral Health Administration
Office of Consumer Partnerships



Chelan, Douglas and
Grant Counties

12:30-4:30 p.m.
50 Simon St SE, Suite A
East Wenatchee WA
*Limited travel assistance
available on request

Transforming
Lives

July 13th, Wenatchee WA

2017 Behavioral Health Consumer Forum

For those in services, their
families, and supporters

Please join us to learn more about integration plans in North Central and engage in discussion about recovery, services, and other topics of interest. Learn more about the Healthcare Authority and the new role Managed Care Organizations will play in your healthcare

- Discuss recovery goals with Mary Jadwisiak, Holding the Hope and Jennifer Bliss, Manager of the Office of Consumer Partnerships
- Talk with representatives of the Accountable Community of Health and the Healthcare Authority
- Listen to a panel of MCO representatives and ask questions such as:
 - How will services be recovery oriented? Include consumer voice? Develop peer support?
 - What needs do you see in your area? What would you like to see?



Register for this event by emailing Jennifer Bliss, blissja@dshs.wa.gov.

Individuals in services and their families living in the region have priority for this training. Others are welcome as space allows.

Behavioral Health Administration
Office of Consumer Partnerships



Chelan, Douglas and
Grant Counties

Transforming Lives

September 22nd, 2017
Moses Lake WA

2017 Behavioral Health Consumer Forum

For those in services, their
families, and supporters

11:00-4:30 p.m.

*Limited travel assistance
available on request

Grant Integrated Services
840 E Plum
Moses Lake WA 98837

Free Pizza!

**Free Raffle!
(Three \$40
gift cards)**

Please join us to learn more about integration plans in your county and engage in discussion about recovery, services, and other topics of interest. Learn more about the Health Care Authority, the Accountable Community of Health, and the new role Managed Care Organizations will play in your healthcare.

- Discuss recovery goals with Mary Jadwisiak, Holding the Hope, and Jennifer Bliss, Manager of the Office of Consumer Partnerships
- Talk with representatives of the North Central Accountable Community of Health and the Health Care Authority
- Discuss strengths and needs in your area, including:
 - How will services be recovery oriented? Include consumer voice? Develop peer support?



Register for this event by emailing Jennifer Bliss, blissja@dshs.wa.gov.

Individuals in services and their families living in the region have priority for this training. Others are welcome as space allows.



North Central Accountable Community of Health

November, 2017



An update from the Executive Director, Linda Evans Parlette

I have been spending my time catching up on the many emails and presentations that I missed while caring for my husband since May. I will take a “point of personal privilege” during the November board meeting to share a bit more.

How does one get through such a stressful time during a period of many NCACH deadlines, increased workload, and multiple changes? You rely on staff and in my case, the Board Chair. Barry stepped in, at my request to fill in many of the gaps I created. I am extremely grateful. I am back “in the saddle” as my late husband would say, and am comforted by the continual support of staff, board members, and community. Planning Bob’s November 20th, “Celebration of Life” and the party he wanted to follow gives me joy.

The NCACH staff has been working hard to form workgroups to gather data and community input for writing the project plans. I will continue to attend those workgroups. I am so appreciative of the attendance from volunteers from all four counties in our region.

As you know, on January 1, 2018, all Medicaid contracts will be fully integrated for medical and behavioral health care in Chelan, Douglas, and Grant counties. Many thanks to Christal Eshelman, our NCACH lead staff, for working with many for shepherding 3 of our counties through the process with oodles of meeting. Thanks also to Isabel Jones and Alice Lind – two star Health Care employees as well as Tamara Caldwell Burns and staff at the Behavioral Health Organization (BHO). As a side note, we learned on October 23rd, that Okanogan County will become a middle adopter on January 1, 2019, joining all but two ACH regions across the state. We all know that financial integration is not the same as clinical integration so there will be a lot of continued work to do as we move toward 2020. Christal is looking forward to having more time now, as the NCACH lead on the OPIOID project and the HUB.

November 16th is the deadline for the preliminary project plan application to be submitted. We look forward to meeting that deadline, enjoying the Thanksgiving holiday, and then moving full speed ahead beginning in December where we can focus on delving deeper into project planning.

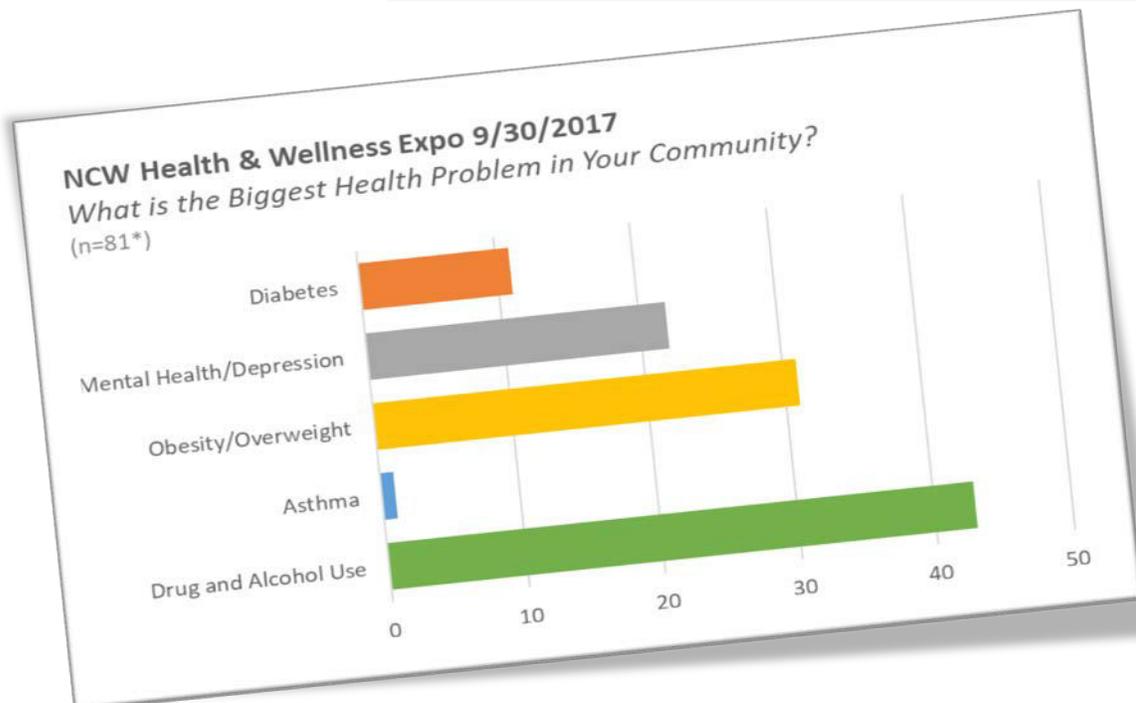
Lastly, Alison White, Executive director of Better Health Together, surprised me with T Shirts for all of the ACH Executive Directors at a meeting we had near SeaTac recently. Alison is missing from this picture, but you will see that she liked the tag line I used while serving as senator from the 12 Legislative District. What she doesn’t know is that I was also known as the 12th Woman! I thought you would enjoy the picture (shown in staff update section).

Charge On!

COMMUNITY ENGAGEMENT

John and Christal attended the North Central Washington Health and Wellness Expo in Moses Lake at the end of September. We asked the community “What is the Biggest Health Problem in Your Community?”

Similar to the other two events we attended in Wenatchee and Grand Coulee, the highest response was Drug and Alcohol Use followed by Obesity. It was a great opportunity to interact with the community and fun to see so many of our Grant County partners!



BOARD SPOTLIGHT



Congrats to Winnie Adams!

Our own Board Member Winnie Adams travelled to Arizona to attend her graduation from Grand Canyon University. Winnie received a Double Master's in Nursing Leadership and Business Administration, which she completed online.

Winnie will be leaving our Board as she has accepted a position with Coordinated Care. We are sad to see her go and will miss her presence at meeting table, but have comfort in knowing that we will be working closely with her in the years to come.

NCACH Governing Board Members

Barry Kling – Chair

Kevin Abel – Vice Chair

Sheila Chilson – Treasurer

Winnie Adams – Secretary

Bruce Buckles

Molly Morris

Kayla Down

Nancy Nash-Mendez

Ray Eickmeyer

Tyler Paris

Jesus Hernandez

Theresa Sullivan

Tim Hoekstra

Senator Judith Warnick

Brooklyn Holton

Doug Wilson

Rick Hourigan

Mike Beaver

NCACH Staff Update

The NCACH Staff along with Board Chair Barry Kling had an all day retreat on October 20th. We had a very productive day to help with project planning. Thank you to Lake Chelan Community Hospital for the use of the meeting room. After the retreat, NCACH Board member Ray Eickmeyer gave John, Christal, Caroline and Teresa a tour of the hospital. Below...John and Christal are pictured with Ray in one of the Lake Chelan Community ambulances.



Charge On!

John Schapman

As we move into project implementation planning, I have been working with teammates to connect with our Coalitions for Health Improvement to provide data to members who can then provide additional recommendations to better refine target populations. As well, our team has engaged in monthly meetings with the MCOs in our region and held our first meeting on October 3rd. Moving into detailed project planning, our team looks forward to both these critical partnerships.

Internally, I have been working with teammates to interview candidates for the New Program Development Position. We have had more applicants than we anticipated and have completed a number of interviews. The goal is to have this process completed by the end of November 2017. As well, all NCACH staff have also been working hard to finalize the project plan application submissions. HCA made some last minute changes in the submission requirements that has created some additional meetings between state partner and the ACH project leads that I have attended, but the great partnership with the state helped all partners come together to create a better submission process. As we get closer to November 16th, I will be spending most days editing the application for final submission.

Christal Eshelman

We are two months away from FIMC Go-Live for Chelan, Douglas, and Grant Counties! And, Okanogan County Commissioners sent a letter of intent to become a Mid-Adopter on January 1, 2019! This means that on January 1, 2019, all four of the counties in North Central ACH will have integrated Medicaid contracts for physical and behavioral health.

While there were no Fully-Integrated Medicaid Contracting Advisory Committee meetings in October, the work to prepare for integration continues through the Workgroups and individualized technical assistance with our five Behavioral Health (BH) providers. Xpio is continuing to work closely with the BH providers to prepare their IT and billing systems for integration. We have initiated bi-weekly conference calls with Xpio and the Health Care Authority (HCA) to keep updated on progress of this work.

The Consumer Engagement Workgroup has picked back up after a lull in August and September. We now have a 1/2 page flyer of the “Things to know about changes to Washington Apple Health” that is available in our four most common languages (English, Spanish, Russian, and Ukrainian). We also have a one-pager that includes a table explaining how enrollees can expect to get care after integration. These materials were created by HCA upon request from the Workgroup. Workgroup members are distributing these materials to various coalitions and organizations to be available for providers and enrollees when needed. For digital copies or to request printed copies of these materials, please contact me at: christal.eshelman@cdhd.wa.gov.

Last month, the Governing Board approved the Early Warning System indicators that will be used in conjunction with regular communication of the providers, MCOs, and HCA to quickly identify issues during the first six months of integration. We are now working with the AIM team at HCA during bi-weekly conference calls to identify the processes to be used to regularly collect, analyze, and report the data.

The Regional Opioid Stakeholders Workgroup is starting to form. The NCACH Executive Committee carefully selected Workgroup members to ensure board regional and sector representation. The first Workgroup meeting was held on October 27th. This meeting included background information on Healthier Washington and the Medicaid Transformation Demonstration, the goals of the Workgroup, project timelines, a preview of regional opioid data, and the beginning draft of a regional opioid initiative matrix. It is fun to work with such a motivated and passionate group of people. I am excited for the coming months where we will be shaping the project plans and bringing forth recommendations to the Governing Board.

Caroline Tillier

As we approach the November 16th project application deadline, we've all been spending a lot of time this month looking at data, community feedback, and talking through preliminary target populations and evidence-based approaches. At the end of September, Christal and I attended the Okanogan CHI meeting and I attended the Grant County CHI meeting on October 10th. We were on the agendas to provide their membership an overview of data as it links to our region's 6 projects. We have received great initial feedback from all three CHIs on the evidence-based approaches and target populations, including requests for additional data. I look forward to supporting the CHIs with additional data they might want to explore, and we will keep sharing their feedback with all of our project workgroups as they continue project planning over the next 8 months. Our team also took a road trip to Seattle to attend a full-day working session with all ACHs and HCA. The primary focus of the session was to articulate a shared data strategy framework as we dive into practical questions we (all ACHs) are eager to answer (e.g. what metrics we will need to collect for pay for reporting, existing data sources for those data, new collection mechanism ACHs will need to put in place, proxy metrics for tracking on going progress, etc.) We just scratched the surface and there will be more of these ACH-wide conversations as we work to identify solutions by the end of 2017.

And last but not least, we had our first meetings with the Transitional Care/Diversion Interventions workgroup and the Opioid workgroup at the end of October – an exciting milestone! With certification requirements behind us, we're finally turning theory into action. I supported Christal and John by pulling together existing data that can help workgroup members understand where we're at, and where we might have the most impact. We look forward to working with community partners in all 4 counties to come up with project implementation plans.

Peter Morgan

During the past period, we've finalized and initial contract with the consulting groups of CCMI & CSI for the design portion of the Learning Collaborative for the Whole Person Care and have been working on getting the initial meeting organized and scheduled and also scheduling a few site visits with a sample of our members. This is where the work will begin to get real and we move from the conceptual to the operational level of the project. Under John Schapmann's direction, I am also working on my sections of the project proposal covering projects 2a (bi-directional behavioral and physical health integration) and 3d (chronic disease management) to ensure the work of the WPCC meets the project requirements set out by the Health Care Authority.

As a part time employee, I'm trying to stay up to speed on ongoing HCA requirements and processes as they affect the WPCC while relying on Sen. Parlette and the other staff to do the heavy lifting. Nevertheless, I did attend the HCA's "Commitment to Value" conference in Seattle on October 18 & 19 and Qualis' conference in Moses Lake on Whole Person Care on October 26th. Both provided information useful to our work and a chance to network with colleagues from the HCA and other ACHs.

I also managed to get in 10 days of vacation, which meant a lot to me.

NCACH Upcoming Meetings

November	Meeting	Time	Location	City/State
6th	Whole Person Care Collaborative Meeting	11:00 AM - 1:00 PM	Confluence Technology Center	Wenatchee, WA
6th	NCACH Governing Board Meeting	1:00 PM - 3:30 PM	Confluence Technology Center	Wenatchee, WA
29th	Fully-Integrated Medicaid Contracting Advisory Committee	10:00 AM - 11:30 AM	Confluence Technology Center	Wenatchee, WA

December	Meeting	Time	Location	City/State
4th	Whole Person Care Collaborative Meeting	11:00 AM - 1:00PM	Confluence Technology Center	Wenatchee, WA
4th	NCACH Governing Board Meeting	1:00 PM - 3:30 PM	Confluence Technology Center	Wenatchee, WA
6th	Okanogan Coalition of Health Improvement	TBA	Okanogan Behavioral Health	Okanogan, WA



North Central Accountable Community of Health

**200 Valley Mall Pkwy
East Wenatchee, WA 98802**

www.ncach.org

Contact for Questions:
Executive Assistant
Teresa Davis
509.886.6432
Teresa.davis@cdhd.wa.gov



The Confederated Tribes of the Colville Reservation
P.O. Box 150, Nespelem, WA 99155

(509) 634-2200
FAX: (509) 634-4116



Friday, June 23, 2017

Linda Parlette, Executive Director
North Central Accountable Community of Health
200 Valley Mall Parkway
East Wenatchee, WA 98802

Dear Senator Parlette,

It is my pleasure to write a letter in support to the North Central Accountable Community of Health (NCACH) as you submit your application for Phase II Certification to the Washington State Health Care Authority. I understand that NCACH is completing Phase II Certification to prepare for the work completed through the Medicaid Demonstration Project.

I understand that the funds gathered during the certification process will help support the administrative infrastructure needed to manage the projects that will be completed by the NCACH and partnering organizations in the North Central regional service area (Chelan, Douglas, Grant, and Okanogan). I understand the Colville Confederated Tribes is considered a partner in the work of the NCACH. That partnership includes an invitation to fill a voting seat on the Governing Board, which Molly Morris has agreed to fill. The Colville Confederated Tribes recognizes that NCACH is in a strong position to lead the work of the Demonstration Project for the region. I fully support the efforts of NCACH as they prepare to take on the work of the Medicaid Demonstration Project.

Sincerely

Dr. Michael Marchand
Chairman, Colville Confederated Tribes

c.c. Mel Tonasket Vice Chair Colville Confederated Tribes
Molly Morris Board Member, North Central Accountable Community of Health

Colville Confederated Tribes Resolutions:

Brief Description:

- These resolutions describe the Colville Confederated Tribes program updates, projects, and directives for the Health Programs
- The below resolutions NCACH staff identified as those resolutions that align with the projects that we are completing under the Medicaid Demonstration Project.
- This information is to give the Governing Board members an awareness of the major issues that our tribal partners are working on

Resolutions:

Affiliated Tribes of Northwest Indians (ATNI):

A regional organization comprised of American Indians/Alaska Natives (AI/AN) and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska.

2017 Annual Convention Resolutions (Spokane, WA):

- **Resolution #17 – 59:** Support for Adoption of “Center for Disease Control Guideline for Prescribing Opioids for Chronic Pain” by Indian Health Service Facilities and Tribal Health Organizations
- **Resolution #17-60:** Support for Legislation Amending Title XIX of the Social Security Act for Adult Inpatient Treatment and grant funding for AI/AN Youth Addiction Treatment Facilities’ Infrastructure
- **Resolution #17-62:** Support for Recommendations to Congress to Obtain Additional data on Indian Health Services (HIS) Health Care Facilities Construction Funding and Distribution Methodologies

The National Congress of American Indians:

Established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal government.

- **Resolution #MOH-17-013:** Funding for Correctional Health Care in Tribal and BIA Facilities
- **Resolution #MOH-17-038:** Support for the Reauthorization of the Special Diabetes Program for Indians



**2017 Annual Conference
Spokane, WA**

RESOLUTION #17 – 59

**“SUPPORT FOR ADOPTION OF “CENTER FOR DISEASE CONTROL
GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN”
BY INDIAN HEALTH SERVICE FACILITIES
AND TRIBAL HEALTH ORGANIZATIONS”**

PREAMBLE

We, the members of the Affiliated Tribes of Northwest Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants rights secured under Indian Treaties, Executive Orders and benefits to which we are entitled under the laws and constitution of the United States and several states, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the welfare of the Indian people, do hereby establish and submit the following resolution:

WHEREAS, the Affiliated Tribes of Northwest Indians (ATNI) are representatives of and advocates for national, regional, and specific tribal concerns; and

WHEREAS, ATNI is a regional organization comprised of American Indians/Alaska Natives (AI/AN) and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska; and

WHEREAS, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of ATNI; and

WHEREAS, opioid prescriptions have risen dramatically over the past 15 to 20 years and the annual incidence of opioid overdoses and deaths have also risen nationally; and

WHEREAS, people in rural counties are nearly twice as likely to overdose on prescription painkillers as people in big cities and many Tribal communities are located in rural areas; and

WHEREAS, AI/AN people are more likely to overdose on prescription painkillers; and

WHEREAS, AI/AN people in the Northwest (Oregon, Idaho, and Washington) are two times more likely to fatally overdose on prescription painkillers compared to non-Hispanic Whites in the region; and

WHEREAS, the California Public Health Department has identified that some of the highest rates of opioid overdose in the United States are in Northern California, with some counties' opioid prescription death rates 2 - 3 times higher than the national average; and

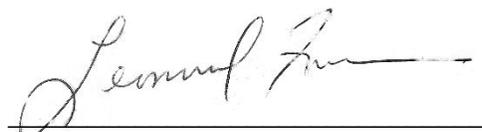
WHEREAS, the Centers for Disease Control and Prevention (CDC) developed and published the CDC Guideline for Prescribing Opioids for Chronic Pain, available at <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>, to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings; and

WHEREAS, adoption of the CDC Guideline for Prescribing Opioids for Chronic Pain by Indian Health Service (IHS) and Tribal Health Organizations in Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska would improve how opioids are prescribed to AI/AN patients; and ensure that AI/AN patients have access to safer, more effective chronic pain treatment, while reducing the number of AI/AN people who abuse or overdose from these drugs; now

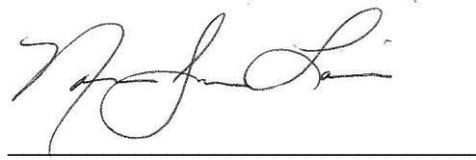
THEREFORE BE IT RESOLVED, that in the absence of any tribal-specific policy to reduce opioid addiction, overdose and death of AI/AN people, the ATNI supports adoption of the CDC Guideline for Prescribing Opioids for Chronic Pain, *available at* <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>, by Indian Health Service and Tribal Health Organizations to reduce opioid addiction, overdose and death of AI/AN people.

CERTIFICATION

The foregoing resolution was adopted at the 2017 Annual Convention of the Affiliated Tribes of Northwest Indians, held at the Davenport Grand Hotel, Spokane, Washington on September 18-21, 2017, with a quorum present.



Leonard Forsman, President



Norma Jean Louie, Secretary



**2017 Annual Convention
Spokane, WA**

RESOLUTION #17 – 60

**“SUPPORT FOR LEGISLATION AMENDING TITLE XIX OF THE SOCIAL SECURITY
ACT FOR ADULT INPATIENT TREATMENT AND GRANT FUNDING FOR AI/AN
YOUTH ADDICTION TREATMENT FACILITIES’ INFRASTRUCTURE”**

PREAMBLE

We, the members of the Affiliated Tribes of Northwest Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants rights secured under Indian Treaties, Executive Orders and benefits to which we are entitled under the laws and constitution of the United States and several states, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the welfare of the Indian people, do hereby establish and submit the following resolution:

WHEREAS, the Affiliated Tribes of Northwest Indians (ATNI) are representatives of and advocates for national, regional, and specific tribal concerns; and

WHEREAS, ATNI is a regional organization comprised of American Indians/Alaska Natives (AI/AN) and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska; and

WHEREAS, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of ATNI; and

WHEREAS, mental health and substance abuse disparities in the AI/AN population are well-documented; and

WHEREAS, among other issues, underage drinking increases the risk of suicide and homicide, physical and sexual assault, use and misuse of other drugs, and is a risk factor for heavy drinking later in life; and

WHEREAS, among adolescents ages 12 to 20, AI/ANs had the highest major depressive episode prevalence in the past year; and

WHEREAS, the suicide rate among AI/AN adolescents and young adults ages 15 to 34 (31 per 100,000) is 2.5 times higher than the national average for that age group (12.2 per 100,000); and

WHEREAS, the 2013 Youth Risk Behavior Survey reports that AI/AN youth had higher rates of drinking alcohol before age 13 compared to national rates (28.2 compared to 18.6 respectively) and data from the American Drug and Alcohol Survey administered to Native youth at 33 schools from 2009-2012 showed much higher prevalence of drug and alcohol use amongst 8th and 10th grade Native youth in comparison to national averages; and

WHEREAS, access to treatment facilities is critical to the well-being of AI/AN people who suffer from mental health or substance abuse issues; and

WHEREAS, the Medicaid Institutions for Mental Diseases (IMD) exclusion under section 1905(a)(B) of the Social Security Act, prohibits “payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases except for inpatient psychiatric hospital services for individuals under age 21;” and

WHEREAS, the law defines “institutions for mental diseases” as any “hospital, nursing facility, or other institution of more than 16 beds, that is the primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services;” and

WHEREAS, the IMD 16-bed capacity restriction and funding limitations keep many AI/AN people from accessing needed inpatient treatment services; and

WHEREAS, the IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services; and

WHEREAS, legislation amending Title XIX of the Social Security Act (SSA) would provide States with an option to provide medical assistance to individuals between the ages of 22 and 64 for inpatient services to treat substance abuse at residential treatment facilities would benefit AI/AN people; and

WHEREAS, amending the SSA to increase the institutions for mental diseases 16-bed limit to 40 or more beds would benefit AI/AN people in need of residential treatment under the Medicaid or Children’s Health Insurance Program (CHIP) program; and

WHEREAS, grant awards are needed to expand the infrastructure and treatment capabilities, including augmenting equipment and bed capacity, of youth addiction treatment facilities serving AI/AN at-risk youth that provide addiction and mental health treatment services to Medicaid or CHIP beneficiaries who have not attained the age of 21 and who are considered part of a medically underserved population; and

WHEREAS, such grant awards must allow for expanding infrastructure, staffing, and treatment capacities of existing facilities (including construction) and new facilities construction; and

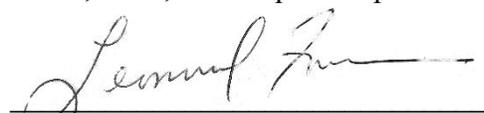
WHEREAS, any grant awards must give priority to providing addiction treatment services to AI/AN Medicaid or CHIP beneficiaries who have not attained the age of 21; now

THEREFORE BE IT RESOLVED, that ATNI urges the U.S. Congress to support legislation that:

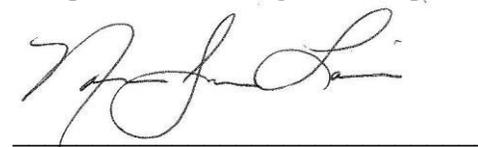
- Amends title XIX of the Social Security Act (SSA) to provide States with an option to provide medical assistance to individuals between the ages of 22 and 64 for inpatient services to treat substance abuse at residential treatment facilities under the Medicaid/CHIP program;
- Amends the SSA to increase the institutions for mental diseases 16-bed limit to 40 or more beds;
- Provides grant awards to expand the infrastructure and treatment capabilities, including augmenting equipment and bed capacity, of eligible youth addiction treatment facilities serving AI/AN at-risk youth that provide addiction and mental health treatment services to Medicaid or CHIP beneficiaries who have not attained the age of 21 and who are considered a medically underserved population;
- Provides that grant awards may be used to expand infrastructure, staffing and treatment capacities of existing facilities (including construction) and new facilities construction; and
- Appropriates at least \$50,000,000 for grant awards with at least 25% of such funds to youth addiction treatment facilities serving AI/AN at-risk youth who are Medicaid or CHIP beneficiaries and who have not attained the age of 21; and with no matching funds requirements.

CERTIFICATION

The foregoing resolution was adopted at the 2017 Annual Convention of the Affiliated Tribes of Northwest Indians, held at the Davenport Grand Hotel, Spokane, Washington on September 18-21, 2017, with a quorum present.



 Leonard Forsman, President



 Norma Jean Louie, Secretary



2017 Annual Convention Spokane, WA

RESOLUTION #17 – 62

“SUPPORT FOR RECOMMENDATIONS TO CONGRESS TO OBTAIN ADDITIONAL DATA ON INDIAN HEALTH SERVICES (IHS) HEALTH CARE FACILITIES CONSTRUCTION FUNDING AND DISTRIBUTION METHODOLOGIES”

PREAMBLE

We, the members of the Affiliated Tribes of Northwest Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants rights secured under Indian Treaties, Executive Orders and benefits to which we are entitled under the laws and constitution of the United States and several states, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the welfare of the Indian people, do hereby establish and submit the following resolution:

WHEREAS, the Affiliated Tribes of Northwest Indians (ATNI) are representatives of and advocates for national, regional, and specific tribal concerns; and

WHEREAS, ATNI is a regional organization comprised of American Indians/Alaska Natives and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska; and

WHEREAS, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of ATNI; and

WHEREAS, the Indian Health Care Improvement Act (IHCIA) is the legislative embodiment of the federal trust and treaty responsibilities to American Indian and Alaska Natives (AI/AN) for healthcare; and

WHEREAS, the IHCIA was first enacted in 1976 and then permanently enacted in 2010 as part of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148); and

WHEREAS, the IHCIA requires the Health and Human Services (HHS) Secretary to submit a report to Congress that describes the comprehensive, national, ranked list of all health care facilities' needs for the Indian Health Service (IHS), Indian Tribes, and Tribal Organizations carrying out health programs under the IHCIA, initially by March 23, 2011, and thereafter update the report every five years¹; and

WHEREAS, the IHCIA also requires the IHS to maintain a health care facility priority system which is to be developed in consultation with Indian Tribes and Tribal Organizations and serve as the basis for the HHS Secretary to submit the above referenced report to Congress²; and

WHEREAS, the initial report submitted to Congress estimated facilities needs and costs based on unfunded projects in the existing Health Care Facilities Construction Priority List (Priority List), in addition to those projects identified in Area Health Services and Facilities Master Plans (Masters Plans) developed in FY 2005 with their costs estimated by using the health care facility priority system; and

WHEREAS, ATNI, Northwest Portland Area Indian Health Board (NPAIHB), and many other Tribes and Tribal organizations do not believe that the report submitted to Congress was adequate to identify a national comprehensive list of facilities needs in light of the fact that the Priority List has been locked since approximately 1991 and Tribes and Tribal Organizations have not had an equitable opportunity to compete for funding in order to be placed on the list; and

WHEREAS, the 2005 Area Master Planning process included inconsistent planning criteria (and the necessary resources to complete thorough and comparable master plans) across the entire IHS system, and neither of these two processes incorporated new authorities for health services or facility types authorized in the 2010 amendments to the IHCIA; and

WHEREAS, the 2016 IHS/Tribal Health Care Facilities' Needs Assessment Report to Congress stated that the current Priority List will not be complete until 2041 and at the current rate of construction appropriations and the replacement timeline, a new 2016 facility would not be replaced for 400 years; and

WHEREAS, many Tribes and Tribal organizations have had to assume substantial debt to build or renovate clinics for Indian people to receive IHS-funded health care; now

THEREFORE BE IT RESOLVED, that ATNI urges the U.S. Congress to instruct the Government Accountability Office to review and issue a report on the IHS Facilities Construction Priority System, including historical and current funding distribution inequities; and

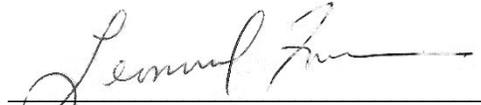
¹ 25 USC § 1631(c)(2)(A)(ii)(I).

² See "Report to Congress on Estimated Need For Tribal and Indian Health Service Health Care Facilities," submitted by the Indian Health Service, circa March 2011.

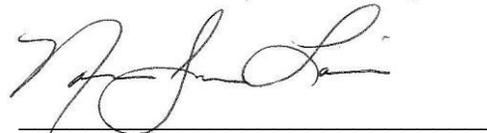
BE IT FINALLY RESOLVED, that based on results of the requested Government Accountability Office report, ATNI urges the U.S. Congress to increase funding to the Indian Health Facilities account in the IHS budget to provide construction, repair and improvement, equipment, and environmental health and facilities support for all IHS Areas equitably, and for Tribal governments through self-determination contracts and self-governance compacts.

CERTIFICATION

The foregoing resolution was adopted at the 2017 Annual Convention of the Affiliated Tribes of Northwest Indians, held at the Davenport Grand Hotel, Spokane, Washington on September 18-21, 2017, with a quorum present.



Leonard Forsman, President



Norma Jean Louie, Secretary



NATIONAL CONGRESS OF AMERICAN INDIANS

The National Congress of American Indians Resolution #MOH-17-013

TITLE: Funding for Correctional Health Care in Tribal and BIA Facilities

EXECUTIVE COMMITTEE

PRESIDENT
Brian Cladoosby
Swinomish Tribe

FIRST VICE-PRESIDENT
Fawn Sharp
Quinault Indian Nation

RECORDING SECRETARY
Aaron Payment
*Sault Ste. Marie Tribe of Chippewa
Indians of Michigan*

TREASURER
W. Ron Allen
Jamestown S'Klallam Tribe

REGIONAL VICE- PRESIDENTS

ALASKA
Jerry Isaac
Native Village of Tanacross

EASTERN OKLAHOMA
Joe Byrd
Cherokee Nation

GREAT PLAINS
Larry Wright
Ponca Tribe of Nebraska

MIDWEST
Roger Rader
Pokagon Band of Potawatomi

NORTHEAST
Lance Gumbs
Shinnecock Indian Nation

NORTHWEST
Mel Sheldon, Jr.
Tulalip Tribes

PACIFIC
Jack Potter, Jr.
Redding Rancheria

ROCKY MOUNTAIN
Darrin Old Coyote
Crow Nation

SOUTHEAST
Larry Townsend
Lumbee Tribe

SOUTHERN PLAINS
Liana Onnen
Prairie Band of Potawatomi Nation

SOUTHWEST
Joe Garcia
Ohkay Owingeh Pueblo

WESTERN
Bruce Ignacio
Ute Indian Tribe

EXECUTIVE DIRECTOR
Jacqueline Pata
Tlingit

NCAI HEADQUARTERS
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WHEREAS, we, the members of the National Congress of American Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants the inherent sovereign rights of our Indian nations, rights secured under Indian treaties and agreements with the United States, and all other rights and benefits to which we are entitled under the laws and Constitution of the United States and the United Nations Declaration on the Rights of Indigenous Peoples, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the health, safety and welfare of the Indian people, do hereby establish and submit the following resolution; and

WHEREAS, the National Congress of American Indians (NCAI) was established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal governments; and

WHEREAS, the Bureau of Indian Affairs (BIA) has oversight of all corrections facilities in Indian Country and the inmates that are incarcerated in them, whether they are operated directly by the BIA or by the tribe pursuant to a 638 contract or self-governance compact; and

WHEREAS, the BIA has no correctional health care budget, and as a result generally does not provide health care personnel or services in its detention facilities; and

WHEREAS, the absence of medical staff in tribal jails compromises the health and safety of inmates and detention personnel because inmates often are not given a medical evaluation when they are taken into custody, which in one instance, resulted in a serious tuberculosis outbreak in a newly constructed tribal jail that effected over 40 inmates and staff; and

WHEREAS, correctional officers must transfer inmates to their local Indian Health Service (IHS) or tribal 638 healthcare provider for all medical services (i.e. emergency, primary, dental, mental and behavioral health); and

WHEREAS, tribes are using significant portions of their BIA corrections allocations to transport and supervise inmates receiving health care – a single inmate with diabetes may need to be transported three times a week for dialysis and be supervised at the health facility for 3 hours each visit; and

WHEREAS, the federal government provides health care in Bureau of Prisons (BOP) and Immigration and Customs Enforcement (ICE) detention facilities through the use of Public Health Service Commissioned Corps Officers, but none of these personnel are working in BIA jails; and

WHEREAS, the Indian Health Service is chronically underfunded and tribal health facilities increasingly rely on Medicaid reimbursements to partially make up the severe shortfall in Indian health care appropriations; and

WHEREAS, Medicaid has an exclusion for outpatient health services for inmates based on the rationale that Congress already directly appropriates funds to pay for the healthcare costs of federal prisoners and that state and local jurisdictions do the same; and

WHEREAS, the Indian Health Service has no correctional health care budget; and

WHEREAS, Medicaid's "inmate exclusion" combined with the lack of funding for correctional health care at either BIA or IHS jeopardizes the financial sustainability of tribal healthcare facilities, forcing IHS and 638 tribal healthcare facilities to absorb, on average, \$1.5 million in annual uncompensated cost when a new tribal jail opens in their service area; and

WHEREAS, there is uncertainty about the extent to which a non-Indian inmate sentenced in tribal court pursuant to VAWA 2013 would be able to receive health care at a local IHS facility; and

WHEREAS, a number of tribes report that they need clear guidance from the IHS and BIA about how health care will be provided to non-Indian inmates and how the costs of that care will be covered before they implement Special Domestic Violence Criminal Jurisdiction over non-Indians; and

WHEREAS, the federal government's failure to budget and pay for tribal correctional healthcare places additional strain on inadequate tribal corrections and health care budgets, exacerbates the already challenging problem of health disparities for American Indians, undermines successful inmate re-entry, and contributes to recidivism.

NOW THEREFORE BE IT RESOLVED, that BIA should partner with the U.S. Public Health Service through a Memorandum of Agreement to get Commission Corps Officers assigned to tribal jails just as they are already assigned to FBOP and ICE detention facilities; and

BE IT FURTHER RESOLVED, that BIA should include a correctional healthcare line item in its annual budget to fund Commission Corps Officers in tribal jails; and Congress should appropriate funds for Commission Corps Officers to be assigned to tribal jails; and

BE IT FURTHER RESOLVED, that Congress should amend Medicaid to allow reimbursement for outpatient services that are provided to individuals who are incarcerated in Indian Country detention facilities; and

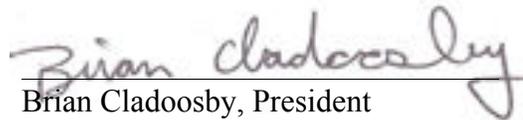
BE IT FURTHER RESOLVED, that Congress should create a catastrophic inmate health care fund that can be used if an inmate sentenced in tribal court needs major medical care; and

BE IT FURTHER RESOLVED, that the Bureau of Prisons (BOP) pilot program that allowed certain inmates to serve their sentence in BOP rather than BIA facilities be reauthorized; and

BE IT FINALLY RESOLVED, that this resolution shall be the policy of NCAI until it is withdrawn or modified by subsequent resolution.

CERTIFICATION

The foregoing resolution was adopted by the General Assembly at the 2017 Midyear Session of the National Congress of American Indians, held at the Mohegan Sun Convention Center, June 12 to June 15, 2017, with a quorum present.


Brian Cladoosby, President

ATTEST:


Aaron Payment, Recording Secretary



NATIONAL CONGRESS OF AMERICAN INDIANS

The National Congress of American Indians Resolution #MOH-17-038

TITLE: Support for Reauthorization of the Special Diabetes Program for Indians

EXECUTIVE COMMITTEE

PRESIDENT
Brian Cladoosby
Swinomish Tribe

FIRST VICE-PRESIDENT
Fawn Sharp
Quinault Indian Nation

RECORDING SECRETARY
Aaron Payment
*Sault Ste. Marie Tribe of Chippewa
Indians of Michigan*

TREASURER
W. Ron Allen
Jamestown S'Klallam Tribe

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Ponca Tribe of Nebraska

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Pokagon Band of Potawatomi

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WHEREAS, we, the members of the National Congress of American Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants the inherent sovereign rights of our Indian nations, rights secured under Indian treaties and agreements with the United States, and all other rights and benefits to which we are entitled under the laws and Constitution of the United States, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise promote the health, safety and welfare of the Indian people, do hereby establish and submit the following resolution; and

WHEREAS, the National Congress of American Indians (NCAI) was established in 1944 and is the oldest and largest national organization of American Indian and Alaska Native tribal governments; and

WHEREAS, AI/AN adults are 2.3 times more likely to have diagnosed diabetes compared with non-Hispanic whites; and

WHEREAS, the death rate due to diabetes for AI/ANs is 1.6 times higher than the general U.S. population; and

WHEREAS, the Balanced Budget Act of 1997 established the Special Diabetes Program for Indians (SDPI) for “the prevention and treatment of diabetes in American Indians and Alaska Natives (AI/AN) for five years; and

WHEREAS, Congress reauthorized SDPI for one to three year periods from 2002 to 2015; and

WHEREAS, the current renewal of SDPI expires in September, 2017; and

WHEREAS, SDPI provides grants for diabetes treatment and prevention services to over 330 IHS, Tribal, and Urban Indian health programs in 35 states and funds Community Directed Grant Programs; and

WHEREAS, SDPI has had positive clinical and community outcomes, including: the average blood sugar level (A1c) decreased from 9.0% in 1996 to 8.1% in 2010; the average LDL (“bad” cholesterol) declined from 118 mg/dL in 1998 to 95 mg/dL in 2010; and more than 80% of SDPI grant programs now use recommended public health strategies to provide diabetes prevention activities and serves for AI/AN children and youth; and

WHEREAS, Tribes have successful SDPI programs with consistent positive clinical and community outcomes; and

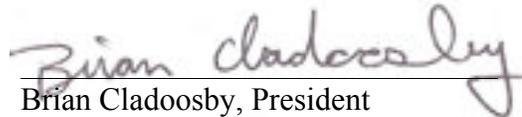
WHEREAS, Tribes' support permanent reauthorization of SDPI at \$200 million per year with medical inflation rate increases annually or, in the alternative, reauthorization of SDPI for 2018 to 2024 at \$150 million in 2018 with medical inflation rate increases annually thereafter.

NOW THEREFORE BE IT RESOLVED, that the National Congress of American Indians (NCAI) supports permanent reauthorization of SDPI at \$200 million per year with medical inflation rate increases annually or, in the alternative, reauthorization of SDPI for 2018 to 2024 at \$150 million per year in 2018 with medical inflation rate increases annually thereafter; and

BE IT FURTHER RESOLVED, that this resolution shall be the policy of NCAI until it is withdrawn or modified by subsequent resolution.

CERTIFICATION

The foregoing resolution was adopted by the General Assembly at the 2017 Midyear Session of the National Congress of American Indians, held at the Mohegan Sun Convention Center, June 12 to June 15, 2017, with a quorum present.


Brian Cladoosby, President

ATTEST:


Aaron Payment, Recording Secretary

SECTION II: PROJECT-LEVEL

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

Transformation Project Description

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

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

Project Selection & Expected Outcomes

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

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

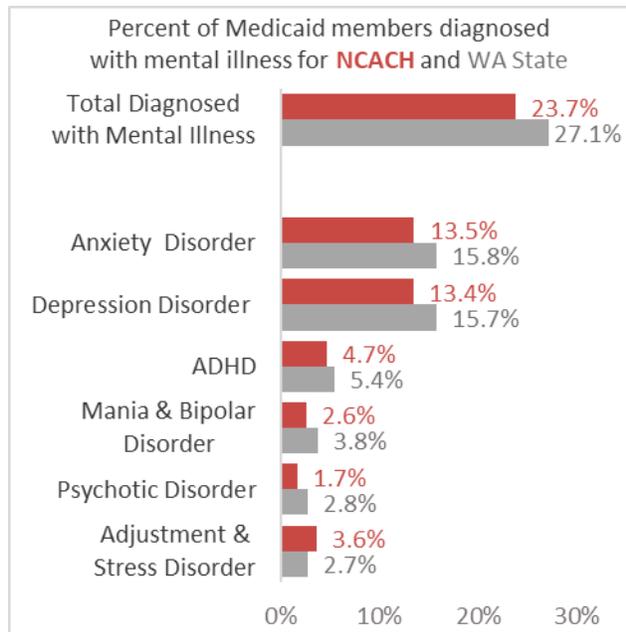
- Provide justification for selecting this project, how it addresses regional priorities, and how it will support sustainable health system transformation for the target population.
- Discuss how the ACH will ensure the selected project is coordinated with, and does not duplicate, existing efforts in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

ACH Response

North Central Washington exemplifies the need for bi-directional integration of behavioral and physical health as selected by the HCA as a mandatory project. The large geography, rural poverty, disparities in access to behavioral health care that track along ethnic lines, result in a considerable amount of untreated or undertreated behavioral health and substance use disorders. This is exacerbated by the shortage of behavioral health providers in our ACH, which ranks among the lowest in the state in ratio of behavioral health providers to population.

Behavioral health needs are widespread in our NCACH region. Based on a survey of community stakeholders (we received a total of 323 responses from three outreach events), drug and alcohol use was the top ranked health need (49% of responses), with mental health/depression coming in third (22% of responses). In addition, the data collection process during our Community Health Needs Assessment (CHNA) resulted in the identification of 16 potential health needs of the community. When 34 community leaders (including representatives from the health and social services sector) convened to prioritize these needs based on a set of criteria, mental health care access and access to care were the top ranked priorities. Additionally, the Affiliated Tribes of Northwest Indians – a consortium of tribes advocating for national, regional, and specific tribal concerns – passed a resolution in September 2017 urging the U.S. Congress to support legislation and appropriate funding to increase access to inpatient substance abuse and mental health treatment facilities serving American Indians/Alaska Natives. The resolution acknowledged the prevalence of depression, suicide and substance abuse for this population¹.

Quantitative data support this community feedback and highlight areas of need and opportunities for impact. Nearly 25% of the Medicaid members in the NCACH region have been diagnosed with mental illness. Anxiety disorders and depression are the most prevalent conditions². More than 5,000 Medicaid members have co-occurring mental illness and substance use disorder diagnoses. In fact, mental and behavioral disorders are the second leading cause of acute hospitalizations, comprising 8% of all hospitalizations that are



Source: DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.

¹ Affiliated Tribes of Northwest Indians, Annual Convention. Resolution #17-60: Support for Legislation Amending Title XIX of the Social Security Act for Adult Inpatient Treatment and Grant Funding for AI/AN Youth Addiction Treatment Facilities Infrastructure. (2017): <http://www.atntribes.org/sites/default/files/Res-17-60.pdf>

² DSHS Research and Data Analysis Division, ACH Profiles - North Central Current State spreadsheet. Measurement period based on a 24-month lookback period from June 2016.

not related to pregnancy or childbirth³. After Better Health Together (BHT) and Greater Columbia, NCACH has the highest percentage of children hospitalized for mental and behavioral health disorders (17% compared to 11% statewide average.)

Mental and behavioral health disorders are the sixth leading cause of Outpatient ED utilization among Medicaid recipients⁴. In fact, Medicaid members who had three or more ED visits were 4.8 times more likely to have a drug dependence compared to those who did not have three or more ED visits. And they were 5.2 times more likely to have a co-occurring mental illness/substance use disorder⁵. NCACH's Diversion Interventions Project will focus on diverting people from emergency care for non-emergent conditions and our Transitional Care Project will promote more effective transitions from acute care back to the community, including beneficiaries with serious mental illness (SMI). Our Care Coordination Project will dovetail with these projects given overlapping target populations. The Whole Person Care Collaborative, through our Bi-Directional Integration Project, will be an important partner in all of these projects since our partnering providers will be responsible for critical primary care and behavioral health services to these patients.

The good news is that we are the top performing ACH during calendar year 2016 based on *Follow-up After Discharge from ED for Mental Illness* measures (for both seven-day and 30-day measures)⁶. While this indicates an area of strength relative to other ACHs, we have room for improvement when it comes to following up for alcohol and drug dependence. Those rates, compared to the mental health measures, are much lower, and they dropped between 2015 and 2016 (we were the top performing ACH in 2015 and ranked fourth in 2016). Specifically, only 24.5% of Medicaid enrollees 18 years of age with a primary diagnosis of alcohol or other drug dependence received follow-up within seven days of discharge from the emergency department for their alcohol and drug health issues (compared to 77.3% for enrollees with a primary diagnosis of mental health). And only 30.6% of Medicaid enrollees with a primary diagnosis of alcohol or other drug dependence received follow up within 30 days (compared to 83.9% for mental health). NCACH is also the lowest performing ACH based on *Antidepressant Medication Management* measures (both acute and continuation)⁷. This is significant since depression not only was flagged by community stakeholders as a community health need, but because major recurrent depression accounted for the highest diagnosis rate (15%) for Medicaid beneficiaries in our region, out of all diagnoses flagged through the Chronic Illness & Disability Payment System⁸. These areas of strength and weakness suggest some inconsistency in coordination of care as patients move across settings and an opportunity for our combined projects to have a positive impact on these measures.

³ HCA RHNI Starter-Kit, "Top Ten Most Common Causes of Statewide Acute Hospitalizations Among Medicaid Recipients, Excluding Pregnancy and Child Delivery Related Hospitalizations, During Jan 1, 2015-Oct 31, 2015".

⁴ HCA AIM, "ED Utilization of Medicaid Recipients Using Hospitals in North Central During Oct 1, 2015-Sep 30, 2016".

⁵ DSHS Research and Data Analysis Division, "Measure Decomposition Data" file. As indicated by RDA, likelihood ratios are "designed to identify demographic and health risk factor characteristics associated with favorable and adverse outcomes on selected metrics, to help inform ACH project planning. Demographic and health risk characteristics that are much more prevalent among persons experiencing adverse outcomes may identify high-opportunity populations for intervention." *Am not sure this citation is correct. Seems like too long of a quote.*

⁶ DSHS Research and Data Analysis Division, "ACH Toolkit Historical Data" file. Based on 2016 data.

⁷ DSHS Research and Data Analysis Division, "ACH Toolkit Historical Data" file. Based on 2016 data.

⁸ DSHS Research and Data Analysis Division, "ACH Profiles updated 02.28.17" file. North Central Current State spreadsheet, *Diagnoses* tab.

Data for specific demographic groups and geographic areas in our region highlight disparities in health outcomes. For example, while health outcomes linked to poor physical health days were higher in all of our counties compared to the statewide rate for 2017, Grant and Okanogan counties had higher rates (4.4 and 4.5, respectively, compared to 3.6 for the state)⁹. In terms of poor mental health days, all counties were at or above the statewide rate of 3.7 in 2017, with Okanogan County being the highest at 4.2. Data from the Behavioral Risk Factor Surveillance System (2013-2015) indicates that Okanogan County’s rate of adults who reported poor mental health was higher than the statewide average (15% compared to 11%¹⁰), the fourth highest rate in all of Washington State. Within our region, Okanogan County had the highest rate, as of June 2016, of Medicaid beneficiaries who have a substance use disorder (SUD) or co-occurring SUD and mental health issues (3.2% and 1.2%, respectively)¹¹, and the 2017 rate of alcohol-impaired driving deaths was 13% higher than the statewide rate (48% compared to 35%)¹².

Gender, race, and age disparities also exist in our region. For example, a higher percentage of females reported poor mental health from 2013-2015 (14.7% compared to 6.5% of males), while 33.8% of Native Americans in our region reported poor mental health (the highest rate for Native Americans across all ACHs)¹³. From 2013-2015, people 25-34 years old reported the highest percentage of poor mental health days (13.4%) in our ACH region¹⁴. Elders in our region also demonstrate higher behavioral health treatment needs compared to statewide averages (as of June 2016), while all other unique Medicaid groups in our region have lower rates¹⁵.

Non-overlapping Medicaid Groups ⇔	Disabled (%) NCACH rate Diff compared to state rate	Non-Disabled Adults (%) NCACH rate Diff compared to state rate	Newly Eligible Adults (%) NCACH rate Diff compared to state rate	Non-Disabled Children (%) NCACH rate Diff compared to state rate	Elders (%) NCACH rate Diff compared to state rate	Overall (%) NCACH rate Diff compared to state rate
Behavioral Health Treatment Needs ↓						
Substance Use Disorder (SUD)	22.6% -1.3%	16.6% -0.5%	17.3% -1.1%	2.1% -0.4%	8.7% 2.5%	9.2% -2.0%
Mental Illness (MI)	64.2% -2.2%	42.3% -1.4%	37.1% -0.8%	14.0% -2.2%	51.3% 5.7%	27.3% -4.3%
Co-occurring SUD + MI	19.5% -1.2%	11.9% -0.6%	10.9% -1.1%	1.0% -0.2%	6.6% 2.1%	6.1% -1.6%

⁹ Robert Wood Johnson Foundation, County Health Rankings (2017).

¹⁰ Healthier Washington Dashboard, *State Measure Browser* tab.

¹¹ HCA Behavioral Health and Co-occurring Disorders data, “Cat 1 Behavioral Health and Chronic Conditions 09.29.17” spreadsheet. Measures based on 24-month lookback period prior to June 2016.

¹² Robert Wood Johnson Foundation, County Health Rankings (2017).

¹³ HCA RHNI “Starter-Kit” Delivery, *Prevalence Estimates – Overall* tab. Based on BRFSS measure for % adults who reported poor mental health during the past 30 days: 2013-2015.

¹⁴ HCA RHNI “Starter-Kit” Delivery, *Prevalence Estimates – Overall* tab. Based on BRFSS measure for % adults who reported poor mental health during the past 30 days: 2013-2015.

¹⁵ DSHS Research and Data Analysis Division, “ACH Profiles updated 02.28.17” file. North Central Current State spreadsheet, *Behavioral Health* tab. Measures based on 24-month lookback period prior to June 2016. *Please check citation.*

NCACH Bi-Directional Integration of Physical and Behavioral Health Project

Co-occurring SUD and Serious Mental Illness (SUD+SMI)	16.1% -1.1%	8.4% -0.3%	7.3% -1.0%	1.0% 0%	5.0% 1.4%	4.3% -1.3%
<i>Source: DSHS Research and Data Analysis Division, "ACH Profiles updated 02.28.17" file. North Central Current State spreadsheet, Behavioral Health tab.</i>						

In terms of diagnoses, 50.1% of elders, 36% of non-disabled adults, and 30% of newly eligible adults in our NCACH region were diagnosed with a mental illness during FY2015-2016. Depression and anxiety disorders were most prevalent, matching statewide patterns. For Medicaid beneficiaries in NCACH with a serious mental illness (SMI), the percentage of those who received any mental health services were lower compared to statewide rates, across all Medicaid groups.

<i>% Beneficiaries with Serious Mental Illness (SMI) who Received any Mental Health Services, FY 2015 - FY 2016</i>	Disabled	Non-Disabled Adults	Newly Eligible Adults	Non-Disabled Children	Elders	Overall
NCACH	26.1%	12.8%	10.3%	5.4%	6.1%	8.8%
State	32.2%	13.8%	11.6%	6.2%	9.9%	11.1%
<i>Source: DSHS Research and Data Analysis Division, "ACH Profiles updated 02.28.17" file. North Central Current State spreadsheet, Behavioral Health tab.</i>						

This indicates some mental health access barriers that are in line with workforce shortages prevalent in our region. For example, eight clinics in our region have a score of 20 or higher for mental health care access (where 25 is the maximum score indicating the highest level of need)¹⁶. Five of these are located in Grant County, two in Okanogan County, and one in Chelan County. Our entire region is designated as a Health Professional Shortage Area for dental health, mental health, and primary care.

NCACH has selected a comprehensive approach to practice transformation that will be the foundation for all clinical process improvement efforts in both behavioral and physical health organizations. In May 2016, we established the Whole Person Care Collaborative (WPCC) involving 20 organizations providing behavioral and physical health care (several of whom provide both), as well as other entities who share and support our vision of whole person care (MCO representatives as well as representatives from emergency services and hospitals partners).

These partners were motivated to join the collaborative for several reasons. First, in September 2016, NCACH elected to become a mid-adopter and to move ahead with Fully Integrated Managed Care (FIMC) beginning in January 2018. While FIMC posed challenges and opportunities for organizations to address both the business as well as the clinical aspects of integration, the NCACH and the WPCC provided a useful framework for addressing the changes collectively. Second, the need to integrate services across organizational boundaries, to adopt population based methods, and adapt to Value-Based Payment suggested a magnitude of change that would be difficult for any single organization. Finally, members joined the WPCC because the region is largely underserved for behavioral health

¹⁶ Health Resources & Services Administration (HRSA) Data Warehouse. <https://datawarehouse.hrsa.gov/>

and there was a recognition that we needed every provider group in order to serve the needs of the region. The legacy of collaborative competition in the NCACH region will serve the goals of transformation and sustainability well.

Recently, our WPCC partners have been working together to define the scope, approach, and content of a shared learning structure under the assumption that we will be able to move further by working together rather than working separately. We are in the midst of designing a targeted learning collaborative with assistance from two consulting organizations, which will provide a backbone to catalyze bi-directional integration improvements. As we transition from planning to implementation, we recognize the need to adapt our current WPCC structure. For example, we may need to distinguish between expectations around advisory functions undertaken by the WPCC (e.g. creating and recommending funding processes) versus expectations for implementation partners involved in targeted learning activities (e.g. learning and action networks for peer learning, targeted cohort trainings, and intensive breakthrough series). Our current vision, subject to Board review and approval, is that our WPCC will need to modify its structure in order to encourage broad and inclusive partner engagement (including social service partners), while also differentiating between a WPCC “Steering Committee” responsible for advisory functions and a WPCC “Learning Community” involving partners that will inherently be more clinical in nature.

Learning activities targeting bi-directional integration will draw from team-oriented, evidence-based principles. For primary care providers, NCACH has preliminarily chosen to follow the Bree Collaborative evidence-based approach and incorporate additional principles of the Collaborative Care Model into the work in our region. For behavioral health providers, NCACH has preliminarily chosen to follow the integration practices outlined in the Milbank Memorial Fund report. During the summer of 2017, members of the WPCC completed an evaluation process conducted by a coach/consultant from Qualis Health to determine their current state of operations relative to an idealized model for population health as defined by the Patient-Centered Medical Home Assessment (PCMH-A) guideline for primary care or the Maine Health Access Foundation (MeHAF) rating scale which is consistent with the Bree Collaborative and Collaborative Care Model for behavioral health organizations. Building on these evaluations, the WPCC Learning Community will take each funded organization at its own starting point and move it further along the continuum of bi-directional integration and whole person care.

The founding notion is that all clinical practices must transform from an acute, episodic, and reactive model built around a fee-for-service payment system to a population based, pro-active model of care that manages both acute and chronic disease in a Value-Based Payment scheme. In this model, behavioral health disorders can be addressed in the same manner as other chronic diseases and treatment integrated into medical practice. The changes required for transformation are extremely difficult to make and require years of committed leadership that can only be achieved with a systematic approach to quality improvement. Some organizations in NCACH have made significant commitments to these improvements and have demonstrated quality improvement in a wide variety of quality measures. Others are at the beginning of this journey. Regardless of where they are on this path, members of the WPCC are committed to making improvements for the sake of improving the health and welfare of the residents of North Central Washington.

To organize and manage this project, the NCACH has contracted with two consulting organizations working together – the Centre for Collaboration, Motivation, and Innovation (CCMI) and CSI Solutions,

Inc. – who have national experience in running large multi-sector learning collaboratives. As described later in the project, they will provide the methodology and infrastructure to organize and manage the way partners will undertake improvement processes, measure and evaluate effects, share results with each other, and pursue further improvements. The NCACH recognizes that this effort has the potential to conflict with other improvement projects underway within individual organizations as well as other cross-organizational improvement initiatives.

To minimize the possibility of conflict with intra-organizational improvement projects, the WPCC has been holding monthly meetings since May 2016 with provider groups to ensure the goals and methods of this project are understood. Additionally, with the assistance of the Practice Transformation Hub and Qualis Healthcare, we have undertaken an assessment of all potential participating provider organizations relative to the PCMH-A and MeHAF assessment tools to ensure that the transformation priorities of our Bi-Directional Project are consistent with the transformation needs and goals of each organization. This is particularly important with our Behavioral Health providers who, because we are transitioning to Fully-Integrated Managed Care in January 2018, are having to address basic business functions (e.g. billing & collections) before they can devote full attention to clinical integration and population management.

To minimize potential conflict with other inter-organizational transformation efforts, we have surveyed members to identify other relevant projects underway that could be the source of duplicate or conflicting efforts. Several members are involved with two different *Transforming Care Practice Initiatives* (TCPI), the National Rural Health Care Consortium, and the Pediatric TCPI initiative. We have been in touch with the leaders of these initiatives and have regular contact with them to ensure their work is compatible with ours and will not result in violations of CMS funding guidelines against duplication of services. Also, to the extent these initiatives involve routine collection and reporting of data through a shared facility, we are working to understand how data collection and reporting processes can be made consistent with those for the WPCC.

In addition, the NCACH participates in other forums such as local Coalition for Health Improvement (CHI) meetings and regional rural Washington State Hospital Association (WSHA) meetings to share information and solicit feedback. At least one and usually several NCACH staff members attend all of these meetings and an NCACH update is a regular agenda item to ensure understanding of and alignment with the work.

Finally, the WPCC is working to avoid duplication or conflict with other improvement processes by including all provider groups in the NCACH region in its design. Our intent is to deploy processes and methods consistent with those already in use, and the coordinated learning activities will only serve to accelerate progress on the path provider organizations have otherwise selected. The potential for duplication or conflict exists in the selection of quality metrics, given that those prescribed by the HCA for Medicaid contracting may differ from those used for Medicare contracting, or those required for MCO or commercial payer contracts. However, we are working to crosswalk the quality metrics targeted through the Chronic Disease and Bi-Directional Integration projects (overseen by the WPCC) to minimize the reporting burden on funded partners.

Our Bi-Directional Integration Project is comprehensive in that it addresses core clinical processes where behavioral and physical health can be addressed in the same setting. The project is also systematic in that it has the potential to include provider organizations who collectively treat 95% or

more of the Medicaid beneficiaries in the NCACH region. We hope to reach approximately 30,000 beneficiaries. Based on FY2015-2016 data, our NCACH region has 7,713 Medicaid beneficiaries with a SUD treatment need and 23,050 Medicaid beneficiaries with a mental illness treatment need¹⁷. The focus on people with behavioral health conditions, while inherent to this particular project, is supported by qualitative and quantitative data indicating areas of need and opportunities for impact (as discussed above). In fact, because this project involves the major behavioral health and primary care organizations caring for Medicaid beneficiaries in our region, our Bi-Directional Integration Project will have the ability to reach practically all ~95,000 beneficiaries in the four-county NCACH region by way of making general improvements to care processes. This level of impact is by far our broadest, and together with our transition to Fully-Integrated Managed Care (FIMC) as of January 1, 2018, presents an exciting opportunity for alignment.

Also, recent data on the prevalence of co-occurring behavioral health/SUD and chronic medical diagnoses suggest that a significant portion of the patients being seen in medical practices will benefit from our WPCC (which is overseeing both Bi-Directional Integration and Chronic Disease projects). For example, 71% of Medicaid beneficiaries with an SUD diagnosis also have one or more chronic conditions (e.g. diabetes, asthma, COPD, cardiovascular issues), while 66% of beneficiaries have a mental health diagnosis and 79% have co-occurring SUD/mental health diagnoses with one or more chronic condition¹⁸. By expanding access to behavioral health services through various means (tele-psychiatry, co-location, integration, improved coordination) and improved behavioral health screening in primary care, we expect to significantly increase the number of patients with a behavioral health diagnoses who are identified and treated. The expansion of services in areas currently dramatically underserved (Okanogan & Grant Counties) by behavioral health should also serve to reduce both the ethnic and geographic disparities in behavioral health outcomes – an important health equity consideration.

The NCACH’s approach to bi-directional integration of behavioral and physical health is built around three main precepts that will promote broad-reaching, system-wide transformation lasting beyond the Demonstration. The first way NCACH will ensure lasting impacts and benefits to all Medicaid beneficiaries is the early commitment to FIMC. The NCACH made the commitment over a year ago in recognition that this change was imminent and necessary. This set the tone for the region in terms of its ability to step up to considerable challenges and to work through them. The transition to integrated financing in 2018 will compel both behavioral health and medical providers to address the needs for clinical integration, which will be supported through the second pillar of impact and sustainability: the WPCC Learning Community.

The WPCC Learning Community is being organized to drive systemic change in clinical practice by focusing on basic operational processes needed to move from an acute, episodic model of care to a proactive, population-based model. Each participating organization will engage in learning sessions, develop and implement change plans to address key clinical processes, measure and evaluate progress, and report results. Through this process, organizations will learn best practices on evidence-based guidelines as well as from each other. They will commit to developing change plans that incorporate evidence-based practices for integration. Primary care providers will draw from the Bree Collaborative’s Behavioral Health report and elements from the Collaborative Care Model. Behavioral health providers will draw from the Milbank Memorial Fund report outlining promising practices and

¹⁷ DSHS Research and Data Analysis Division, “ACH Profiles updated 02.28.17”, *Behavioral Health* tab.

¹⁸ DSHS Research and Data Analysis Division, “Cat 1 Behavioral Health and Chronic Conditions” dataset, released end of September 2017.

resources for integrating physical health services into behavioral health organizations. We expect all WPCC Learning Community partners to specifically outline health disparities in their patient population and articulate, in their change plans, how they will address health equity issues. We also intend on leveraging the WPCC Learning Community to share and review data that might help providers drive some of their own quality improvement efforts. In addition, the WPCC Learning Community will help us explore ways to address workforce issues unique to our region. At this point, eight organizations have signed membership agreements indicating their intent to participate in the learning collaborative, to develop change as an outgrowth of the process, and to implement the change plans during the course of the Demonstration process. See Bi-Directional Integration Project - Attachment A for a preview of our preliminary change plan process.

The third piece of sustainability is the commitment to Value-Based Payments. NCACH has been clear that changes in clinical operations during the Demonstration by any provider organization should only be undertaken if they could be sustained through changes in reimbursement once the Demonstration is completed. We are aware of examples of highly successful innovation projects in other states that had to be shut down once grant funds ran out and have cautioned against that here. NCACH has made a point of including MCO representation on our NCACH Governing Board and as advisors to the WPCC on sustainability. As the keepers of the purse, the MCOs will need to be convinced of the value of the practice transformation undertaken in this and other projects to ensure they develop the means and the methods to sustain them through Value-Based Payments.

Implementation Approach and Timing

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

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

Partnering Providers

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

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

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

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

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

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

ACH Response

NCACH established and has been operating the Whole Person Care Collaborative (WPCC) as a "proof of concept" through the ACH's original State Innovation Model grant since 2015. Its purpose was to engage provider groups in establishing a learning collaborative to help them adopt the principles of population management and catalyze transformation toward patient centered medical home style practices. With the adoption of the Demonstration in January 2017, the WPCC took on responsibility for oversight of our Bi-Direction Integrational Project as well as our Chronic Disease Project. Members of the WPCC will also be responsible for implementing clinical practices and processes necessary to support NCACH's four other projects, including our Care Coordination, Transitional Care, Diversion Interventions, and Opioid Projects.

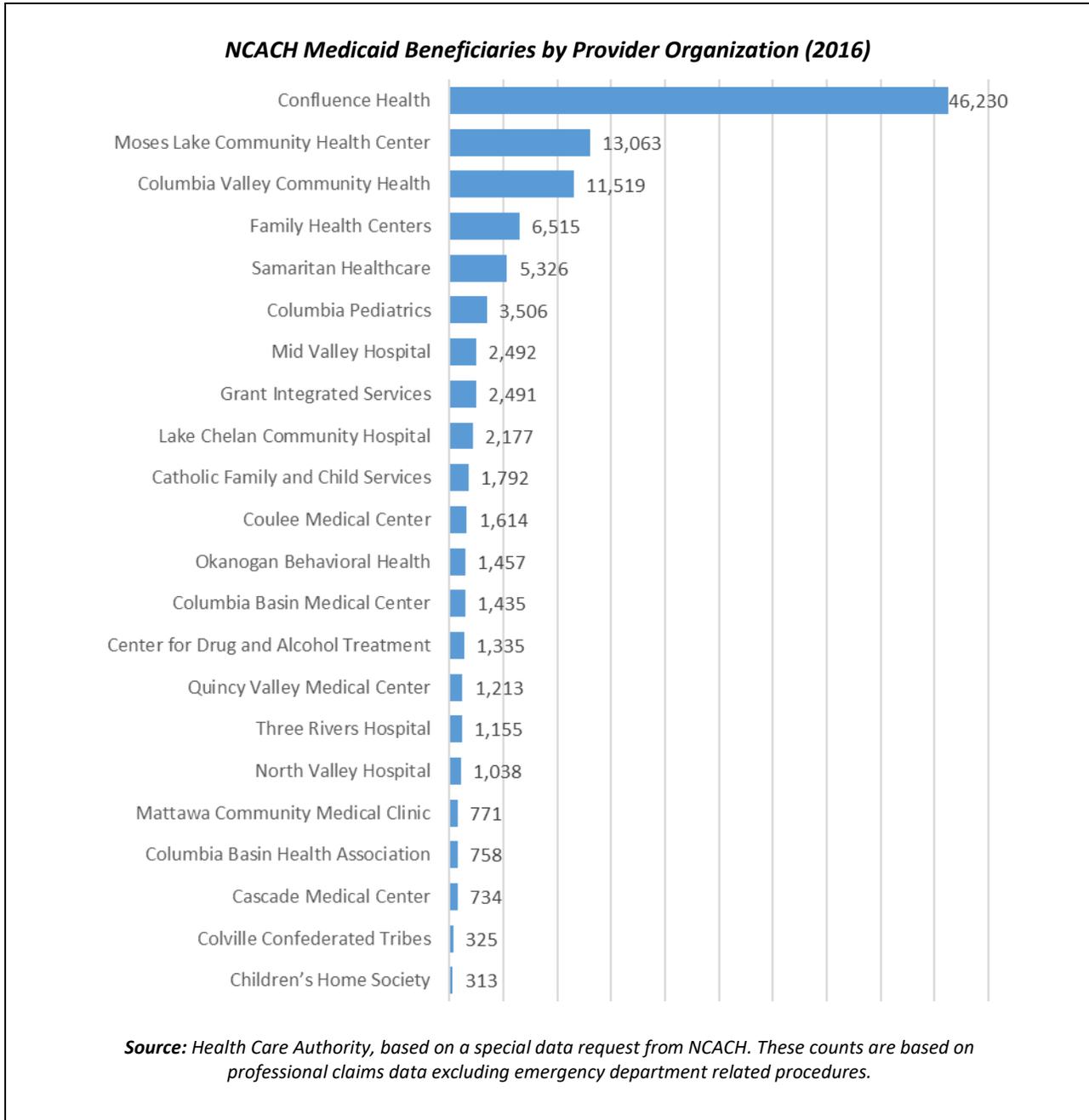
The NCACH has reached out to all major healthcare provider organizations, including hospital based medical groups, Federally Qualified Health Centers, Rural Health Clinics, tribal clinics, and behavioral health providers who provide the vast majority of outpatient professional services to Medicaid beneficiaries in the NCACH region. The members are established organizations who have been serving the Medicaid population, and in many cases, were set up specifically to serve them. Medicaid beneficiaries constitute a significant portion of their business and there is little question they intend to continue to serve them (see table and chart below). Community-based organizations working on housing, transportation, access to healthy foods, and other social determinates of health will be critical partners through the interplay between the WPCC and our Care Coordination Project. Through targeted focus groups, we will be reaching out to social service providers by the end of January 2018 to learn how best to engage and support them in this work.

Since May 4th 2016, the WPCC has held monthly meetings of the clinical provider group and has regularly achieved attendance, in person and by phone, from a majority of the group. A charter for the WPCC describing its purpose, goals, and membership obligations was approved in August 2017 as well as a membership agreement certifying that members understand the charter and agree to participate as

indicated in the membership responsibilities (see Bi-Directional Integration Project - Attachment B for our current WPCC charter). As mentioned earlier, the WPCC will need to modify its structure in order to encourage broad and inclusive partner engagement (including social service partners), while also differentiating between a WPCC “Steering Committee” responsible for advisory functions and a WPCC “Learning Community” involving partners that inherently will be more clinical in nature. Currently, we have eight signed member agreements with others expressing intent to sign in the near future. As the list of partnering providers involved in implementation becomes clearer, we plan on asking them to assert their commitment to serving the Medicaid population in our funding agreements.

MCO involvement in the NCACH has been a priority given our planned transition to FIMC and there is an MCO designated position on the NCACH Governing Board in recognition that they will be the sustaining sponsors of delivery system transformation efforts beyond the conclusion of the Demonstration. In addition, each of the MCOs regularly send representatives to WPCC meetings and provide consultation on the approach the WPCC has taken to the Bi-Directional Integration and Chronic Disease projects. As discussions continue on the progression toward Value-Based Payments for provider organizations, the MCOs will be asked to participate to ensure alignment of the payment processes with the clinical processes being proposed by the WPCC.

NCACH WPCC Organizations		
Physical Health Providers		
	Organization Name	# of sites in NCW
1	Cascade Medical Center	1
2	Columbia Basin Medical Center (Columbia Basin Family Health Center)	1
3	Columbia Basin Health Association (Wahluke Family Medicine)	1
4	Columbia Valley Community Health	3
5	Colville Confederated Tribes	2
6	Confluence Health	12
7	Coulee Medical Center	2
8	Family Health Centers	6
9	Lake Chelan Community Hospital	1
10	Mid Valley Hospital	1
11	Moses Lake Community Health Center	3
12	North Valley Hospital	1
13	Quincy Valley Medical Center	1
14	Samaritan Healthcare	1
15	Three Rivers Hospital	1
		37
Behavioral Health Providers		
1	Catholic Family and Child Services	7
2	Center for Drug and Alcohol Treatment	1
3	Children’s Home Society	2
4	Grant Integrated Services	1
5	Okanogan Behavioral Health	1
		12
Managed Care Organizations		
1	Coordinated Care	
2	Molina Healthcare	
3	Amerigroup	
Transformation Initiatives & Potential Resources		
1	Qualis Health – Gwen Cox	
2	P-TCPI – Tawn Thompson	
3	NRACC-TCPI - Sue Dietz	
4	AIMS Center - Sara Barker	
5	CCMI - Connie Davis, Mike Hindmarsh	
6	CSI Soutions, Inc. - Kathleen Reims, Roger Chaufournier	
7	Attune Health Parners: Barbara Wall, Michelle Vest	
8	Kaiser Permanente of Washington Research Institute - Michael Parchman, Katie Coleman	



Regional Assets, Anticipated Challenges and Proposed Solutions

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

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

ACH Response

The greatest asset NCACH brings to this project is a large and cohesive group of providers and partners who came together through the WPCC to improve the quality of care to the population. This group includes 20 organizations who have been participating in monthly meetings since May 2016 to share ideas and to move the WPCC from the conceptual level—where vision, purpose, and principles were agreed on—to specific agreements on how the project will be managed and incentive payments will be awarded.

Our progress to date is attributable to the fact that the original idea for the WPCC was developed during the SIM grant phase so that the concept had already been vetted before the Demonstration was signed. The early adoption of the WPCC is also an indication of strong and visionary leadership among our provider organizations, many of whom have experience with learning collaboratives and quality improvement methods. Also, because a large percentage of Medicaid services are provided by a handful of organizations and the leadership of these organizations work well together, consensus to undertake the WPCC was relatively easy to achieve. Note that 80% of Medicaid patients (based on outpatient professional encounters) are served by the top 6 organizations in the four-county region, 43% by a single organization (Confluence Health).

Another asset of the NCACH is that several organizations have been leaders and visible public advocates for many of the actions represented by the Demonstration and specifically the six projects chosen by the NCACH. There is considerable experience within the group with bi-directional integration of care, systematic quality improvement, and population management. In addition, there is widespread feeling among the provider groups that the payment system must evolve to support and reward them for improving the health of the community at-large. These voices have been at the table from the very beginning and supportive of NCACH leadership and staff. In short, the Demonstration will support and provide resources to move organizations more quickly in a direction they were already headed.

Having decided to approach this work of establishing a WPCC Learning Community as early as quarter 1 of 2018, the challenge has been to find an organization with sufficient skill and experience to set up and run one of the magnitude we have in mind. After looking for some time, NCACH has had the good fortune to contract with a group of consultants with a national reputation and experience in running large, diverse learning collaboratives. Connie Davis and Mike Hindmarsh from the Centre for Collaboration, Motivation, and Innovation (CCMI) were part of a team that worked with Ed Wagner on the Chronic Care Model before forming a consulting group. Roger Chaufournier and Kathy Reims from CSI Solutions, Inc., also bring a wealth of expertise in the field. All four are Institute for Healthcare Improvement (IHI) faculty and are currently working with us to design our WPCC Learning Community.

Earlier this year, NCACH recognized a gap in data and analytic capacity. Over the past several months, we have addressed this gap in a variety of ways: (1) hired a full-time data analyst to do in-house data analysis, (2) contracted with Providence Center for Outcomes Research and Education (CORE) to provide technical assistance and consultation to assist NCACH with data-related needs for the project planning process (3) formed a Health Information Technology/Health Information Exchange (HIT/HIE) Workgroup to address regional population health management systems and information exchanges that can be expanded, enhanced, or initiated, and (4) contracted with CCMI and CSI Solutions, Inc. for technical support in developing a WPCC Learning Community as well as performance monitoring software, tools, dashboards, and processes. The steps we have taken to address a previously

identified weakness have not only turned data and analytic capacity into an area of strength for NCACH, but demonstrate that we can rapidly and systematically address future identified challenges.

In addition, the fact that the County Commissioners of Grant, Chelan, and Douglas Counties opted to move ahead with Fully Integrated Managed Care in 2018 provided a level of urgency to bring providers to the table more quickly. The desire on the part of our WPCC members to move quickly has helped us to jump-start other work. NCACH was an early adopter of the Practice Transformation Support Hub, which we deployed during the spring and summer of 2017 to assess the capabilities of all our provider organizations. Using the Patient-Centered Medical Home Assessment (PCMH-A) and the Maine Health Access Foundation (MeHAF) assessment tools, our Qualis Health consultant logged over 20,000 miles to visit more than 13 organizations and approximately 30 sites during the past six months. The result is that we have a good sense of the capabilities and improvement opportunities for our WPCC members that will allow us to target learning sessions and improvement strategies within the WPCC Learning Community.

Challenges and Barriers

One of the great challenges facing the NCACH is the scope and scale of our Demonstration projects. At this point, while all provider groups have not officially signed up for our Learning Community, we have the potential to sign up as many as 20 provider organizations with 49 sites across an ACH with almost a four-hour drive time from end to end. The differences in size, scope of services, and sophistication with quality improvement and population management methods, and a diversity of interests will require management skills to keep all parties engaged and moving forward. Fortunately, we have consulting help from two organizations with the skill, experience, and technology (including a web portal for monitoring progress and reporting results) to manage a collaborative of this type. Some of the decisions to be made early in the design phase of the collaborative have to do with segmentation of the providers into appropriate learning groups and to determine the frequency of web-based and in-person learning sessions. We also have expertise from within the WPCC group which we plan to leverage. The goal of the collaborative is not to get every organization to the same place but to improve each one from its assessed starting point. We plan to negotiate reasonably ambitious expectations with each provider group and work to provide the supports needed for them to succeed.

Lack of outcome data availability at the provider level is a challenge and a barrier to managing progress. At the outset of the project, we had expected to have provider level outcome data available to establish accountability at the organization level. For NCACH to be able to accept responsibility for aggregate ACH accountability, it needs to be able to identify sources of variation in performance and to manage them accordingly. The goal is simply to ensure that each provider organization is committed, is doing the right work, and can show progress in moving the population-based outcome metrics. To address this need, we will continue to work with the Health Care Authority, fellow ACHs, and MCOs to obtain provider specific outcome data. In the short-term, we will rely on the learning collaborative web portal and self-reported process to demonstrate each organization's adherence to the process they have committed to improve in their change plans and track improved outcomes. We will need to demonstrate the link between the data we capture and report internally and data that comes to the ACH via the HCA when it's reported some months later.

Another challenge in moving forward consistently across providers is the differential impact on the behavioral health providers of moving to FIMC. For the past ten months, behavioral health providers'

first priority has been to build the financial and business systems capacity necessary to bill for and collect payment from MCOs for services previously paid through the counties. Clinical integration may have to take a back seat to stabilizing business processes once they go live with FIMC in January 2018. With our consultants, we'll assess this situation and determine whether differential treatment of the behavioral health providers is warranted in quarter 1 and 2 of 2018. The WPCC has a sub-group of behavioral health providers working to ensure that the overall approach to our change plans and WPCC Learning Community adequately addresses their needs. To mitigate this risk, NCACH also will utilize our consultants Centre for Collaboration, Motivation, and Innovation (CCMI) and CSI Solutions, Inc. to work directly with each behavioral health provider to determine the appropriate time for them to submit change plans and make any adjustments to the scoring methodology that will ensure that it best addresses their business model. In addition, the AIMS (Advancing Integrated Mental Health Solutions) Center has agreed to work as a subcontractor to our WPCC Learning Community contractors in the design of the learning framework.

Workforce shortages, particularly in behavioral health are a persistent problem in the NCACH region and will continue to present challenges. Because our entire region is designated as a Health Professional Shortage Area for dental health, mental health, and primary care, we will leverage the WPCC to explore workforce solutions for our region. Based on population/primary care provider ratios, workforce shortages are most prevalent in Grant and Okanogan counties.¹⁹ The top five Primary Care Service Areas experiencing shortages include: Royal City, Carlton, Coulee City, Tonasket, and Moses Lake. Fortunately, one of the goals of the Bi-Directional Integration Project will be to reduce waste and redundancy in the delivery of behavioral health services thus improving access to care. To mitigate this risk, NCACH will also work with local community colleges and assess best practices for behavioral health recruitment within our community (i.e. organization base preceptor programs for behavioral healthcare professionals) to come up with a robust workforce strategic plan in quarter 3 of 2018.

Monitoring and Continuous Improvement

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

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

ACH Response

¹⁹ Health Resources & Services Administration (HRSA) Data Warehouse: <https://datawarehouse.hrsa.gov/>

The NCACH Bi-Directional Integration Project will be managed through the Whole Person Care Collaborative (WPCC). WPCC Members currently eligible for funding through the Demonstration include providers who are ready and able to participate in the WPCC Learning Community during quarter 1 and 2 of 2018. Involvement will include participating in joint learning sessions and implementing mutually agreed-upon improvement activities based on evidence-based approaches.

During the initial phases of the WPCC Learning Community beginning in February 2018, our CCMI and CSI Solutions, Inc. consultants will provide contextual learning sessions to set the ground rules for participating in the WPCC Learning Community and to verify each organization's baseline for leadership engagement, quality improvement, and population management. These are foundational issues necessary for organizations to sustain any operational changes undertaken during the Demonstration. Undertaking a change process without systems to regularly evaluate, monitor, and continuously improve is often wasted energy and this WPCC Learning Community will make sustainability a high priority. Once baseline performance has been determined, the focus of the Learning Community will shift to setting each organization's improvement priorities depending on their capability to address change and where they fall on the SAMHSA (Substance Abuse and Mental Health Services Administration) continuum of bi-directional integration²⁰.

While the exact mechanism and timing for activities of the WPCC Learning Community will be finalized in January 2018, the learning process will involve:

- A variety of peer learning activities and opportunities of varying intensity and specificity, virtual and in-person to meet goals of participating organizations;
- Coaching follow-up with the practice teams to support quality improvement and development of change plans;
- Quarterly meetings and annual summits to share progress; and,
- Monthly reporting progress on process metrics through the Learning Community's web portal.

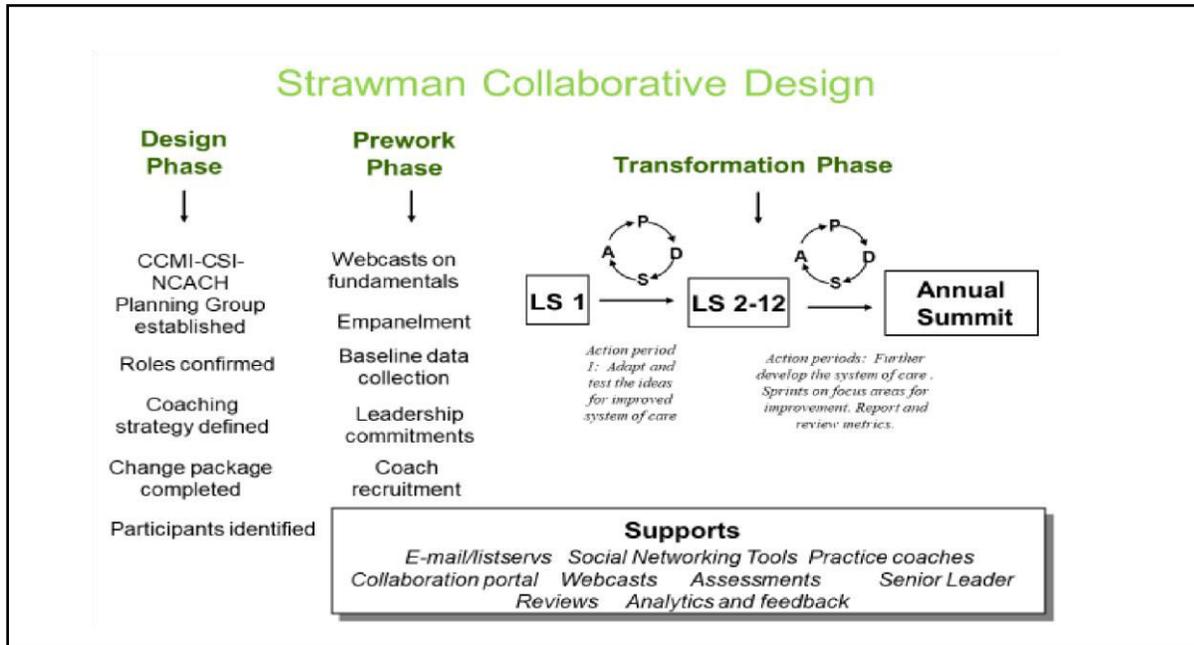
These activities will allow NCACH to keep abreast of work being done on a week-to-week basis and to work with providers on problem identification and resolution. Delays will be dealt with according to the nature and extent of the delay and the level of engagement of the parties involved. Generally speaking, NCACH will need to differentiate between:

- Delays due to provider-specific problems in execution which might be remedied through additional support, selective re-negotiation of timelines, or ultimately withholding incentive payments if non-compliance becomes an issue; and,
- Delays that are systemic and widespread because of project design or changes in the environment that affect more than a few providers. To the extent the delays are widespread, NCACH may need to make modifications to the project scope, expectations or find creative ways to meet them.

Our Governing Board and WPCC have a good track record of collaborative problem solving. They are committed to the goals of the project and can walk the fine line of holding each other accountable. Overall, the NCACH Board and WPCC are skilled in pushing for results and acknowledging when something is not working and engaging in a collective problem-solving process. With the help of our contractors from CCMI and CSI Solutions, Inc., we will develop and implement continuous

²⁰ See <http://www.integratedpca.org/samhsarsquos-standard-framework-for-levels-of-integrated-healthcare.html>

improvement (CI) processes based on best practices for clinical and health systems improvement, bringing in expertise from contractors and partners where needed (see diagram below or Bi-Directional Integration Project - Attachment C for a larger version of this graphic). This framework draws on learning series involving Plan-Do-Study-Act (PDSA) cycles outlined by the Institute for Healthcare Improvement. We are also looking into using a customized web portal developed by CSI Solutions, Inc. (Healthcare Communities) that would serve multiple functions, including learning communities, document sharing, tracking of process measures through reporting and surveys, and tracking of clinical measures through a dashboard.



Source: CCMI Presentation to Whole Person Care Collaborative on 11/5/2017, based on Institute for Health Improvement learning model for “breakthrough series”.

Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

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

NCACH Bi-Directional Integration of Physical and Behavioral Health Project

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

YES	NO
X	

Project Sustainability

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

ACH Response

Operational Sustainability

One of the main reasons NCACH adopted the Whole Person Care Collaborative (WPPC) as the backbone strategy for implementing bi-directional integration is to address project sustainability. Change of the magnitude envisioned by the practice transformation goals of the HCA will be profound and disruptive for many providers. In the experience of the NCACH leadership and the WPCC, this type of change requires a certain infrastructure to be sustainable. It requires organizational leadership and a culture of resiliency to change as well as commitment to the goals or reasons for changing. In an environment such as the NCACH region – where many organizations are small, fragile, and geographically isolated – it can be hard to move beyond the needs of day-to-day survival. While being part of a large organization can be helpful, for smaller organizations, a supportive community of like-minded organizations can help provide the moral support and intellectual capital needed to sustain long-term change.

The WPCC Learning Community is designed to create community. It has been and will continue to provide a forum where leaders can develop mutual trust and commitment to common goals on behalf of the broader community. If managed well, these relationships and the experience of having worked through difficult problems together is a pillar of sustainability that will continue whether or not there is an ACH to support it.

Secondly, the WPCC structure will provide joint-learning opportunities for leaders exposed to best practices that have been demonstrated to be successful in other areas (other ACHs or other regions) or by other providers within the region. Professional isolation and inability to know what others are doing can lead to a vision deficit that the WPCC can help address. Collaborative learning will provide the material, the inspiration, and the peer accountability for performance that will raise the bar among all providers. The term “co-opetition” (competition + collaboration) has been tossed around in some circles and describes what we aim to achieve.

A third component of sustained operational change is a stable and capable quality improvement process. Many in leadership have the experience of pushing change into an operational setting without the ability to monitor and manage it. When strategies fail, it can be hard to distinguish between a bad idea, a good idea poorly implemented, or a good idea not really implemented at all. The WPCC Learning Community will work to create an ongoing quality improvement infrastructure and processes within all the member organizations as a first order of business. Based on a review of our assessments to date, some providers have robust processes in place; however, most do not. The contract with the WPCC Learning Community consultants will result in a design for the WPCC by the end of February 2018. It will likely involve segmentation of providers into affinity groups based on capability. We expect that most organizations will have work to establish or improve their quality improvement processes and work can begin at that time.

Financial Sustainability

From the beginning of the Demonstration, NCACH leadership has been clear that any operational improvements resulting from the Demonstration must be designed with long-term funding sources to sustain them. The obvious source of funding will be the evolution of MCO Value-Based Payment (VBP) practices with providers. NCACH has a representative on the HCA Medicaid Value-Based Action Team overseeing the state-wide process and is in the process of developing an NCACH regional oversight group made up of the CFOs of regional provider organizations during quarter 1 of 2018. The intent of the latter group is to ensure common understanding of the VBP and that all organizations are optimizing revenue under these payment structures and are budgeting appropriately. Given that these payment processes are still evolving, we plan to be diligent at every step of the way. Beyond VBP, NCACH will also be looking for other funding opportunities to support innovation or to extend some of the Demonstration projects that may need a little more time to develop.

Investing in Change Through the Whole Person Care Collaborative (WPCC)

Theory of Change and the Role of the Whole Person Care Collaborative

Background

The North Central Accountable Community of Health has elected to address health improvement through six different Medicaid Demonstration Projects that will involve a broad array of organizations well beyond medical care as will be described in future documents. However, because many purposes of the Medicaid Demonstration Projects cannot be addressed without changes in the care of patients, clinical provider organizations have a major role to play and many of the Demonstration dollars will be invested in them.

The NCACH board has designated the Whole Person Care Collaborative (WPCC) as the workgroup to coordinate and fund provider organizations' improvement activities affecting all 6 demonstration projects. WPCC will directly manage projects 2a (bi-directional integration of physical and behavioral health care) and 3d (chronic disease prevention and control) and will also coordinate provider involvement with the workgroups managing the other 4 projects. Project plans will describe how other projects not directly covered by the WPCC (2b-Care Coordination, 2c-Transitional Care, 2d-Diversion, and 3A-Opioid Use) will be organized and funded. **This document describes the process through which Demonstration investments in provider organizations could be made in an accountable, effective and transparent manner.**

The core activity of the Collaborative is to plan and implement evidence-based practices necessary for provider organizations to improve effectiveness in two ways:

- **Clinically**, by providing Whole Person Care that integrates behavioral and physical health care, and more proactively identifies and addresses the medical and social health needs of the population to mitigate their negative health effects, and;
- **Financially**, by aligning clinical practices around the significantly different incentives and demands of new payment methods (mainly Value-Based Payment or VBP) now being implemented.

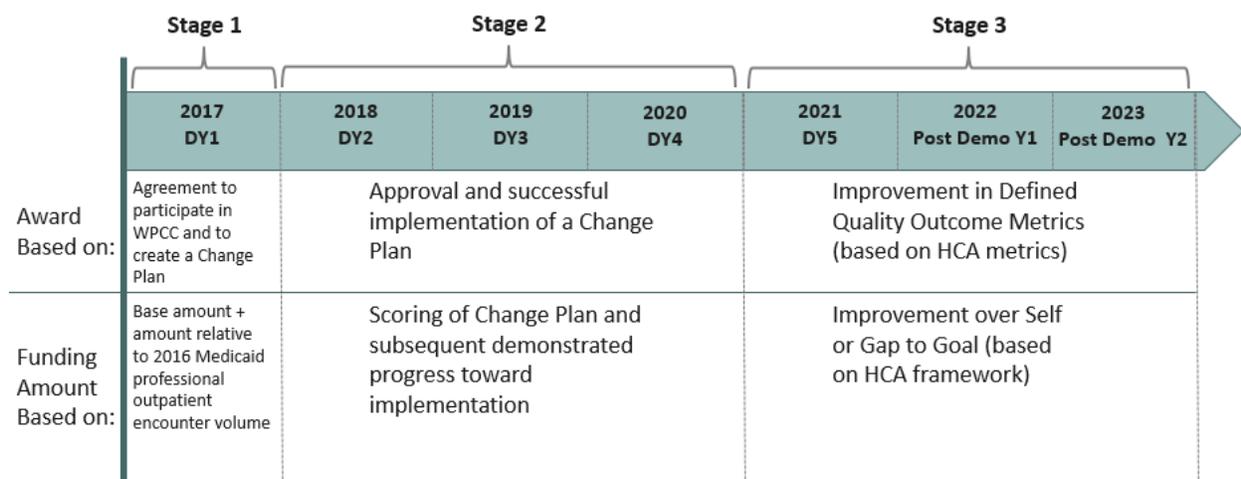
Because Medicaid Demonstration ends in 2021 (with incentive payments based on performance potentially coming in through 2023), the WPCC can support only improvement activities that can be sustained through Medicaid value-based payment mechanisms in the long run. Similar new payment approaches are being implemented in Medicare under MACRA and commercial payers, so changes developed under the Demonstration should be relevant to a large proportion of most providers' patient populations.

It is important to emphasize that the purpose of Demonstration funds is not simply to help pay the operating costs of provider organizations during the life of the Demonstration, leaving a shortfall when Demonstration dollars are gone. The point is to help provider organizations make the investments needed to reconfigure their organizations and practices so that by the end of the Demonstration, they will be able to function effectively without subsidy from Demonstration dollars.

Stages for Creating Sustainable Change

The effort to create sustainable change of that kind has three stages:

1. Development of a *Change Plan*.
2. Implementation of that plan, using specific structure and process metrics to measure progress along the way.
3. Sustaining and demonstrating improvement in clinical outcomes specific to each organization.



Participating organizations can expect Demonstration funds to be used to support them in the planning, implementation, and sustaining of changes through the Demonstration period. Demonstration funding is substantial – *depending on a variety of performance measures*, our region can potentially earn up to \$50 million dollars over the course of the 5-year demonstration (2017-2021.) **The overall effort to provide integrated Whole Person Care is the highest priority of the Demonstration.**

Ongoing Work of the Collaborative

The WPC Collaborative should become very effective as a learning collaborative for member organizations. For that to work, we will have to maintain some trust and transparency among WPCC members, so that we can learn from each other's challenges as well as our successes. At the same time, we are all accountable for the way Demonstration dollars are used, and the Demonstration projects must be implemented in an accountable and transparent manner. WPCC would be the collection point for information on progress in implementing change plans. Both of these purposes – an effective learning collaborative, and accountability for public funds in order to earn further Demonstration dollars – will push us to cultivate openness and sharing of information among WPCC members.

Stage 1: Developing Change Plans

During the last part of 2017, all organizations in the NCACH region (Chelan, Douglas, Grant and Okanogan Counties) providing primary health care or behavioral health and who have undergone operational assessments to identify where they stand on the road to Whole Person Care are invited to submit Change Plans. Change Plans must be high in quality to justify significant investment of Demonstration funds in their implementation.

It is expected that the plans of different organizations will differ considerably; there is no one plan or pattern that fits every provider organization in this region. Although organizations in our region vary a great deal in size and in the degree to which they already achieve whole person care, none are so perfect that significant improvements cannot be made. In recognition that each organization is in a different place relative to an idealized model of Whole Person Care, the funding process is designed to support and fund improvement rather than reward or penalize organizations based on their current state.

It is not quick or easy to develop plans of this kind, if only because they require significant involvement by several parties including front-line providers who are also busy doing their normal work. Development of a workable change plan costs money, at a minimum in the form of substantial staff time. Many organizations will benefit from outside expertise on change management and plan development, and may have limited experience with VBP and the new options for care delivery it enables. Demonstration funding can support the cost of consultants to support effective change planning.

Timeframe for Stage 1 Change Plan Development

Oct-Dec 2017 Stage 1 Change Planning Awards made

Jun 2018 Change plans due by the end of June 2018

Potential uses of Stage 1 Change Planning Awards

- Consultants or temporary staff support for change management, VBP, IT, or other topics
- Payments to providers and other staff for participation in Change Plan development
- Cost of staff time used in plan development instead of revenue-producing activities, including part time or replacement staff to support current operations.
- Costs for staff involvement in other activities necessary for plan development

Change Plan Application

Application for Stage 1 funding will require the following:

1. Completing the Qualis assessment relative to MeHaf or PCMH-A standards and submitting a *Preliminary Improvement Plan* resulting from the assessment. The Preliminary Improvement Plan should describe the results of the assessment and indicate the operational priority areas to be targeted in the Change Plan (these can be subject to change in the final Change Plan.)
2. A budget indicating how the funds will be used in the development of the Change Plan.
3. Signing and submitting a signed Membership Agreement to participate in the Whole Person Care Collaborative, indicating understanding and acceptance of the purpose and participation requirements for the Collaborative.
4. A signed Memorandum of Understanding with the NCACH addressing terms and conditions, including reporting requirements, for use of NCACH funds. (TBD)

Allocation of Demonstration Funds for Stage 1 Change Planning Awards

Although provider organizations will face many of the same challenges in developing Change Plans regardless of size, the level of Medicaid activity by each organization will influence the cost of Change Planning. As such, Stage 1 Change Planning Awards will be allocated to WPCC member organizations using the following **Base-Plus methodology**.

Base

Every WPCC member organization will receive a base Change Planning Award of \$75,000

Plus

Additional funds will be based on the organization's rank relative to its 2016 Medicaid professional outpatient encounter volume

Top quintile	+ \$30,000
Second quintile	+ \$25,000
Third quintile	+ \$20,000
Fourth quintile	+ \$15,000
Bottom quintile	+ \$10,000

Using this Base-Plus methodology, **WPCC member organizations should expect an award between \$85,000-\$105,000 to boost and catalyze change planning during Stage 1.**

Stage 2: Evaluating and Scoring Change Plans

Change Plans will be the basis for allocation of additional Demonstration funding during 2018-2020.

This section previews the topics to be addressed by every Change Plan, and indicates the number of points that can be earned for each topic out of a total of 100 points. The scoring of Change Plans will be done by a neutral third party, with support from NCACH staff if needed. **The change plan framework, including criteria, scoring, and questions to guide change plan development will be finalized before Stage 1 awards are made. Reporting requirements during Stage 2 will also be clarified.**

At this time we know it is likely that several million dollars will be available annually for Stage 2 Implementation Awards, but the exact amount available to NCACH is not yet known because it depends on HCA's evaluation of project plans to be submitted in November 2017 and subsequent reporting requirements. **As a result, Stage 2 award amounts on the basis of Change Plan scores cannot be determined yet.** As the amount of funding for Stage 2 awards becomes clear, the Executive Committee will develop an allocation method and propose it to the Governing Board for review and approval.

The following table describes the topics to be addressed in sections of the Change Plan, and provides a preliminary indication of the number of points (out of a total of 100) that can be earned by each section. Each section of the Change Plan should define metrics by which progress in change plan implementation should be measured. For example, if use of telehealth for mental health services is planned, agreements with telehealth providers could be documented early on, and later the provider organization could report how many such encounters occurred during implementation. We need ways to track actual implementation of the plan, and will favor metrics that are as practical and convenient as possible when it comes to data collection and reporting. Inclusion of appropriate implementation metrics in each section will be considered in scoring. **This table is a "draft" only** but provides a preliminary indication of the information that will be required to link change plans to the evidence based approaches to not only projects 2a and 3d, but all projects undertaken by the NCACH.

#	Criteria	Description	Points
1	Demonstrates organizational readiness and commitment to transforming care	Traditional models of healthcare are generally reactive, encounter-based and designed to treat discrete and acute episodes of care that are site or provider specific. Transition to models of care that are pro-active, population based and coordinate care across a continuum of sites and providers will require a long-term commitment to change. The Change Plan should demonstrate the organization possesses the necessary foundations of leadership commitment, a durable and capable system of quality improvement, and systems for empanelment and population management necessary to undertake this journey. The proposal should describe the organization's capabilities in this area <u>and/or</u> plans to develop and improve them. Changes Plans will be scored based on how well they demonstrate an understanding and commitment to the change process, how it will be managed, how progress will be tracked, measured, and reported. Additionally, organizations should describe how providers and their clinical teams would have significant involvement in guiding the change process.	15

2	Addresses most important improvement opportunities identified in the assessment phase	<p>The Change Plan demonstrates an understanding of the organization's current state relative to evidence-based and idealized models (e.g. PCMH-A or MeHAF) of whole person care as well as its most significant opportunities for improvement toward that model. The proposal should cite evidence of a self-assessment (Qualis or other) as well as qualitative data to support the priorities for improvement and approach taken. Changes Plans will be scored based on how well they demonstrate linkages between proposed process improvements and the way they proactively address the planned/necessary care needs of patients with chronic disease in both primary care and behavioral health agency settings, particularly those with depression, cardiovascular disease, diabetes, and asthma.</p> <p>Demonstration resources</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic Care Model www.improvingchroniccare.org 	25
3	Promotes the bi-directional integration of Physical and Behavioral Health	<p>A Change Plan should address bi-directional integration of physical and behavioral health, as it will be implemented in this organization, including any cooperative arrangements to be made with partners. The plan should be detailed and practical and should include measures not only to conveniently access BH and medical providers in the same facilities (whether through co-location, telehealth, or other means), but also measures to change the practices of front-line providers in such a way that medical and BH providers collaborate effectively on the care of patients. For primary care practices, Change Plans will be scored based on how well they address the Bree Collaborative's Behavioral Health Integration Report and Recommendations, or the AIMS Collaborative Care Model. For behavioral health agencies, Change Plans should demonstrate how the unique health care needs of people with serious mental illness and or substance use disorders will be addressed (e.g. multi co-existing chronic conditions, poor access to primary care, reduced life expectancy) through off-site enhanced collaboration, co-located enhanced collaboration, or through co-located integrated care.</p> <p>Demonstration resources</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bree Collaborative "Standards for Integrated Care" http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf <input type="checkbox"/> Collaborative Care Model: http://aims.uw.edu/collaborative-care <ul style="list-style-type: none"> o AIMS Center/WA Council for Behavioral Health Project 2A Resources: https://www.thewashingtoncouncil.org/training-technical-assistance/ <input type="checkbox"/> Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness http://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf <p>Other Resources</p> <ul style="list-style-type: none"> <input type="checkbox"/> SAMHSA-HRSA Center for Integrated Health Solutions http://www.integration.samhsa.gov/integrated-care-models <input type="checkbox"/> Approaches to Integrating Physical Health Services into Behavioral Health Organizations http://www.integration.samhsa.gov/Approaches_to_Integrating_Physical_Health_Services_into_BH_Organizations_RIC.pdf 	20
4	Addresses the Opioid Epidemic	<p>The Change Plan should address the organization's capacity and intentions to help address the Opioid epidemic. This could include adoption of regional and state prescribing guidelines regarding opioids and benzodiazepines, increases in the number of suboxone prescribers among the organization's prescribers, or other measures appropriate for the organization. It should also include the designation of a point person for the organization to participate in county and regional opioid related initiatives.</p> <p>Demonstration resources</p>	5

		<ul style="list-style-type: none"> • AMDG’s Interagency Guideline on Prescribing Opioids for Pain, http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpoidGuideline.pdf • CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016 https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm • Substance Use during Pregnancy: Guidelines for Screening and Management, http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy/13_PregSubs_E16L.pdf 	
5	Addresses methods for addressing social determinants of health	The essence of more effectively addressing the social determinants of health – those outside-the clinic factors that greatly influence health and the effectiveness of health care – is to connect patients with resources that can help them deal with those factors. Many of those resources are community agencies and services that address factors such as employment, housing, nutrition & food sufficiency, education, childcare, chronic disease self-management. The proposal should describe the organization’s plans to refer patients to and coordinate care with agencies in support of patient wellness.	5
6	Financial Sustainability through Value-Based Payment	The demonstration project can provide change management support and short-term investments in innovative approaches to care. However, any changes in care must have a plan for funding through future value-based payment mechanisms beyond the demonstration period. The Change Plan should provide a budget showing as much detail as possible about the costs of implementing the planned changes between now and the end of 2021. To the extent these operational changes will require Demonstration Project funding to implement, describe how they will be sustained through value-based payment arrangements beyond the demonstration period.	10
7	Care Coordination, Transition and Diversion	<p>An important aspect of population health is the management of care across the continuum of providers, facilities, organizations and agencies involved in a patient’s care. The Change Plan should describe how care both within the organization and outside can be coordinated to ensure unnecessary lapses in or duplication of care can be avoided, with particular attention to strategies for addressing psychiatric admissions, readmissions, and Emergency Room visits. The Change Plan should address how proactive population management will ensure care is provided at the right time and in the right place to avoid unnecessary use of Emergency Rooms and Hospitals (Diversion) and how patients treated in those settings receive appropriate follow up care to address avoidable readmission (Transition.) Also, the NCACH Pathways Care Coordination HUB project is designed to make connections with community resources relatively quick and easy for providers, and to provide a framework for coordinating and funding care coordination. The Change Plan should discuss how any current care coordination efforts provided by the organization could become part of the HUB effort. At a minimum (since it will take some time for the HUB to reach the entire region) the plan should demonstrate an understanding of the HUB concept and indicate a willingness to cooperate with the HUB when it becomes available to the organization’s patients or clients.</p> <p>Demonstration resources</p> <ul style="list-style-type: none"> • Pathways Community HUB https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf • The Care Transitions Intervention® (CTI®), http://caretransitions.org • Care Transitions Interventions in Mental Health http://www.integration.samhsa.gov/Care transition interventions in mental health.pdf • Emergency Department (ED) Diversion, http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/ 	10

		<p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038086/ - a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.</p> <ul style="list-style-type: none"> Community Paramedicine Model, http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf - an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. Additional resources include: http://communityparamedic.org/, http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf, and https://www.ruralhealthinfo.org/topics/community-paramedicine. Law Enforcement Assisted Diversion, LEAD® http://www.leadbureau.org/ 	
8	Access to Care	<p>North Central Washington is underserved in terms of common provider/population ratios that make it difficult for patients to visit a provider. Additional barriers, including insurance coverage, lack of after hours coverage, geography, weather, transportation, and language can reduce timely access to appropriate care and result in unnecessary exacerbations of readily preventable or treatable conditions. Fortunately, improvements in technology and innovative approaches to access, including telemedicine, e-medicine, phone visits, nurse triage/advice lines, and case management services can be effective in leveraging traditional provider visits and are increasingly reimbursed by insurers. The Change Plan should describe innovative approaches the organization is taking to improve access to in-person care with providers as well as other innovative approaches to respond to patient needs.</p>	10
	Total		100

A few elements may be required but are not scored separately:

- The plan should indicate the extent (if any) to which the physical infrastructure of the organization may need to be altered to accommodate expected changes. For example, offices might need to be reconfigured to allow for co-location of BH or primary care providers, or for members of an expanded care team. Costs for such changes should be included in the budget.
- A discussion, especially for smaller providers, of the way the applicant plans to use collaboration among provider organizations to make more efficient use of funds. For example, two or three smaller organizations could share the same Change Management consultant in plan development. IT consultants could be shared. Or multiple organizations could cooperate on 24/7 nurse call lines which would not be affordable to any single small organization.
- The plan must indicate a commitment to share plans, metrics, results, problems and experiences with other members of the Whole Person Care Collaborative in an open learning-oriented manner to support an effective learning collaborative. If the applicant expects to withhold certain kinds of information (such as proprietary business information) this section should explain how it will be possible to achieve a meaningful learning collaborative without sharing information of that kind.

- The plan should give a concise description of the member’s services, staffing, facilities and patient population to assure reviewers have a good understanding of the organization.
- The applicant may add other elements to the Change Plan to clarify its approach to Demonstration work, though there is no reward for quantity.

Timeframe for Stage 2 Evaluation and Implementation

Jul-Sep 2018

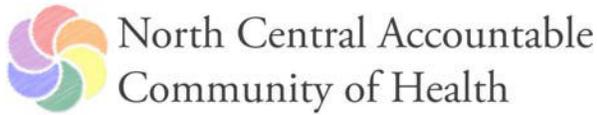
After evaluation of change plans, the first installment of Stage 2 Change Implementation Awards will be made

Oct-Dec 2018

Change Plan implementation begins. Subsequent Implementation Awards will be based on demonstrated progress as reported in semi-annual reports to the NCACH.

Stage 3: Sustaining Change and Demonstrating Improvement in Outcomes

In order for the NCACH to achieve its goal of health improvement, all organizations must improve regardless of their starting point. It’s therefore the intent of the Collaborative is to challenge each organization equally and to reward incremental improvement and to avoid penalizing or rewarding organizations for their current state. The WPCC will work with the HCA and the member organizations to define each organization’s baseline performance on some or all of the clinical outcome measures which can be substantially improved through the Change Plans. (See attached *Approved Project Metrics Appendix*) Incentive payments to participating WPCC members will be based on their relative contribution to aggregate ACH improvement in these clinical outcomes and amounts will be subject to incentive funds awarded to the ACH by the HCA.



Whole Person Care Collaborative Charter

Background

In order to participate in the State Innovation Model (SIM) grant program and prepare for fully integrated Medicaid contracting by 2020, the North Central ACH Governing board selected whole person care as the primary project under SIM. A Primary Care Transformation Workgroup was formed and in the fall of 2016 the workgroup adopted a broad vision of whole person care and formed the Whole Person Care Collaborative. The term “collaborative” was used because the ACH Board intends to create organized and standardized systems to better integrate care between provider organizations across North Central Washington (NCW) and the Board believes the collective and cooperative efforts of these organizations will provide the most effective means to achieve this aim.

Charge

The Whole Person Care Collaborative (WPCC) will promote alignment of provider transformation efforts in the North Central Region with a shared vision of whole person care. The region’s vision of whole person care is for patients to receive care that integrates behavioral and physical care, and effectively connects patients to resources that can help mitigate the negative effects of social determinants of health. The work of WPCC will also strive to deliver Whole Person Care in a way that is financially sustainable for provider organizations.

NCACH plans to use WPCC as the primary means through which to allocate Demonstration funding to provider organizations. The WPCC will create a structured and systematic process for participating provider groups in NCW to collaborate on and receive funding to support adoption of evidenced-based and other innovative practices that will:

- Enable primary care and behavioral health providers in NCW to better integrate behavioral health and medical care,
- Better integrate and coordinate care activities with organizations addressing social determinants of health,
- Achieve the population-based clinical outcome goals of the Medicaid Demonstration project relevant to the projects addressed by the Collaborative as outlined by the HCA in the Demonstration Project Toolkit, and;
- Adapt successfully to value-based payment initiatives across payers (e.g., MACRA) by supporting participating practices in delivering effective whole person care and thriving economically under evolving incentives and reimbursement models.

Composition

The Whole Person Care Collaborative is open to organizations in Grant, Chelan, Douglas, and Okanogan Counties. Representatives from the following sectors will be encouraged to participate as members, and will be broken into the following categories:

Members who are able to receive Demonstration funding through the Collaborative:

- Behavioral Healthcare Provider Organizations
- Primary Healthcare Provider Organizations

Members who are active partners in Demonstration work through the Collaborative, including but not limited to the following:

- Managed Care Organizations
- Emergency Service Organizations

A member organization is one who has signed a membership agreement, referenced in this charter, which describes the benefits, duties, and obligations of members with respect to the quality improvement work of the collaborative. The WPCC is a sub-committee of the ACH board, and will be chaired by the director of the Whole Person Care Collaborative.

Meetings

Meetings are open to the public and all interested organizations are welcome to attend. WPCC meetings are normally held one time a month. An effort will be made to hold meetings in each of the counties throughout the year. All meetings will have an option to participate via teleconference for those unable to attend in person. The NCACH WPCC Chair, Governing Board Chair, and staff shall be responsible for establishing the agendas. Notes for all meetings will be provided by NCACH staff within 2 weeks of each meeting. All meeting materials (agendas, notes, presentations, etc.) will be publicly available on the NCACH website under the WPCC page.

Member Obligations

1. Every WPCC member organization will conduct its own baseline assessment (using Qualis or the consultant of their choice) to establish their current operational state relative to the PCMH- A tool for Primary Care and MeHAF tool for Behavioral Health, and improvement opportunities to be addressed in the transition to whole person care and value-based payment.
2. Every WPCC member organization will work with the consultant of its choice (or its internal experts if available) to develop its own Change Plan. WPCC will provide a Change Plan template, but each organization must develop its own internal plan. This plan should be as specific as possible in identifying necessary changes in arrangements for behavioral health integration, changes in staffing patterns, IT changes, care coordination arrangements, and other measures that will be needed to provide whole person care. The plan should include a budget reflecting the costs of this transition to be supported by demonstration funding and how the changes will be sustained through value based payment beyond the period of the demonstration. The Change Plan should also include a timeline for an implementation plan identifying who in the organization will be involved in shaping and implementing these changes. The Change Plans will be submitted to the WPCC for evaluation and recommendations and they will be the basis for most of the Demonstration funding allocated to provider organizations.
3. Every WPCC member organization commits to be part of a learning collaborative structure that includes collecting and sharing their Change Plan results and progress toward implementation with other members of the collaborative.

WPCC Roles and Responsibilities

1. WPCC will develop Change Plan methodology and make recommendations to the NCACH Governing Board on plan details that will be supported through the Medicaid Demonstration.
2. WPCC will work with member organizations as needed to improve plans, using Demonstration funds if needed, and as available, to enable the organization to acquire needed clinical resources.
3. The WPCC will, as directed by the NCACH Governing Board:
 - a. Provide mechanisms for measuring performance of the ACH, sub-regions, and member organizations and progress over time.
 - b. Provide opportunities for members to share best practices, engage in peer learning, and leverage available statewide practice transformation resources
 - c. Provide training and coaching opportunities as needed to address organizational change and clinical practice improvement.
 - d. Evaluate and recommend improvements in shared systems as necessary to improve care across organizations (*e.g. 24/7 nurse advice systems, health information exchange/interoperability, care management systems, other IT solutions*)
4. The WPCC will evaluate the progress of individual members relative to project work plans, Demonstration milestones, and progress toward achievement of relevant clinical quality metrics associated with the WPCC improvements. It will provide the board with regular monthly updates on the contribution of the WPCC toward meeting the Demonstration Project objectives and on changes or adjustments to the strategies that may be necessary.

Authority

The WPCC is an advisory body that will inform decision-making and ensure regional priorities and local considerations are incorporated in program design decisions. Recommendations and input developed by the WPCC will be shared in regular monthly progress reports to the NCACH Governing Board.

Footnote: *NCACH performance on HCA's Demonstration metrics will have a part in determining the amount of Demonstration funding available. In Demonstration Years (DY) 1 and 2, funding allocations will be determined by ACH performance on a series of pay-for-reporting (P4R) measures. In DY 3-5, funding allocations will be determined by ACH performance on a combination of P4R and pay-for-performance measures.*

**North Central Accountable Community of Health
Whole Person Care Collaborative
Membership Participation Agreement**

Organization Name

commits to participate in the NCACH Whole Person Care Collaborative as a member according to the following terms of agreement:

1. We have read and understand the Whole Person Care Collaborative (WPCC) Charter and agree to the terms and conditions outlined therein, including the Charge, Member Obligations, and the Role and Responsibilities of the WPCC.

2. We agree to designate a representative to participate in the regular meetings of the WPCC and to provide guidance and support for the effort.

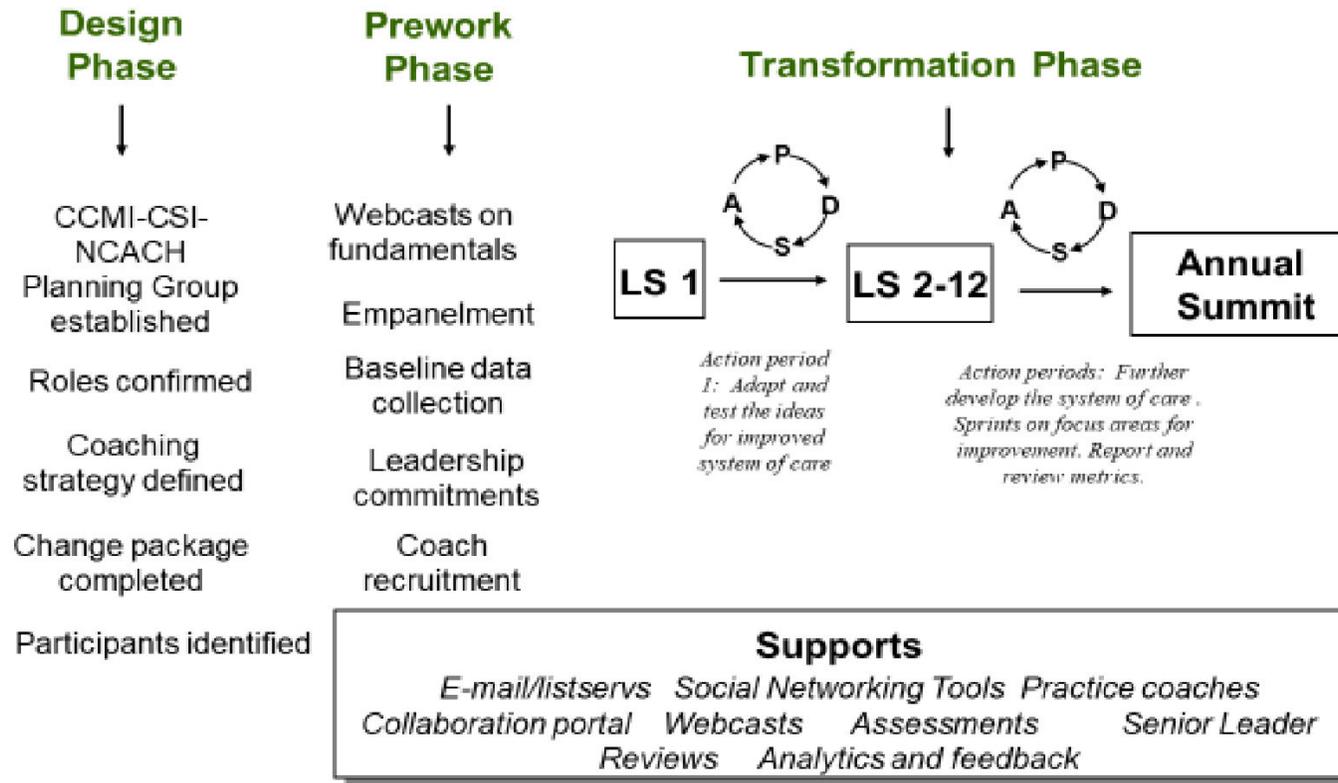
3. For the purposes of understanding sources of variation across the region and improving the health and well-being of the entire population of NCH, we agree to share organization-specific health outcome data (*non-PHI identifiable and not provider specific*) relevant to the Demonstration Project with the ACH.

Signature

Date

Name and Title

Strawman Collaborative Design



SECTION II: PROJECT-LEVEL

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

Transformation Project Description

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

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

Project Selection & Expected Outcomes

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

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

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

ACH Response

In December of 2016, a regional Community Health Needs Assessment was released that identified the highest health needs in the North Central Accountable Community of Health (NCACH) region (Chelan, Douglas, Grant, and Okanogan Counties). Of those needs, mental health care access and access to care were identified as the two highest priority areas. These health needs and issues were identified through systematic, comprehensive data collection and analysis, and benefited from participation of 39 community partners. As a follow up to this assessment, North Central Accountable Community of Health (NCACH) staff also gathered feedback from community members to assist with project selection through an online survey and using in-person presentations to all three of our Coalitions for Health Improvement. The survey asked individuals to evaluate each of the optional projects based on being critical to achieving whole person care, feasibility to improve metrics, sustainability, and relevancy to all four counties. Overall, community-based care coordination (the Care Coordination Project) ranked the highest in terms of being relevant to all four counties, being able to improve outcomes during the Medicaid Transformation Project Demonstration (the Demonstration) period, and being sustainable after the Demonstration. During our project selection process, surveyed community members noted that this project is key to NCACH's ability to meet the triple aim. They also noted that community-based care coordination would help NCACH address the social determinants of health.

The NCACH region is similar to many other regions in that we have a fragmented and often duplicated care coordination delivery system. Where care coordination services are being provided, they are usually being provided at a high level and deliver a significant benefit to the client. However, the Care Coordination Project will help develop a regional platform, through the Pathways Community HUB model, that can coordinate the services of the current care coordination agencies in the region. This will prevent duplication of services to clients and place clients with the most appropriate level of care coordinator (i.e. community health worker, nurse, social worker, etc.).

NCACH has selected the Pathways Community HUB model as the evidence-based approach from the Demonstration Project Toolkit provided by the Washington State Health Care Authority. Although the Pathways Community HUB model is the only evidence-based approach offered in the Project Toolkit, NCACH conducted extensive research, held conversations with the founders of the model, and held a two-day Whole Person Care Workshop to ensure this approach was a fit for the North Central region. NCACH and our partners see the true value that Pathways Community HUB can bring to our region to facilitate a more coordinated and accountable form of care in our region.

NCACH is currently investigating the costs, function, and interoperability of the Care Coordination Systems (CCS) information technology (IT) platform for our Pathways Community HUB. There are three key advantages to selecting the CCS platform:

- 1) CCS offers connectivity with electronic health records (EHRs), the Emergency Department Information Exchange (EDIE) system (a multi-state health information exchange (HIE) for emergency departments), PreManage (a hospital HIE), Washington Information Network (WIN) 211 (a statewide social service registry), and OneHealthPort (a statewide Medicaid HIE).
- 2) CCS was specifically designed for the Pathways Community HUB model and its pay for outcomes methodology.

- 3) CCS is closely connected with one of the founders of the Pathways Community HUB model (Dr. Sarah Redding).

A key issue to consider is how NCACH will work with providers to educate our partners on how the Pathways Community HUB IT platform will directly interface with their organization's EHRs. We plan on addressing this in our Health Information Technology/Health Information Exchange (HIT/HIE) Workgroup. This workgroup will provide strategic advice and input into population health management systems required to implement Demonstration projects in the short-term, and to promote continued health improvement and care coordination in the long-run.

NCACH is dedicated to integrating CCS into partnering provider current health information technology (HIT) systems wherever possible to ensure there is communication and coordination among all providers that care for Pathways Community HUB clients. Additionally, NCACH has initiated conversations with Washington Information Network 211 (WIN211) regarding social service inventory integration for the Pathways Community HUB. This work is still in the exploratory phase but is a prime example of how NCACH is working to leverage existing resources rather than duplicate efforts.

The Pathways Community HUB will directly address a portion of Domain I workforce development strategies by training community health workers in the region to provide community-based care coordination services. NCACH plans to partner with Pathways Community HUB care coordination agencies to approach our local community colleges to develop a community health worker training program that meets Pathways Community HUB standards.

A key aspect of the Pathways Community HUB model is that it does not replace, but rather supplements and supports existing care coordinators and care coordination services. NCACH will preserve this element by regularly convening stakeholders involved in care coordination work through the Pathways Community HUB Workgroup and the Coalitions for Health Improvement (described below) to help develop the processes that will be utilized by the Pathways Community HUB. An additional benefit of the Pathways Community HUB model to the current care coordination delivery system, is the pay-for-outcome methodology the Pathways Community HUB utilizes.

NCACH has been engaged in conversations with Health Homes leads and Managed Care Organizations (MCOs) to ensure that the development of a Pathways Community HUB is coordinated with current Health Homes efforts. We recognize and value the care coordination and resources that Health Homes brings to our region. Given that clients become eligible for Health Homes by having a predictive risk score that exceeds a certain level, we anticipate there will be some overlap between the Pathways Community HUB selected target population and that of Health Homes. We want to ensure we maximize the benefit of both programs, that they support one another, and that they are not duplicative. We intend to build off and adapt the bi-directional referral process that North Sound Accountable Community of Health and Molina Healthcare have begun to develop (See Care Coordination Project - Attachment A). Additionally, our fee-for-service Health Homes lead (also the fee-for-service Health Homes lead for Better Health Together region and Whitman County) has engaged in conversations directly with CCS to develop a Health Homes module for the CCS IT platform. If this effort is successful, the Pathways Community HUB and our fee-for-service Health Homes lead would be using the same IT platform which would lead to better communication and coordination of care coordination services.

We are actively meeting with our bordering Accountable Communities of Health (Better Health Together and Greater Columbia Accountable Community of Health) to ensure care coordination efforts are in alignment so we minimize burden and increase communication among our providers who serve populations from two or more regions.

NCACH will continue to work with the local Coalitions for Health Improvement (CHIs) to ensure duplication does not occur. The CHIs are local coalitions, started by NCACH, in each of the three local health jurisdictions (Chelan-Douglas, Grant, and Okanogan). These broad based coalitions are open to all members in the community and serve two main functions associated with the work of Pathways Community HUB:

1. Provide input on the selected target population and identify areas within their community where existing care coordination efforts exist.
2. Work to better engage local partnering providers and referral partners in the work of Pathways Community HUB and to enhance care coordination activities in the community.

Working with these partners and Coalitions, NCACH staff will work with the Pathways Community HUB Subcommittee (described below) to develop a regional current state capacity report of care coordination by quarter 2 of 2018. By quarter 3 of 2018, NCACH will develop a matrix of how all Demonstration projects connect to each other to ensure that we do not duplicate services across the six NCACH selected projects.

NCACH views community-based care coordination as the link that crosses between clinical and community settings. NCACH has preliminarily defined our target population as Medicaid beneficiaries with one or more chronic diseases or a behavioral condition (mental illness or moderate to severe substance use disorder). Through discussions with the HUB Workgroup over the next seven months, we will need to further refine, narrow and/or adjust our initial target population based on feasibility constraints. We intend to refine our target population by focusing on high utilizers of emergency departments (ED) who intersect with the Transitional Care and Diversion Interventions Projects, as well as the projects led by our Whole Person Care Collaborative (Bi-Directional Integration Project and Chronic Disease Project). This approach will allow us to leverage community-based care coordination as a way to support and align our projects, thus having a bigger impact on these populations and achieving our performance measurement goals. It is also a way of matching the highest need population with the highest intensity of care coordination.

NCACH decided to synchronize preliminary target populations of the Care Coordination Project (Pathways Community HUB model) with other projects, particularly high ED utilizers with behavioral health and/or chronic conditions. This is supported from quantitative data indicating areas of need and opportunities for impact outlined in the following paragraphs.

As shown in the table below, Medicaid members in our North Central region who had three or more ED visits were four or more times more likely to exhibit behavioral health and chronic disease risk factors, compared to those who did not have three or more ED visits¹.

¹ DSHS Research and Data Analysis, "Measure Decomposition Data" file released October 27, 2017. Many of these measures are based on Chronic Disease Payment System (CDPS) risk groups. CDPS is a diagnostic classification system that Medicaid programs can use to make health-based capitated payments for TANF and disabled Medicaid beneficiaries.

Behavioral health and chronic conditions are also reflected in emergency department utilization data for our NCACH region. During the October 2015 - September 2016 time period, diseases of the respiratory system accounted for 11% of ED visits (the third most common cause), while mental and behavioral disorders accounted for 5% of ED visits (the sixth most common cause)².

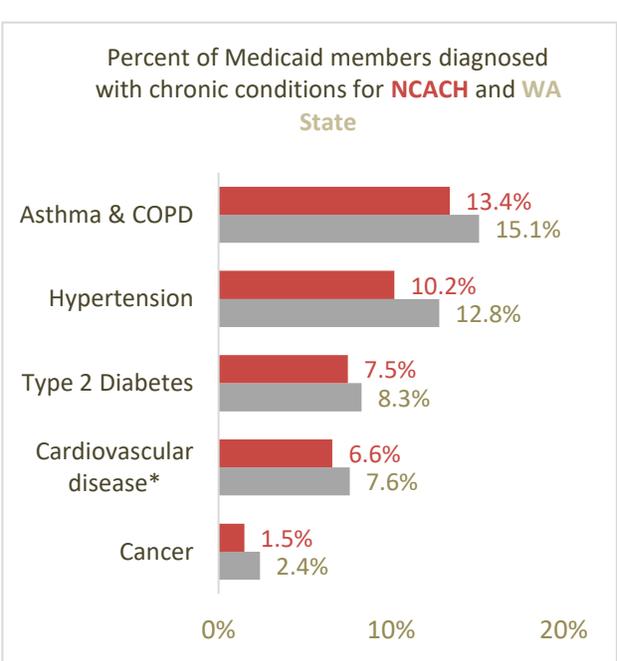
Risk Factor for ED Utilization	X times more likely to exhibit risk factor, if have 3+ ED visits
Type 1 diabetes (high)	7.2
Pulmonary (very high)	6.8
Cardiovascular (very high)	6.6
Renal (extra high)	6
Co-occurring mental illness/substance use disorder	5.2
Substance abuse (low)	4.8
Pulmonary (medium)	4.7
Cardiovascular (medium)	4.1

Source: DSHS Research and Data Analysis, "Measure Decomposition Data" file released October 27, 2017

Rank	Cause of ED Utilization	Count	%
1	Symptoms, signs & abnormal clinical and lab findings	8,007	24
2	Injury, poisoning, and certain other consequences of external causes	7,822	23
3	Diseases of the respiratory system	3,860	11
4	Diseases of the digestive system	2,169	6
5	Diseases of the musculoskeletal system and connective tissue	1,635	5
6	Mental and behavioral disorders	1,554	5
7	Diseases of the skin and subcutaneous tissue	1,423	4
8	Diseases of the genitourinary system	1,352	4
9	Pregnancy, childbirth and the puerperium	1,195	4
10	Infectious and parasitic diseases	1,104	3

*Source: HCA ED utilization by Facility data set, "North Central" tab.
Measurement period: October 2015 – September 2016*

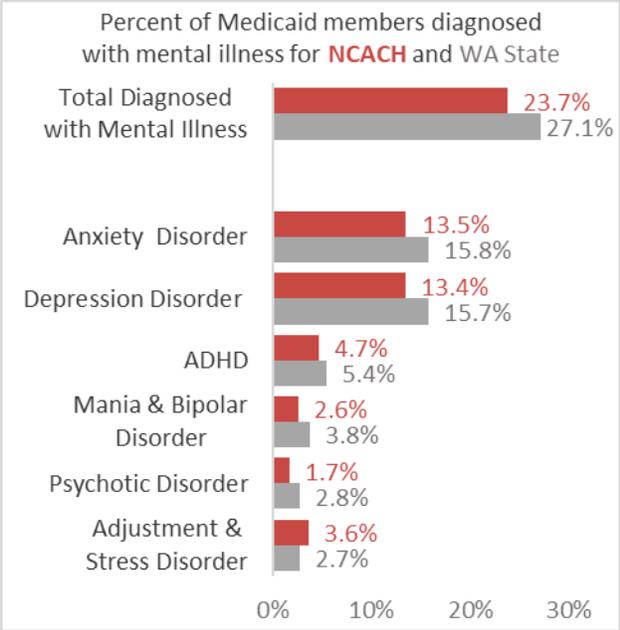
² Health Care Authority, "ED utilization by Facility" data set. (Oct 1, 2015 - Sep 30, 2016).



Source: DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.

In terms of behavioral health needs, roughly 25% of Medicaid members in the NCACH region have been diagnosed with mental illness, with anxiety disorders and depression being the most prevalent conditions⁴. More than 5,000 Medicaid members have co-occurring mental illness and substance use disorder diagnoses. Data from the Behavioral Risk Factor Surveillance System indicates that Okanogan County’s rate of adults who reported poor mental health was higher than the statewide average (15% compared to 11%⁵) – the fourth highest rate in all of Washington State. Within our region, Okanogan County has the highest rate of Medicaid beneficiaries who have a substance use disorder (SUD) or co-occurring SUD and mental health issues (3.2% and 1.2%,

Overall, the NCACH region has lower rates of chronic conditions than the statewide average. Chronic diseases and behavioral health conditions, however, have a disparate impact on certain populations. For example, over the 2013-2015 time period, the broader population in our region had an estimated asthma rate of 10.1% (compared to 9.5% for the state), but the prevalence of asthma for Native Americans in our region is 21.2%. Over the 2013-2015 time period, nearly 10% of adults in the region reported having diabetes, the highest rate compared to other ACHs, and 2% above the statewide average. Diabetes rates are highest in Grant and Okanogan Counties (12% and 11% respectively)³. Data for specific demographic groups continue to highlight disparities in health outcomes. For example, Hispanics in our region have twice the rate of diabetes compared to Whites (17.7% versus 8.6%).



Source: DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.

³ HCA RHNI Start Kit, “Prevalence Estimates – Overall” tab. Based on the annual Behavioral Risk Factor Surveillance System (BRFSS) using three years combined data (2013-2015).

⁴ DSHS ACH Profiles produced by RDA. North Central Current State spreadsheet.

⁵ Healthier Washington Dashboard, Statewide Measures Browser.

respectively⁶), and the rate of alcohol-impaired driving deaths was 13% higher than the statewide rate (48% compared to 35%)⁷. Gender, race, and age disparities also exist in our region. For example, a higher percentage of females report poor mental health (14.7% compared to 6.5% of males), while 33.8% of Native Americans in our region report poor mental health (the highest rate for Native Americans across all ACHs)⁸. People 25-34 years old report the highest percentage of poor mental health days (13.4%) in our ACH region⁹. Elders in our region also demonstrate higher behavioral health treatment needs compared to statewide averages, while all other unique Medicaid groups in our region have lower rates¹⁰. All of these data highlight potential health equity issues that we will expect our workgroup to consider and address through the Pathways Community HUB.

High-utilizers of EDs have a big impact on cost, a key concern in Healthier Washington's Demonstration project (and in the Triple Aim). In fact, all six of our selected projects are being held accountable to an *Outpatient Emergency Department* performance measure (the only measure that appears in all projects). In the coming months, we will have access to disaggregated data through a special data sharing agreement with HCA, allowing us to dig further into ED utilization, including diagnoses and demographics. This will help us further refine our target population and implementation approach.

NCACH anticipates priority population selection to be determined by March 2018. NCACH intends to launch the Pathways Community HUB with a targeted and narrow initial population (including location), though the initial population size will need to be large enough to have a relative impact and proof of concept. Once the infrastructure and capacity is built out, we will expand target populations and geographies to a broad-spectrum approach serving high-risk/high-cost beneficiaries that would benefit from care coordination. To produce cost savings and show a return on investment (ROI) during the Demonstration period, it will be necessary to focus on providing care coordination services to the most of high-risk/high-cost individuals. Though detailed business plans and ROI calculations need to be explored, preliminarily we hope to reach all Medicaid high ED utilizer adults (about 1,600¹¹). Additionally, we will explore eventually expanding the target population to include behavioral health and chronic conditions. Preliminary populations the Pathways Community HUB could expand to serve include NCACH residents being released from emergency departments and hospitals based on a primary diagnosis of mental and behavioral disorders (about 1,700¹²), Medicaid beneficiaries with an asthma diagnosis (about 2,700¹³), and Medicaid beneficiaries with a diabetes

⁶ HCA Behavioral Health and Co-occurring Disorders data, "Cat 1 Behavioral Health and Chronic Conditions 09.29.17" spreadsheet.

⁷ Robert Wood Johnson Foundation, County Health Rankings (2017).

⁸ HCA RHNI "Starter-Kit" Delivery, "Prevalence Estimates – Overall" tab. Based on BRFSS measure for % adults who reported poor mental health during the past 30 days: 2013-2015.

⁹ HCA RHNI "Starter-Kit" Delivery, "Prevalence Estimates – Overall" tab. Based on BRFSS measure for % adults who reported poor mental health during the past 30 days: 2013-2015.

¹⁰ DSHS RDA, ACH Profiles updated 02.28.17. North Central Current State spreadsheet, "Behavioral Health" tab.

¹¹ DSHS Research and Data Analysis, "Measure Decomposition Data" file released October 27, 2017.

¹² Based on HCA data. Hospitalization data included in "Starter Kit" showed 171 counts of acute hospitalizations among Medicaid recipients for mental and behavioral disorders. ED utilization by Facility showed 1,554 ED visits among Medicaid recipients for mental and behavioral disorders.

¹³ HCA RHNI "Starter-Kit" Delivery, "Chronic Disease Estimates, Medicaid Population, During Jan 1, 2015-Dec 31, 2015".

diagnosis (about 3,000¹⁴). With this approach, we expect to be able to show an ROI through improved care coordination and reduced health care costs for individuals enrolled in the Pathways Community HUB.

In addition to benefiting the potential target populations outlined above, the Pathways Community HUB will benefit the entire Medicaid population through improved clinical-community linkages and improved care coordination structures and processes. Through our work to develop and implement a Pathways Community HUB, NCACH and partners will facilitate clinical-community linkages and appropriate referral systems (such as Health Homes). Once these connections are made, the entire Medicaid population will benefit from the improved systems in place, not just those directly being served by the Pathways Community HUB. One of the key advantages of the Pathways Community HUB is the elimination of duplication of services and accessing appropriate levels of services for clients. By eliminating duplication and handling high-needs beneficiaries through more cost effective community-based care coordination, value-based purchasing models will enable saved resources to be redirected, resulting in improved access to care for all Medicaid beneficiaries.

NCACH is advocating for an effective collaborative of ACHs working to implement the Pathways Community HUB and values the opportunities that would afford to organize some activities at the state level rather than separately in each ACH (e.g., IT arrangements, community health worker training capacity). This collaboration will help enhance the efforts NCACH has made toward the Pathways Community HUB model at a local level.

On September 8, 2017, the NCACH Governing Board held a one-day board retreat to address more fully topics that needed Board attention. The Pathways Community HUB was one of the main discussions. NCACH staff presented on the Pathways Community HUB model, case studies of successful operational HUBs, and the status of other Washington ACHs in Pathways Community HUB planning (See Care Coordination Project - Attachment B). During Board discussion, it became clear that it was necessary for a subgroup of Board members to delve deeper into understanding the logistics of developing a Pathways Community HUB, the business model, and IT specifications. During the September Governing Board meeting the following week, NCACH officially formed the Pathways Community HUB Subcommittee (HUB Subcommittee). A wide range of partnering providers are represented on the HUB Subcommittee from the following sectors and populations:

- Primary care providers
- Housing
- Education
- Public health
- Care coordination agencies
- Managed care organizations
- Local government
- Behavioral health providers
- Hospitals
- Tribal

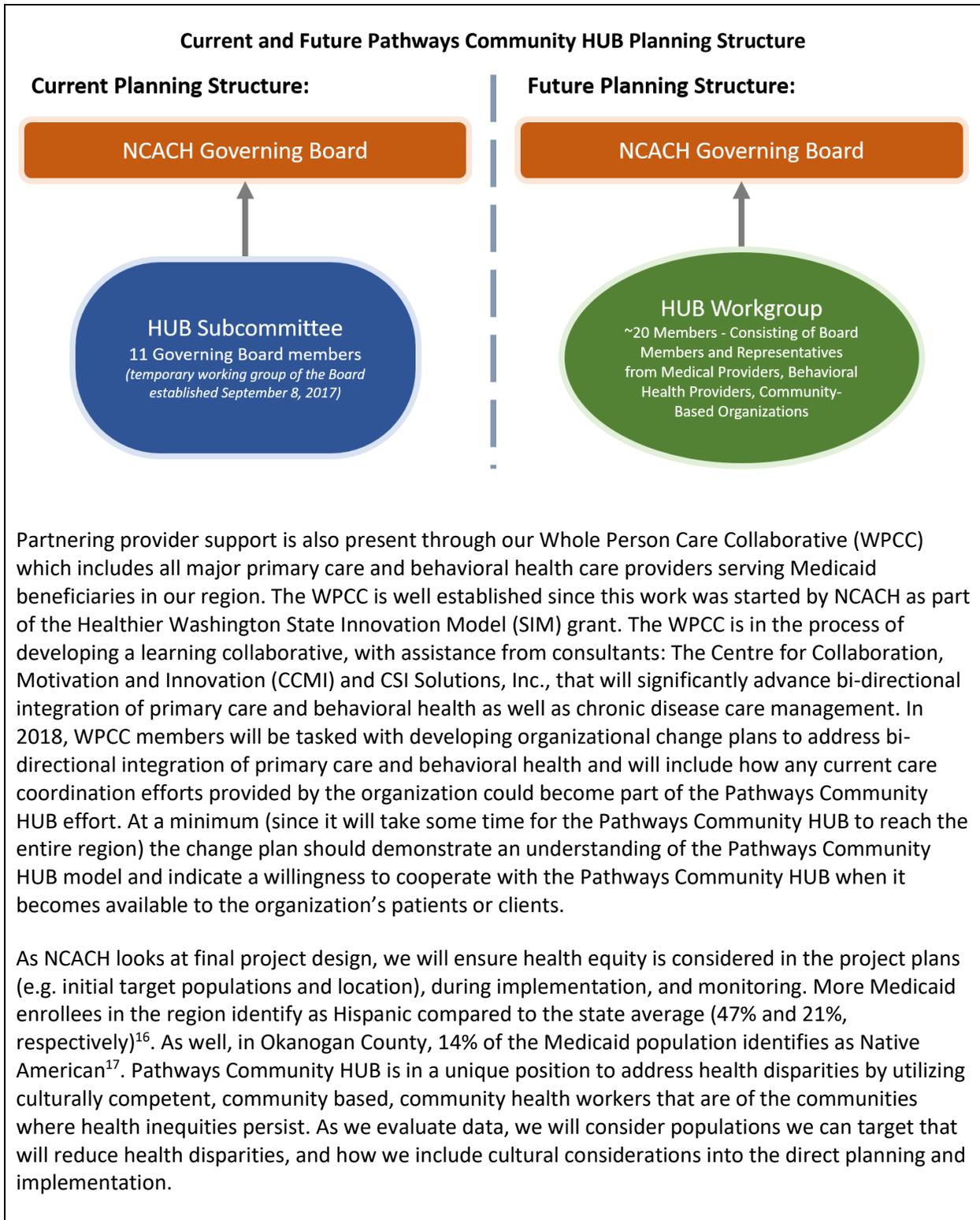
¹⁴ HCA RHNI “Starter-Kit” Delivery, “Chronic Disease Estimates, Medicaid Population, During Jan 1, 2015-Dec 31, 2015”.

- Hispanic community

On October 2, 2017, the Board approved for NCACH to enter into an initial engagement with Care Coordination Systems (CCS) to gain access to key materials to advance our understanding of the work plan to develop a Pathways Community HUB, business and sustainability models, and IT interoperability specifications. Healthy Generations, a non-profit in Washington State, submitted an Advisory and Training Agreement proposal to each ACH that selected community based care coordination as a project. In a deliberate process to ensure success, the NCACH Board is requesting a live demonstration of the Pathways Community HUB and CCS prior to entering into contracts with Healthy Generations or Care Coordination Systems. At the November 6, 2017 Board meeting, the Board moved to invite Care Coordination Systems to present the Pathways Community HUB model and IT system to the Board. This presentation, scheduled for November 30, 2017, will pave the way for next steps of this project, including entering into a contract with a consultant to help us with the RFP process for selecting a HUB lead agency and completing the assessment of care coordination in the region.

NCACH does not intend to serve as the Pathways Community HUB lead agency (lead agency) and thus is eager to identify a lead agency. The HUB Subcommittee was established with the purpose of developing a request for proposal (RFP) to recruit a regional and neutral¹⁵ organization to serve as the lead agency and to develop an inventory of current care coordination services (target date for completion is no later than quarter 2 of 2018). Once the initial work is completed of selecting a consultant and developing an RFP process, the Board recognizes the need to formally establish a Pathways Community HUB Workgroup (HUB Workgroup) that will be composed of partnering providers, both clinical and community based (see figure below). We have had a lot of interest from partnering providers and CHIs to be involved in the development of the Pathways Community HUB and plan to engage those partners fully once NCACH has issued an RFP and a lead agency is identified.

¹⁵ Pathways Community HUB Certification Pre-Requisites and Standards (Revised February 2017). The Rockville Institute.



¹⁶ HCA RHNI “Starter-Kit” Delivery, “Demographics – Medicaid” tab. Based on HCA Medicaid enrollment and claims data for the 2015 calendar year.

¹⁷ Healthier Washington Dashboard. October 1, 2015-September 30, 2016. HCA Medicaid enrollment and claims data.

One of NCACH's key strategies is to target Demonstration funds to support changes in systems and processes that can lay the ground work for long-term sustainability. NCACH will work with expert consultants to develop sustainable business models that use braided funding strategies to plan for long-term sustainable funding. The NCACH Governing Board is open to supporting additional staff resources and direct services initially, but we must show a strong plan toward sustainability. It is imperative and a key component of the Pathways Community HUB model to secure funding from more than one source in order to make the model successful and sustainable in our region. With guidance from our consultant experts on contracting models, NCACH will work with MCOs, foundations, community-based organizations, and local jurisdictions to sustain the Pathways Community HUB beyond the Demonstration.

Implementation Approach and Timing

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

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

Partnering Providers

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

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

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

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

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

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

ACH Response

Given the overarching goals of the Demonstration, the HUB Subcommittee knows that it is charged with focusing on the Medicaid population and will ensure that the selected Pathways Community HUB lead agency maintain this focus. As we move into project implementation, developing funding recommendations, and formally establishing a HUB Workgroup, the HUB Subcommittee will target providers serving the Medicaid population through care coordination services to have a representative on the HUB Workgroup. This is critical since it is the on-the-ground activities and practices of our healthcare providers and community-based organizations that will drive improvements to the Medicaid-specific metrics selected and measured by the Washington State Health Care Authority (HCA).

NCACH views one of the major roles of the Pathways Community HUB in the Demonstration to be a robust clinical-community linkage in addressing the social determinants of health. For this reason, NCACH recognizes the necessity to engage not only medical providers but also social service providers in the early stages of planning and development. Additionally, in order to achieve a sustainable Pathways community HUB, we feel it is necessary to have the payers at the table from the beginning to engage in design, planning, and implementation. With this in mind, when the Board approves the formation of the HUB Workgroup during quarter 2 of 2018, we will ensure medical providers, social service providers, and payers are equitably represented on the HUB Workgroup.

Members selected for the HUB Workgroup will be vetted and recruited by our Board Executive Committee with a specific focus on sector representatives who serve a significant portion of the Medicaid population. Specifically, we expect to have workgroup members representing the criminal justice system, housing agencies, employment agencies, education, care coordination agencies, Federally Qualified Health Centers, and MCOs. These representatives work with many Medicaid beneficiaries in our region with a strong overlap between the community members these organizations serve. As the list of care coordination agencies and partnering providers involved in Pathways Community HUB implementation becomes clearer, we plan to ask them to assert their commitment to serving the Medicaid population in our memorandums of understanding.

Partnering providers engaged through our WPCC all serve the Medicaid population, though the volume and proportion of Medicaid patients varies from provider to provider. On our HUB Subcommittee, for example, we have representatives from Family Health Centers (approximately 6,500 Medicaid clients in 2016) and Coulee Medical Center (approximately 1,600 Medicaid clients in 2016). We also have a representative from Confluence which handles the largest volume of the

Medicaid population (over 46,000 Medicaid clients in 2016)¹⁸. While we do not have similar encounter data for social service agencies, we also have the City of Wenatchee, North Central Educational Service District, and the Okanogan County Housing Authority represented on the HUB Subcommittee.

In order to leverage MCOs' expertise in project implementation, and ensure there is no duplication, all three MCOs operating in our region after January 2018 (when we transition to Fully-Integrated Managed Care) have a seat on every one of our project workgroups. MCOs in our region will be Amerigroup, Coordinated Care, and Molina. This provides opportunities for them to be active participants in the development of the Community Pathways HUB and share their expertise and data with the rest of the workgroup members. In particular, MCOs have a unique and fundamental understanding of the Health Homes program which will be extremely valuable in coordination of services. This also allows each MCO to be highly involved in the development of the funding structure. In addition to workgroup membership, the MCO sector has a seat on our Governing Board. Through mutual agreement among the MCOs active in our NCACH region, representatives take turns rotating as their sector representative and share notes from our Board meetings with all other MCOs. In addition, we initiated monthly meetings between NCACH staff and MCO partners in order to proactively anticipate where our Demonstration projects might support MCO system improvements, especially as they relate to Value-Based Payments. All of these engagement mechanisms with MCOs are critical. This is not just about avoiding duplication; this is about ensuring alignment, using Demonstration investments to help providers adapt to value-based payments, and ensuring sustainability of the Pathways Community HUB beyond the Demonstration.

Regional Assets, Anticipated Challenges and Proposed Solutions

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

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

ACH Response

One of NCACH's greatest assets is the level of commitment and engagement of our health and social service partners. Our WPCC is made up of all major primary care and behavioral health care providers serving Medicaid beneficiaries in our region. The WPCC is well established since this work was started as part of the Healthier Washington SIM grant. The WPCC has started to develop a learning collaborative that will significantly advance bi-directional integration of primary care and behavioral health as well as chronic disease care management. Other regions have reached out to us to learn more about this collaborative model, and MCO partners have noted that we are farther along in terms of integrating our health care providers into a cohesive whole. The WPCC will touch all six of our projects through their organizational change plans (described in previous section) that they will be tasked with developing in 2018.

¹⁸ Beneficiary Counts for Selected Medicaid Providers in North Central ACH, claim and beneficiary counts for 2016. Revised September 9, 2017. Washington Health Care Authority, AIM Team.

In addition to the clinical provider support provided by the WPCC, NCACH is fortunate to have strong support for the Pathways Community HUB from engaged and motivated partners. This is in part due to a Whole Person Care Workshop NCACH organized in Lake Chelan, WA on January 26-27, 2017 that was attended by over 120 community partners. The second day of the workshop was dedicated to educating attendees on connecting patients with community resources which included a three hour session on the Pathways Community HUB model. Dr. Sarah Redding, one of the founders of the model, presented at the workshop. This workshop has proven to be a big asset in our work to move forward a Pathways Community HUB. The workshop provided an excellent educational foundation on the Pathways Community HUB model for NCACH to build on and allowed many partners to understand how a Pathways Community HUB would better serve the populations they interact with. This allowed our partners to recognize the true need for a more coordinated form of care coordination in our region.

Earlier this year, NCACH recognized a gap in data and analytic capacity. Over the past several months, we have addressed this gap in a variety of ways: (1) hired a full-time data analyst to do in-house data analysis, (2) contracted with the Center for Outcomes Research and Education (CORE) to provide technical assistance and consultation to assist NCACH with data-related needs for the project planning process (3) formed an HIT/HIE Workgroup to address regional population health management systems and information exchanges that can be expanded, enhanced, or initiated, and (4) contracted with the Centre for Collaboration, Motivation, and Innovation (CCMI) and CSI Solutions, Inc. for technical support in developing a Learning Collaborative as well as performance monitoring software, tools, dashboards, and processes. The steps we have taken to address a previously identified weakness have not only turned data and analytic capacity into an area of strength for NCACH, but demonstrate that we can rapidly and systematically address future identified challenges.

The biggest challenge inherent with implementing a new program such as the Pathways Community HUB is to make it sustainable. While NCACH has spent considerable energy to address these concerns, it remains a challenge that we will need to attract sustained funding in order for the Pathways Community HUB to be viable. Through contracts with consultants we will receive payer identification and engagement, guidance on contracting MCOs and other payers along with preliminary forecasts and pro forma budget in order to inform our long-term sustainability plans. We believe if we are able to secure initial contracts to allow us to show an ROI, we will be able to make a business case for additional funding sources to invest in this program.

The NCACH region is an extremely rural region with only 19.4 persons per square mile¹⁹. Okanogan County, our largest county by geography (5315 square miles), is even more rural with only 7.8 people per square mile²⁰. The rural geography of our region, and thus travel distance to health care providers, is one of the factors that led mental health care access and access to health care to be identified as the top two needs in our 2016 Regional Community Health Needs Assessment²¹. The Pathways Community HUB will map clinical and social service agencies in the region with particular attention to transportation services available to Medicaid beneficiaries in rural areas. The Pathways Community HUB will work closely with transportation agencies to address transportation service gaps based on identified areas of need.

¹⁹ US Census Bureau, 2010-14.

²⁰ US Census Bureau, 2010-14.

²¹ 2016 Community Health Needs Assessment, Chelan-Douglas Health District.

Furthermore, the Pathways Community HUB technology platform will be able to quantify the need for additional transportation services through data collection of incomplete pathways. A 'pathway' corresponds to an identified risk that clients faces (i.e., lack of transportation). Once the risk has been mitigated, the pathway is considered complete (i.e., transportation service acquired). If a care coordinator is unable to complete a pathway with a client, the pathway is considered incomplete with a documented reason for closing the pathway without completing it (e.g. transportation service not available in client's location). This will allow NCACH and its partners, using concrete and quantifiable data, to advocate for expanded services, capacity building investments, and policy change. While this is a potential barrier to success, NCACH recognizes that it empowers the Pathways Community HUB to be truly transformational in accessing care and social services in the region.

One of the realities given the rural and expansive nature of our region is a more fragmented social service network. NCACH is initiating a social services focus group to develop a strategic plan on how to better align community-based organizations within the Demonstration project to address non-medical needs that can impact care (i.e. housing). This focus group will come up with initial recommendations our region can use in quarter 2 of 2018. Additionally, NCACH staff and Pathways Community HUB leadership will work with partners to identify and prioritize weak or missing elements in both our health care and social service networks. While Demonstration investments will not be sufficient to fill all the gaps, we are committed to working with partners to identify creative solutions and other potential sources of funding. For example, we might leverage technology to promote telemedicine services or consider using outside consultants to provide technical assistance around accessing state or federal dollars available for affordable or temporary housing investments.

Monitoring and Continuous Improvement

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

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

ACH Response

The goal of NCACH's monitoring plan is to use real-time or close to real-time data to support project implementation and continuous improvement. Largely pulling from the Pathways Community HUB database or existing data sources, NCACH will track operational, process, and outcomes measures for each project, including community-based care coordination, and for the ACH overall. Existing data sources include the Healthier Washington dashboard, the Department of Health Quarterly Drug Overdose Dashboard, the Department of Health Prescription Monitoring Program (PMP) Dashboard, the HCA DSRIP Dashboard, and other reports and products currently available from or under development

by the state. We will work with workgroups to supplement this data with regional and partner data. Monitoring data will be used to drive shared learning, form the foundation of rapid-cycle continuous improvement processes, and support program evaluation efforts. This will allow the ACH and key partners to identify and respond to issues, barriers, and successes quickly. Key elements of this system include:

Convening key stakeholders. Through the HUB Subcommittee, the NCACH is convening key stakeholders to guide decisions for our Care Coordination Project. This group includes clinical and program subject matter experts who will make recommendations regarding project implementation, while also informing our Quality Improvement Plan (QIP). NCACH will work with stakeholder groups to monitor implementation progress on a quarterly basis and triage issues that arise in implementation, such as access to data or recruitment and enrollment delays. These issues will first be addressed at the appropriate level of NCACH staff, the HUB lead agency, or the HUB Workgroup. Depending on scale and severity of potential impact on successful implementation, these issues will be escalated to NCACH leadership, the NCACH Governing Board, and/or HCA as appropriate. Key stakeholders for this project include care coordination agencies, social service agencies, primary care providers, behavioral health providers, criminal justice stakeholders, hospitals, emergency medical services, education, and MCOs. The exact approach and tools to support partner reporting and rapid cycle monitoring and improvement will be developed in 2018 with guidance from our specific project workgroups (including the WPCC, Opioid Workgroup, Transitional Care and Diversion Interventions Workgroup, and Pathways Community HUB Workgroup). The development of continuous monitoring and improvement systems will be led by ACH staff with technical assistance from our consultants (e.g. CORE and CCMI/CSI).

Identifying monitoring metrics, data sources, benchmarks, and targets. Monitoring metrics will vary by project, and will include ACH toolkit pay-for-reporting and pay-for-performance metrics, as well as regional accountability and QIP metrics. NCACH data staff will begin working with key contractors (i.e., CORE) beginning Quarter 3 of 2018 to develop and recommend a detailed QIP that NCACH will support to monitor the health impact of our Care Coordination Project. NCACH staff will facilitate linkages where input from our regional HIT/HIE Workgroup or the statewide HIT/HIE efforts led by the HCA may be needed. NCACH also will ask MCOs to review quality metrics and agree on quality reporting for Value-Based Payment models. For the implementation phase, many metrics will be process or operational in focus. Using the Demonstration Project Toolkit as a guide, NCACH staff will engage workgroup members to help identify benchmarks and, where possible, improvement targets. For the implementation phase, many metrics will be process or operational in focus. Potential metrics for our Care Coordination Project are listed in the table below; final metrics will be identified in the implementation plan.

Potential Monitoring Metrics – Care Coordination Project

Implementation/Operational Measures – Regional monitoring metrics to track implementation progress

Measures TBD; examples may include:

- Number of partners adopting Pathways IT platform for care coordination
- Number of EHRs with Pathways IT platform integrated
- Number of payer contracts in place
- Number of agencies contracted to perform care coordination
- Number of Community Health Workers Trained
- Number of pathways completed
- Number of clients enrolled in Pathways program

Toolkit P4R Measures – Required metrics for ACH reporting

- Number of partners trained by focus area: projected vs. actual and cumulative
- Number of partners participating and implementing each selected pathway
- Percent of primary care providers in partnering provider organizations meeting Patient-Centered Medical Home requirement
- Percent partnering provider organizations using selected care management technology platform
- Percent partnering provider organization sharing information (via HIE) to better coordinate care
- Percent of partner provider organizations with staffing ratios equal or better than recommended
- Number of new patients with a care plan
- Total number of patients with an active care plan
- Number of new patients with an active care plan
- VBP arrangement with payments / metrics to support adopted model

Toolkit P4P Measures – Incentive measures, which will be reported by HCA and tracked by the ACH

- Follow-up after Discharge from ED for:
 - Mental Health
 - Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Mental Health Treatment Penetration (Broad Version)
- Inpatient Hospital Utilization
- Outpatient Emergency Department Visits per 1000 member months
- Percent Homeless (Narrow Definition)
- Plan All-Cause Readmission Rate (30 Days)
- Substance Use Disorder Treatment Penetration

Quality Improvement Plan Metrics – Regional performance metrics

QIP metrics will be identified by Demo Year 3, Q2

Building data infrastructure to collect, aggregate, analyze, and report data for monitoring. NCACH plans to develop a data infrastructure to collect and aggregate project information, in order to support continuous analysis, monitoring and improvement. The Pathways Community HUB model and associated software (Care Coordination Systems) is specifically designed for, and will further be tailored to NCACH requirements, to provide real-time assessment and reports of the Pathways Community HUB launch, services delivered, and scaling. The potential regional data infrastructure to support monitoring and continuous improvement (see figure on following page) should be designed to complement existing data assets (such as the Fully-Integrated Managed Care Early Warning System, Healthier Washington Dashboard, or other dashboards under development, and reporting from regional associations). The CCS platform offers an already developed and tested system to securely collect, combine, store, and report data specific to the Pathways HUB implementation across our region. In addition to these specific utilization metrics (# of clients, # of contacts, # of pathways completed, etc), we may want to collect more qualitative information from our partners to monitor progress and inform course correction (e.g narrative reports, surveys) Through our Whole Person Care Collaborative, we are planning on using a customized web portal (Healthcare Communities) developed by one of our current contractors, CSI Solutions, Inc. Originally developed in 2005, this platform has grown to support nearly 70 communities, including CMS’s Transforming Clinical Practices Initiative. This portal would serve multiple functions, providing centralized access to resource sharing, document sharing, tracking of process measures through consistent form-fillable reporting templates and surveys, and tracking of measures through dashboards. Based on conversations with CSI Solutions, it seems very likely that we can leverage this web portal for monitoring progress and reporting associated with the rest of our projects. Ideally, partners would submit monthly reports through this online portal.

Reports from implementation partners will focus on project milestones and process details that can be used to support overall monitoring, identify potential challenges or barriers that individual or multiple partners are experiencing, and identify potential champions and best practices. Reporting will be contractually required of project partners, though every effort will be made to keep these reports simple and streamlined in order to minimize the reporting burden for partners (one of our key design

principles). Data from partner reporting will complement existing data resources, including the Healthier Washington Data Dashboard and the Department of Health Drug Overdose Dashboard, (both currently operational), as well as the Department of Health Prescription Monitoring Program (PMP) Dashboard and the HCA DSRIP Dashboard. Some of these data assets are currently under development by the State using a Tableau interface, with the hopes of being released in early 2018 and updated on a quarterly basis.

Other ACHs are also investigating options, and NCACH has participated in several webinars from vendors offering these types of solutions. For example, a webinar presented by one New York DSRIP provider with SpectraMedix, their data infrastructure partners; a webinar organized by the Washington Health Alliance regarding a healthcare quality improvement tool from 10xHealth; a webex on a Salesforce platform built by Persistent Systems which was designed for another New York DSRIP provider to see a 360 view of project management and progress; and a webinar with the Washington State Hospital Association on a specific quality benchmarking system they are interested in making available to ACHs. NCACH staff will continue exploring options, consult with other ACHs who may have investigated their own solutions, and solicit input from our regional HIT/HIE Workgroup. We plan on identifying a strategy for collecting all of this data by the end of 2018. Ideally, we would find a way to use the same platform for most or all of our projects in order to minimize administrative costs.

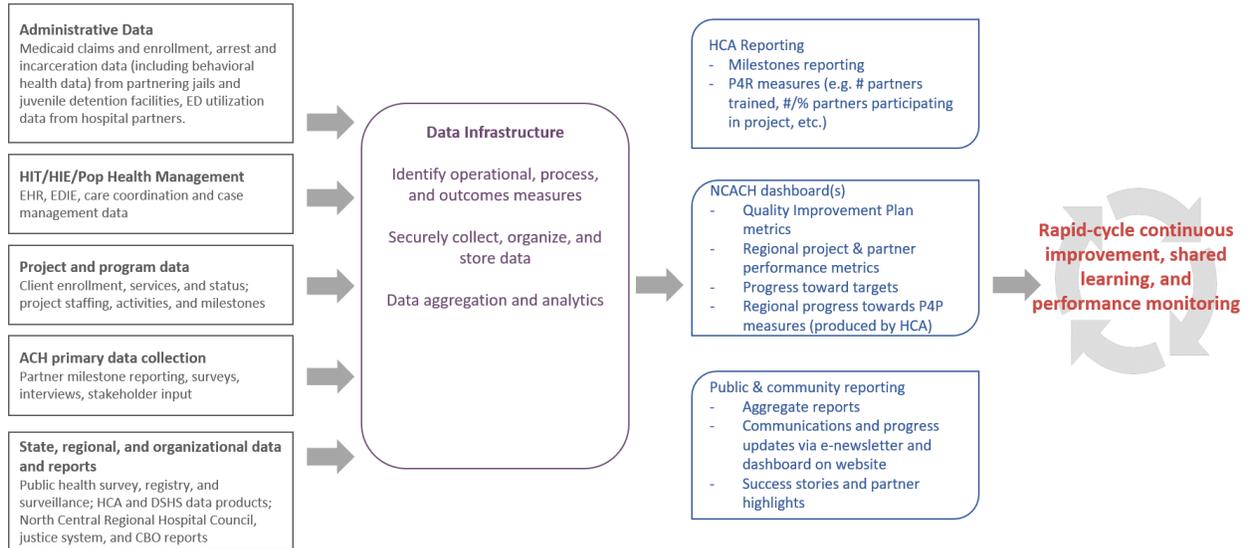
As part of the data infrastructure work, NCACH will identify data sources and a plan for data collection, establish data use agreements with partnering providers (potentially including MCOs), establish data governance models, comply with relevant privacy and security regulations, implement processes for transferring data, and identify tools to collect, manage, store, analyze, visualize, and report data. Efforts will be made to minimize the reporting burden on partnering providers, leveraging existing data reporting where possible.

Implementing continuous improvement (CI) processes. Drawing on this data infrastructure, NCACH will develop continuous improvement processes based on best practices for clinical and health systems improvement. We will bring in expertise from contractors where needed (e.g., CORE or CCMI/CSI). Drawing on monthly reports from partnering providers and the Pathways Community HUB, and ad-hoc check-ins with partnering providers and community stakeholders, staff will regularly monitor performance and understand, in real-time, whether we are on the path to reaching expected outcomes. Project workgroups will also be involved in project monitoring and course correction, through quarterly improvement cycles accompanied by collaborative peer learning sessions. With each cycle, NCACH and partners will adapt, test, and refine strategies, document learnings and results, and spread learnings across partners. These processes should allow for identification of barriers, challenges, and risks. Through the HUB Workgroup and partnering providers, NCACH will work to address barriers and challenges to successful implementation. If it is determined by NCACH or the HUB Workgroup that planned timelines and milestones still cannot be or are not being met, NCACH will escalate the issues to HCA. NCACH will communicate a revised plan to HCA with an explanation of why timelines weren't met, strategies for eliminating barriers and addressing challenges to implementation, a plan for adapting the timeline, and, if necessary, planned reallocation of resources by NCACH to reach targets/milestones and achieve successful implementation. Risk prevention and mitigation strategies will be shared with other partners and projects where appropriate.

Quality improvement efforts will be coordinated with existing local and statewide technical assistance providers, including Qualis, the Practice Transformation Support Hub, MCO initiatives, and HCA

resources. For example, the HCA AIM team is planning on creating monitoring reports containing specific project level detail (they anticipate that production of these reports would start in 2018). Peer learning from other ACHs implementing the Pathways HUB will add value. Information, reports, and assessments from other quality improvement efforts may also be helpful data sources to monitor ACH and partner progress (e.g. MCO assessments and measures). NCACH envisions supporting quality improvement in a variety of ways, ranging from connecting partnering providers to relevant trainings and resources to creating new opportunities for partnering providers. NCACH may provide training or technical assistance to providers around specific issues or barriers, such as HIT/HIE adoption or workforce development. NCACH’s goal is for partners to be as successful as possible in project implementation and will design quality improvement efforts that offer a flexible approach. If partners are identified as struggling in a particular area, or lagging behind, NCACH intends to determine what will be needed to ensure that partner’s success and determine whether existing or additional resources can be provided. This may involve extensions, and/or more comprehensive or intensive technical assistance.

Planned approach for monitoring and continuous improvement



(See Care Coordination Project - Attachment C for larger version)

Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying

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

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

YES	NO
X	

Project Sustainability

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

ACH Response

One of NCACH’s key strategies is to target Demonstration funds to support changes in systems and processes that can lay the ground work for long-term sustainability. The NCACH Governing Board is open to supporting additional staff resources and direct services, but only where a strong path toward sustainability is articulated by our partnering providers. Many of Washington State’s Medicaid Demonstration projects, including the Care Coordination Project (Pathways Community HUB model), are ultimately about improving linkages to promote more effective coordination and holistic care. This kind of system transformation can be accelerated through capacity building investments, including facilitating cross-sector communication, making discrete capital investments, rethinking processes, or changing the way resources are allocated.

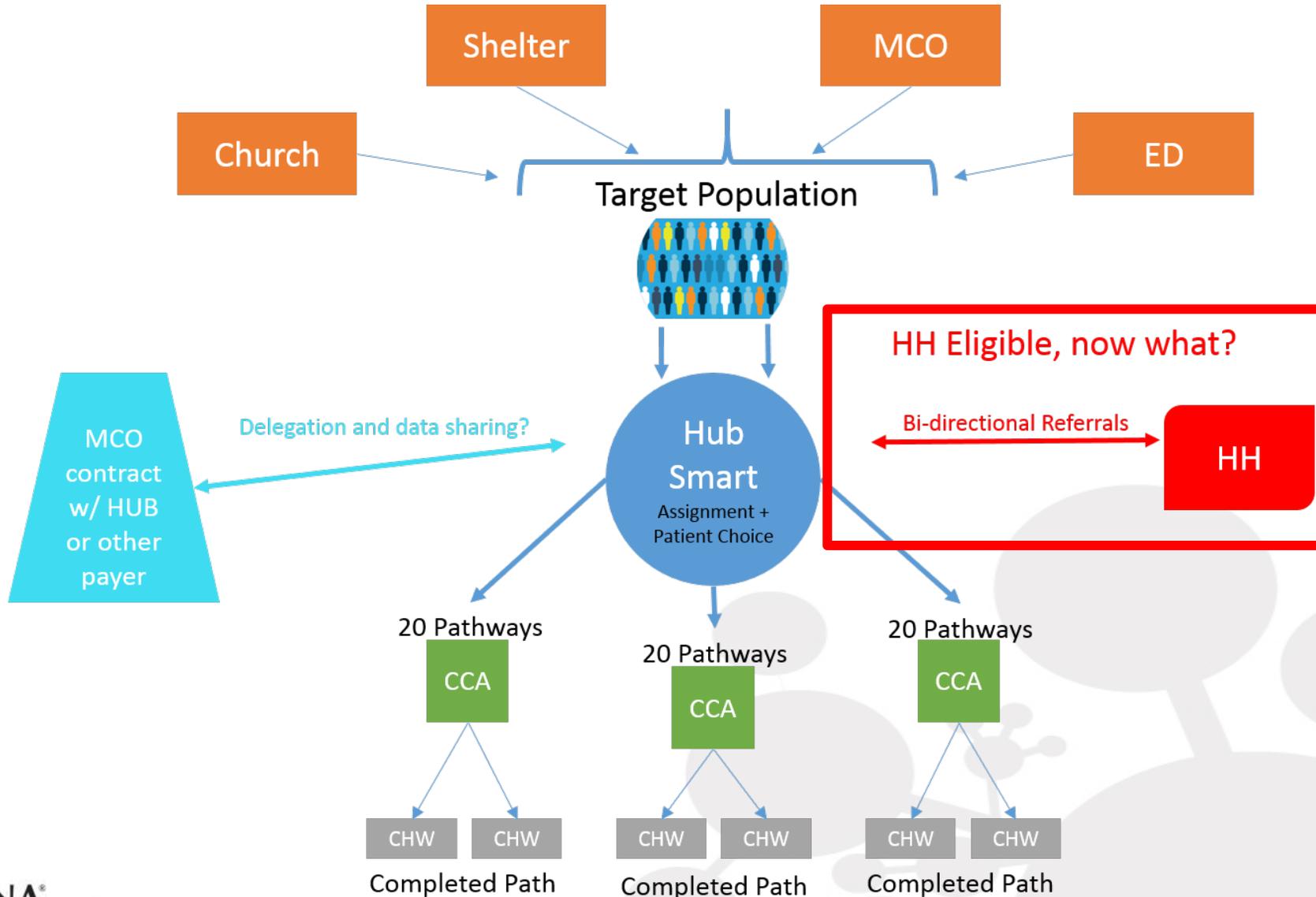
The Pathways Community HUB will lay the groundwork for more robust and interoperable IT systems and coordination mechanisms between the health care system and community-based organizations. This kind of capacity building is critical to the continued efforts of our partners. These investments are part of our approach for expanding, using, supporting, and maintaining population health management systems across all of NCACH’s selected projects.

The Pathways Community HUB will help further enhance improvements to all systems that impact the health of a Medicaid beneficiary by quantifying gaps in services and care. The Pathways Community HUB is able to report on completed and uncompleted pathways. A ‘pathway’ corresponds to an identified risk that clients faces (e.g. unemployment). Once that risk has been mitigated, the pathway is considered complete (e.g. an employment pathway is considered complete once a client has been employed for three months). If a care coordinator is unable to complete a pathway with a client, the pathway is considered incomplete with a documented reason for closing the pathway without completing it. Data collected on uncompleted pathways and the corresponding reasons can be used as evidence to advocate for expanded services, capacity building investments, and policy change.

NCACH Community-Based Care Coordination

As care coordination improves, acute care facilities will see a decrease in patient visits and therefore revenue. NCACH, the HUB Workgroup, and the workgroups for the other five projects will need to work closely with MCOs to ensure that demonstrated improvement in care can be rewarded through direct contracting if we want to be able to maintain strong services for acute care facilities. It will be NCACH's charge to consider these and other capacity investments in the overall sustainability plan for the Demonstration.

Pathways Overview





North Central Accountable Community of Health

Pathways Community HUB Planning

NCACH Governing Board Retreat

September 8, 2017

On the Docket

- ▶ Develop a shared understanding of the Pathways Community HUB model
 - ▶ Review Project Toolkit and Pathways Community HUB model
 - ▶ Steps to Implementation and Timeline
 - ▶ Certification Pre-requisites and Standards
- ▶ Review the status of other WA ACHs
- ▶ Understand the purpose of the Workgroup
- ▶ Review Draft Workgroup Charter
- ▶ Begin considering options for HUB lead agency

Project 2B: Community-Based Care Coordination

- ▶ Project Objective:

Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.

- ▶ Evidence-Based Approach: Pathways Community HUB

Foundation of the HUB Model

Find: Comprehensive Risk Assessment

Treat: Assign Pathways and Ensure Health and Social Services are Received

Measure: Track/Measure Results (Connections to Care)

Pathways Community HUB Model

A comprehensive community care coordination approach to connect those at risk.

- ▶ Risk Factors are addressed through “Pathways”
 - ▶ A standardized process that identifies, defines, and resolves an individuals needs by connecting them to community-based services
- ▶ Risk Factors are defined by the community and may include:
 - ▶ Health Diagnosis (ex: Behavioral Health, Chronic Conditions)
 - ▶ Pregnancy Status
 - ▶ Health Behaviors (ex: tobacco use)
 - ▶ Utilization Patterns (ex: ED or 911 use)
 - ▶ Social Complexity (ex: incarceration, food insecurity, housing instability)
- ▶ Risk Factors that the community selects determine the target population

Pathways Community HUB Model

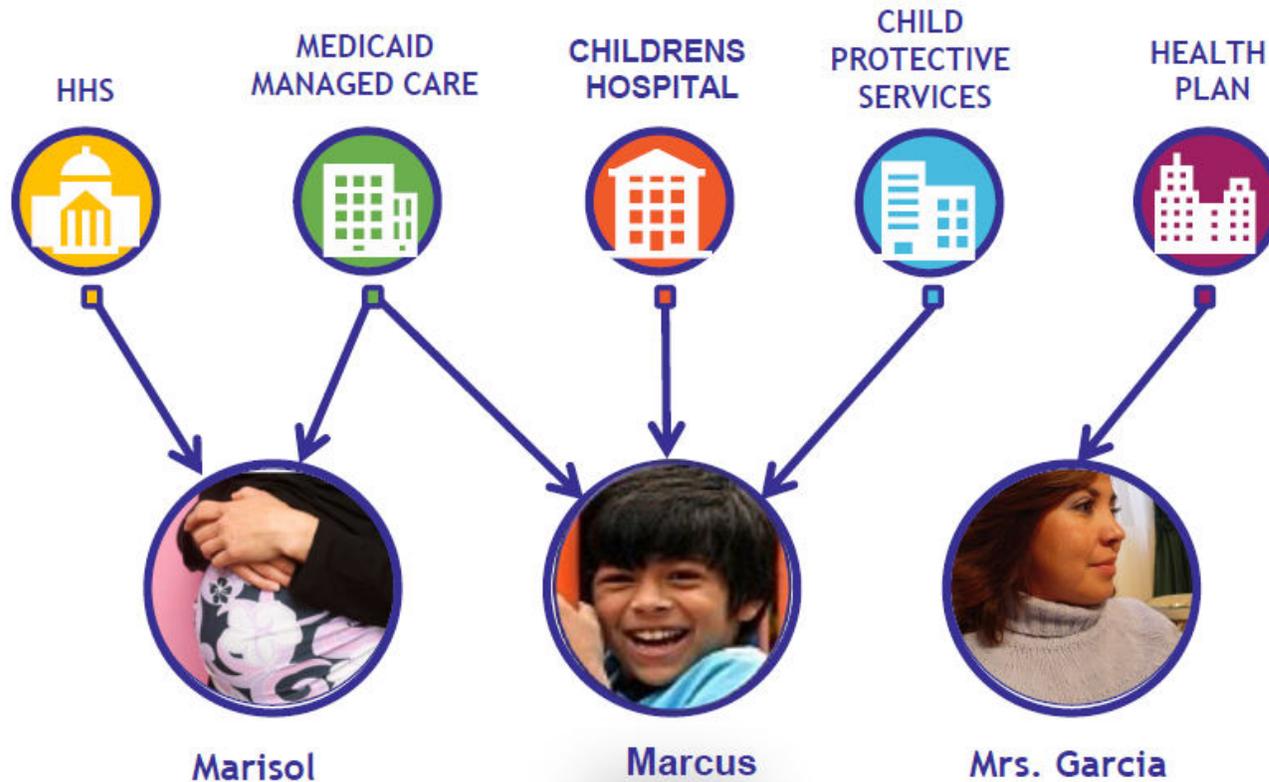
- ▶ Removes “silos” and fragmentation
- ▶ Uses existing community resources
- ▶ Focuses on common metrics to identify & track risks (risk reduction)
- ▶ Holistic community care coordination with one care coordinator
- ▶ Pays for outcomes
- ▶ Sustainable
- ▶ Owned by the community

HUB Functions

The HUB provides standard training, workflows, tools, and a platform to track and share information.

- ▶ The HUB performs the following key functions:
 - ▶ Centrally track the progress of individual clients
 - ▶ Monitor the performance of individual workers
 - ▶ Improve outcomes for priority populations
 - ▶ Evaluate overall organizational performance
 - ▶ Facilitate communication between providers and care coordinators
 - ▶ Highlight gaps in community resources

Current Community Care Coordination



Multiple care coordinators involved –
limited communication

Regional Organization and Tracking of Care Coordination



Pathways Protocols

- ▶ A Pathway is a standardized process that identifies, defines, and resolves an at-risk individual's needs.
- ▶ Each Pathway represents one type of risk factor that is tracked through to completion and a measurable outcome.
- ▶ Follow standardized protocols to conduct individualized comprehensive assessment and problem-solving to help individuals.
- ▶ Protocols help navigate the fragmented health and social service systems by supporting the identification and elimination of barriers.
- ▶ Protocols address and strive to minimize disparities that exist in the community.

20 Standardized Pathways

- ▶ Adult Education
- ▶ Employment
- ▶ Health Insurance
- ▶ Housing
- ▶ Medical Home
- ▶ Medical Referral
- ▶ Medication Assessment
- ▶ Medication Management
- ▶ Smoking Cessation
- ▶ Social Service Referral
- ▶ Behavioral Referral
- ▶ Developmental Screening
- ▶ Developmental Referral
- ▶ Education
- ▶ Family Planning
- ▶ Immunization Screening
- ▶ Immunization Referral
- ▶ Lead Screening
- ▶ Pregnancy
- ▶ Postpartum

Distinctions between Pathways, the HUB, CCAs, & CCCs

Pathways

- ▶ Patient-centered, care coordination tool
- ▶ Identifies and “translates” patient risks
- ▶ Measured outcomes
- ▶ Payments for measured Pathway outcomes

Community HUB

- ▶ Tracks Pathways (outcomes) across agencies
- ▶ Streamlines referrals
- ▶ Eliminates duplication
- ▶ Provide infrastructure for community-based care coordination
- ▶ Involves braided funding – Pathways can be purchased by different funders
- ▶ Invoicing System

Care Coordination Agencies (CCAs)

- ▶ Accept assignments from the HUB
- ▶ Recruit, hire, manage, and deploy CHWs

Community Care Coordinators (CHWs)

- ▶ Meet with client in their homes
- ▶ Coordinates with case managers from other agencies

Current Operational HUBs - Ohio

- ▶ Central Ohio Pathways Community HUB (Community Health Access Program)**
 - ▶ High Risk Pregnant Women
 - ▶ Low Birth Weight reduced from 13.0% to 6.1%; Intervention group averaged 5.6 Pathways
 - ▶ Cost savings \$3.36 for 1st year of life; \$5.59 long-term for every \$1 spent
- ▶ Northwest Ohio Pathways HUB**
 - ▶ High Risk, Low Income Pregnant Women
 - ▶ Low Birth Weight reduced from 13.2% (County rate) to 9.5% (Pathways rate)

Current Operational HUBs – New Mexico

- ▶ Pathways to a Healthy Bernalillo County – University of New Mexico Health Sciences Center**
 - ▶ Target Population – Low income, Uninsured Adults with 2 risk factors; Unemployed, Uses ER frequently, Housing Instability, Not receiving services, Hungry
 - ▶ ROI Analysis
 - ▶ Health Care Home Pathway – Net savings of \$1.7 million → Benefit-cost ratio of 3.47
 - ▶ Medical Debt Pathway – eliminated 2/3 of medical debt, reduced ED use by over 50%; savings from more efficient utilization of the healthcare system were enough to fully offset the cost of administering the Medical Debt pathway
 - ▶ Housing pathway - \$1.20 - \$2.00 in benefit for every \$1 in program expenditures
 - ▶ Employment Pathway – ~\$13 in additional income for \$1 spent on employment pathway
 - ▶ Behavioral Health Pathway – ~\$1.87 in reduced healthcare costs for every \$1
 - ▶ Legal Services Pathway – Ratio of net benefits to pathways costs is 7.4

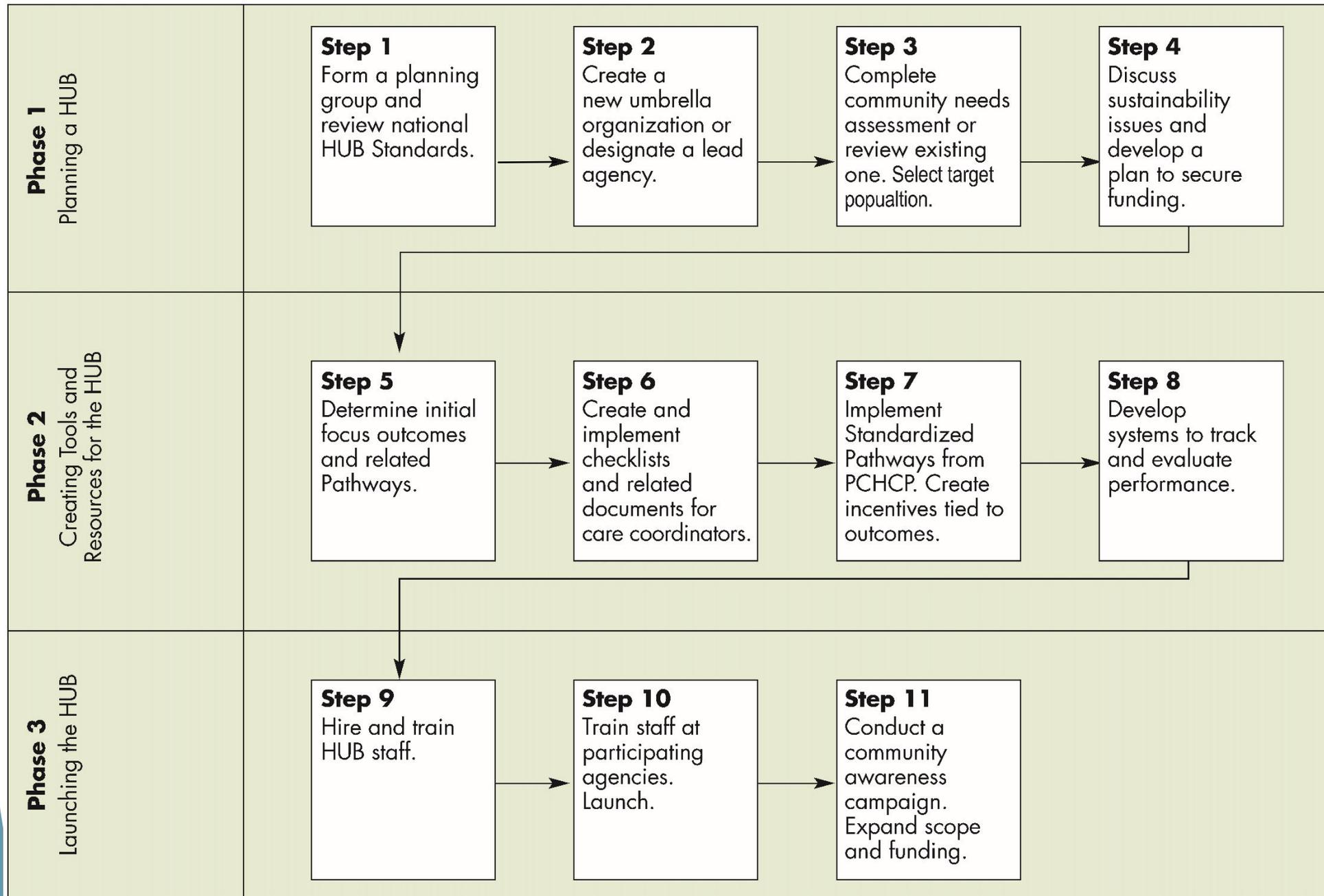
Current Operational HUBs - Michigan

- ▶ Michigan Pathways to Better Health
 - ▶ Saginaw Pathways to Better Health (serves 9 counties)**
 - ▶ Muskegon Community Health Project (serves 4 counties)**
 - ▶ Recently released prisoners (n ≈ 2500)
 - ▶ Contributing factor in significant decline in recidivism rates
 - ▶ Ingham County Pathways HUB (serves 6 counties)**
- ▶ 2+ Chronic Conditions & 5+ ER visits or 3+ hospitalizations
 - ▶ Fewer 911 calls and lower cost

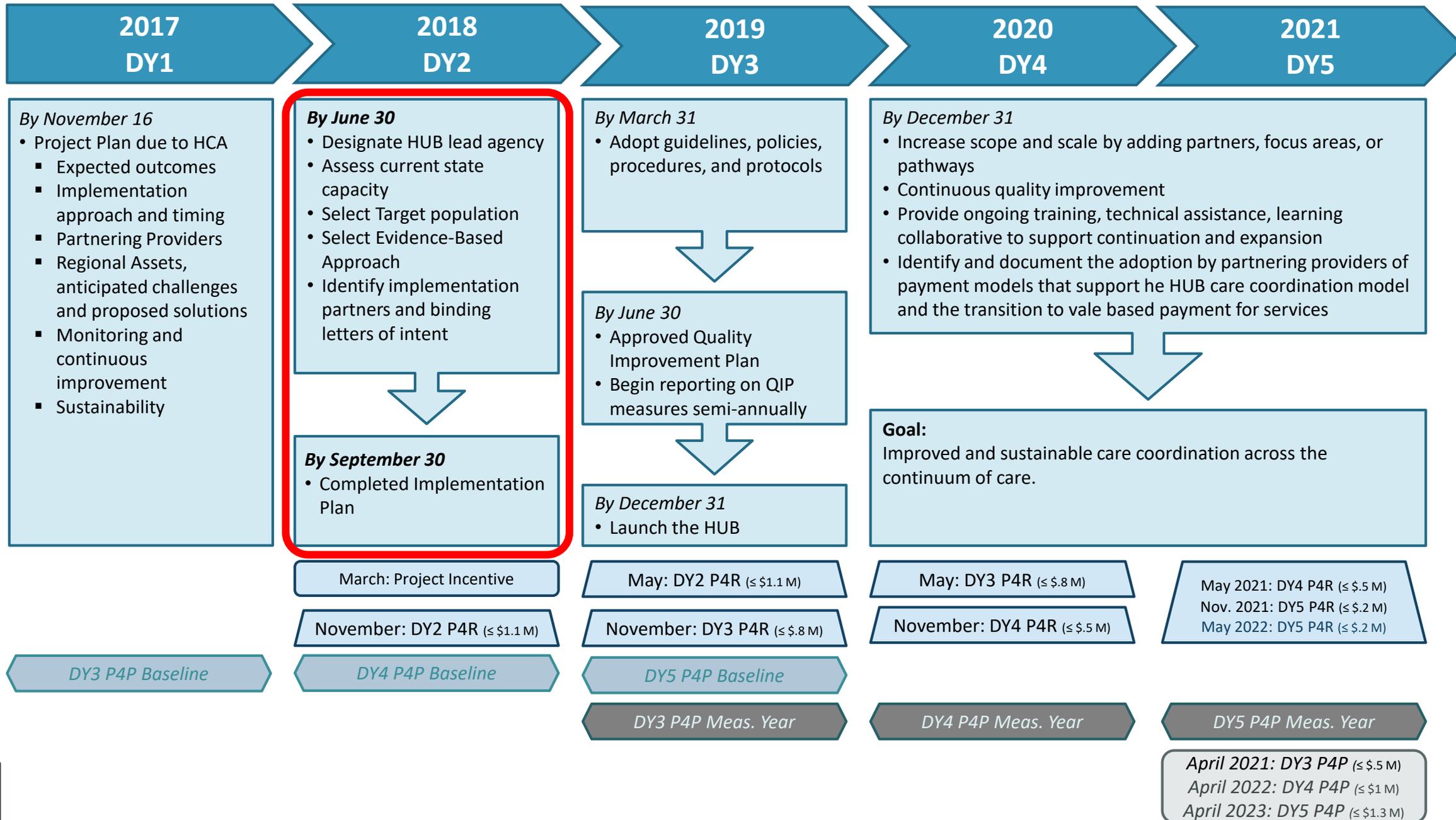
Current Operational HUBs - Oregon

- ▶ Northeast Oregon Network (NEON) Pathways Community Hub, La Grande OR
 - ▶ Adults diagnosed or at risk for developing cardiac or diabetic conditions
- ▶ Coalition of Community Health Clinics Access and Referral Program, Portland OR
 - ▶ Homeless, low-income, and uninsured individuals earning under 200% FPL
- ▶ HealthMatters of Central Oregon, Bend OR
 - ▶ Children 0-18 years – increase well child visits, immunizations, food stamps, transportation, housing

Phases and Steps of Building a Community HUB



HUB Implementation Timeline



Pathways Community HUB Certification Program

- ▶ A learning network representing 16 Community HUBs in 10 states recommended that a certification process for the HUB model be developed.
- ▶ Fidelity to the model is essential – it became clear that using some components of the model and leaving out others, did not lead to risk reduction and positive outcome production.
- ▶ National center for assessing community HUB compliance with established standards for implementing the HUB model.
- ▶ The Certification Program has
 - ▶ 11 Pre-requisites that must be met before a HUB can move forward with certification
 - ▶ 17 Standards to be met
- ▶ Two levels of certification (Level 1: 9 HUBs, Level 2: 1 HUB)

Certification Pre-Requisites

- ▶ The HUB is an independent legal entity or an affiliated component of a legal entity.
- ▶ The Pathways Community HUB has been operating for a minimum of 6 months using standardized Pathways.
- ▶ **The HUB is based in the community and/or region it serves.**
- ▶ **There is only one Pathways Community HUB located within the community and/or region it serves.**
- ▶ The HUB reviews and/or conducts community needs assessments.
- ▶ The HUB coordinates a network of care coordination agencies serving at-risk clients.
- ▶ The HUB uses standardized Pathways.
- ▶ The HUB monitors the caseloads of care coordinators at each care coordination agency.
- ▶ The HUB has written agreements with its care coordination agency members.
- ▶ The HUB aligns payments with measured outcomes in its contracts with payers and care coordination agency members.
- ▶ The HUB complies with the Health Information Privacy and Accountability Act (HIPAA).

Certification Standards

- ▶ The HUB has infrastructure and capacity to fully implement the Pathways Community HUB Model.
- ▶ The HUB Director possesses the experience and skills to effectively manage the HUB, including a commitment to community health and equity as well as strong business and communication skills.
- ▶ All HUB staff receive Pathways Community HUB training.
- ▶ **The HUB engages and is advised by a Community Advisory Board.**
- ▶ **The HUB is a neutral entity and operates in a transparent and accountable manner.**
- ▶ The HUB is committed to continual quality improvement.
- ▶ The HUB and its care coordination agency members have effective Human Resource policies and procedures.
- ▶ The HUB and its care coordination agency members are culturally sensitive organizations that provide culturally and linguistically appropriate services.

Certification Standards continued...

- ▶ Community care coordinators have comprehensive training, education, and support.
- ▶ Community health workers are supported by effective and culturally competent supervisors Working within the professional scope of their license.
- ▶ The HUB ensures care coordination services address the medical, behavioral health, oral health, social, environmental, and educational needs of those who are at risk.
- ▶ The HUB assesses and monitors each client's risk status.
- ▶ The HUB tracks, monitors, and reports on client services.
- ▶ The HUB promotes collaboration, inter-sectoral teamwork, and community-clinical linkages.
- ▶ The HUB conducts a cost benefit analysis.
- ▶ The HUB communicates its strategies, programs, and progress to the community it serves.
- ▶ The HUB has contracts with more than one payer.

Washington ACHs

- ▶ Pierce County ACH
 - ▶ Pilot in Early Spring 2018
 - ▶ ACH will be HUB lead agency
 - ▶ Potential Target Population: Women of child bearing age with SUD
- ▶ Southwest Washington ACH (Clark, Skamania, Klickitat Counties)
 - ▶ Pilot in Spring 2018
 - ▶ ACH will be HUB lead agency
 - ▶ Merged with organization that currently employs Care Coordinators

Washington ACHs continued...

- ▶ Better Health Together (Spokane, Ferry, Stevens, Pend Oreille, Lincoln, Adams Counties)
 - ▶ Ferry County Jail Transitions Pilot
 - ▶ Pilot started in March 2017
 - ▶ ~0-3 inmates released per day
 - ▶ Clients are handpicked by Administrator to be good candidates for Pathways (ie. Non-violent)
 - ▶ Contracted with Rural Resources to provide Care Coordination (not currently paying for outcomes, but will start with Spokane pilot)
 - ▶ 15 clients currently on CHW caseload
 - ▶ Expand to Spokane county Fall 2017
 - ▶ Official launch in March 2018
 - ▶ Target populations: Jail Transitions, Pregnant women, Opioid Use Disorder, Foster Children, Chronic Diseases
 - ▶ Currently negotiating with Molina for Pathway outcome payments
 - ▶ Expand population to include family members of covered lives

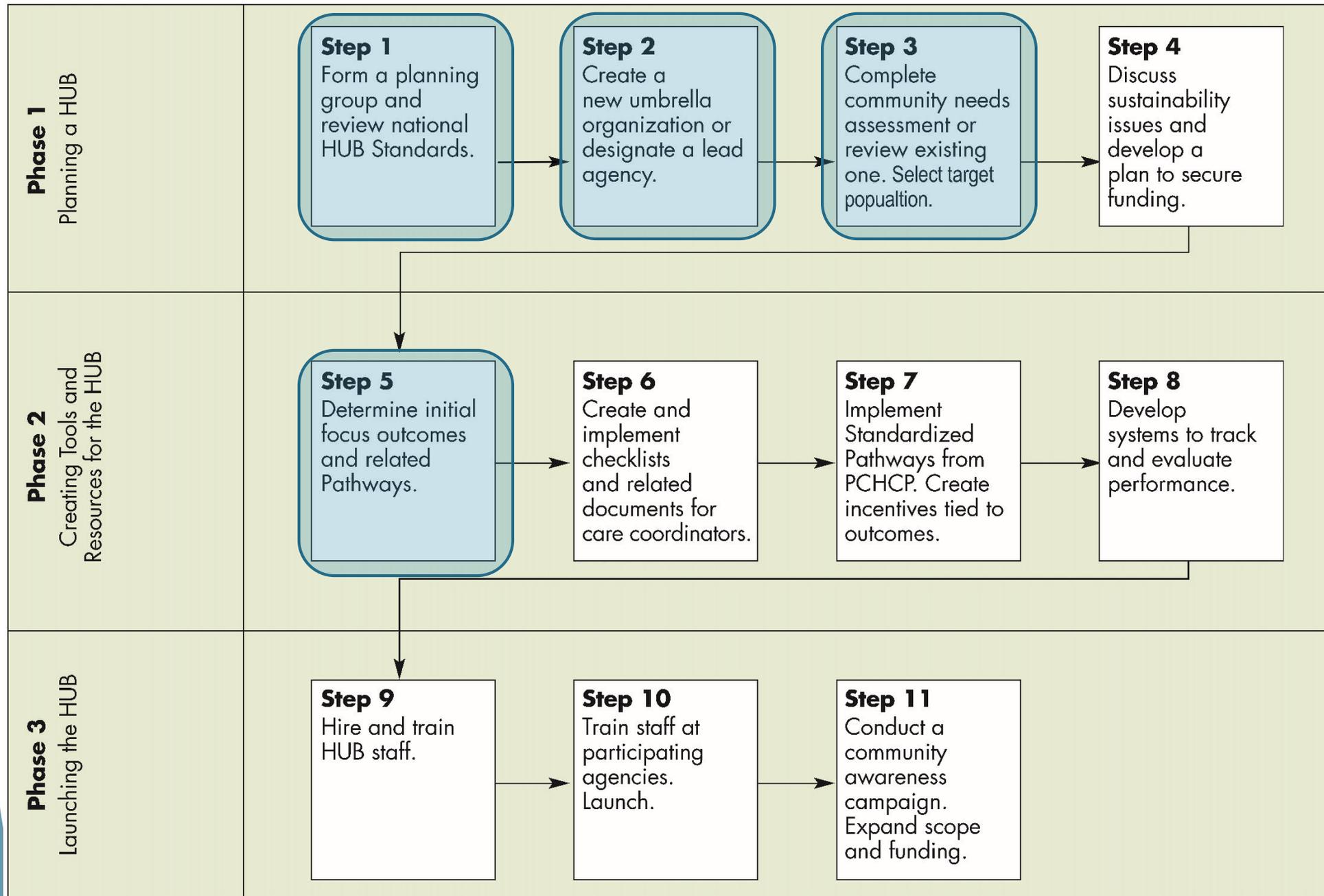
Care Coordination Systems

- ▶ Pathways Community HUB IT Platform
- ▶ Provides:
 - ▶ Project plans
 - ▶ Implementation worksheets
 - ▶ Policies, procedures, protocols
 - ▶ Roles and responsibilities descriptions
 - ▶ Financial model and budget
 - ▶ Target population modeling and identification
 - ▶ ROI analysis
 - ▶ Business associate and legal agreements
 - ▶ Professional development curriculum

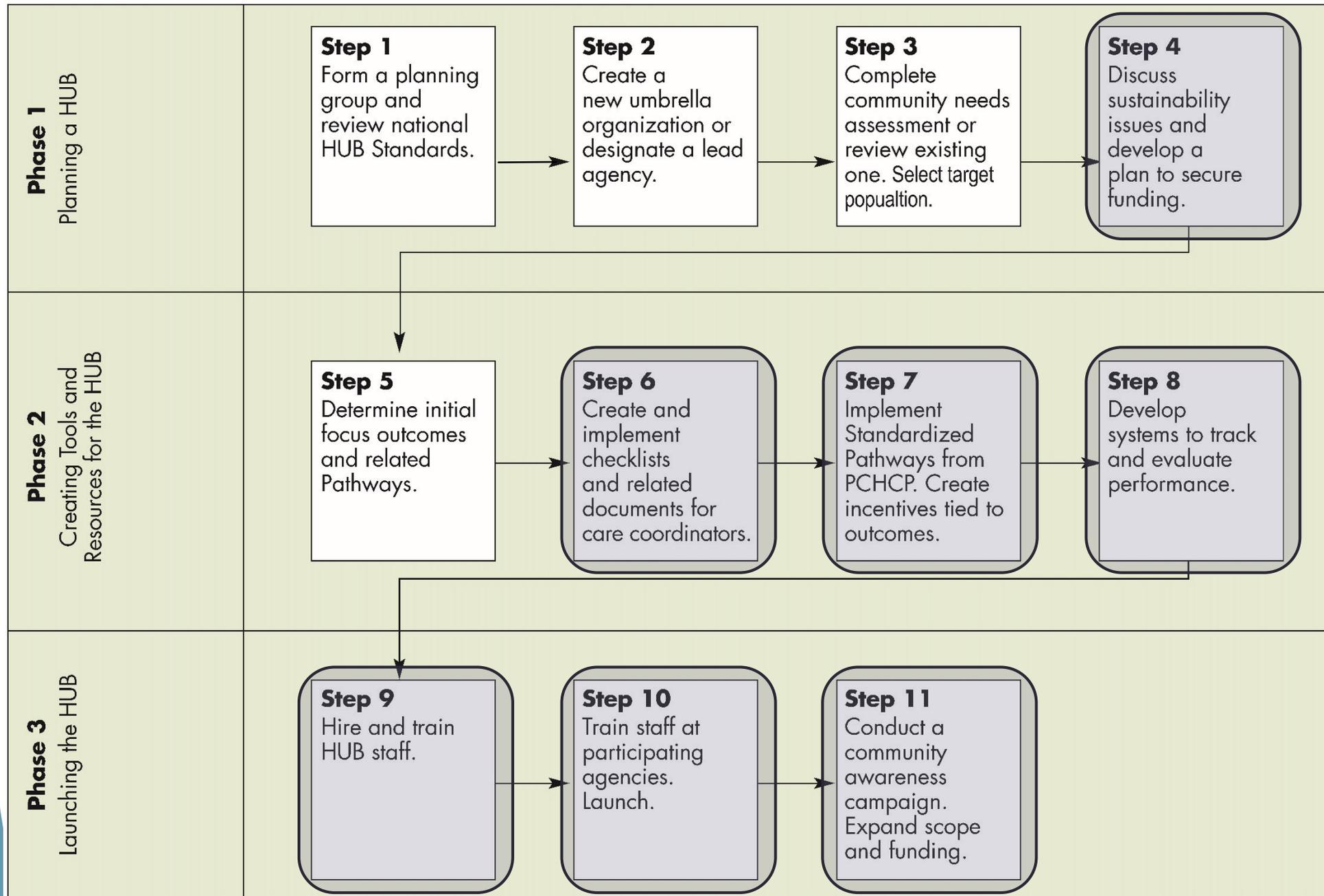
Next Steps...

- ▶ HUB Workgroup
 - ▶ Select a lead agency
 - ▶ Complete/review Community Needs Assessment
 - ▶ Select a target population
 - ▶ Determine initial focus outcomes and related pathways
- ▶ Review Draft Charter
- ▶ Options for HUB lead agency

Responsibility/Recommendations of the Workgroup



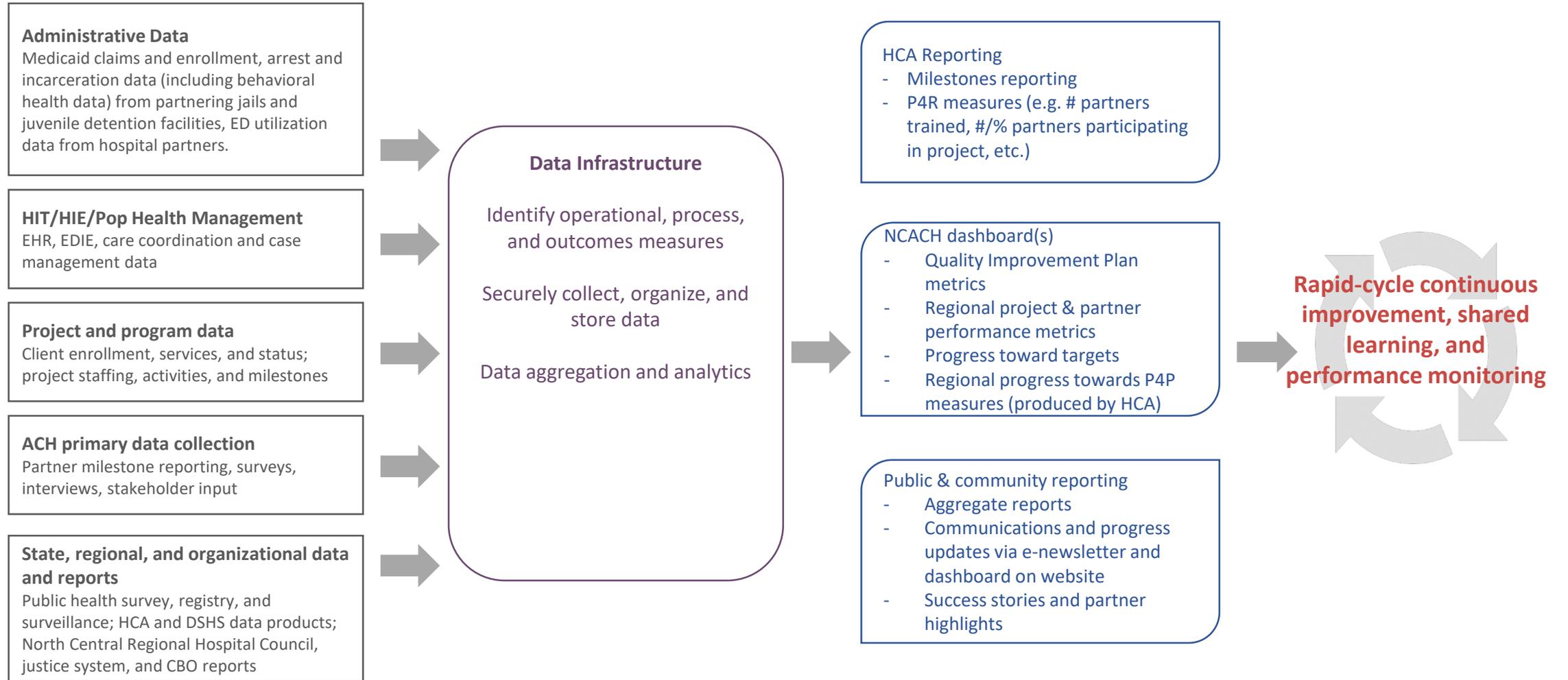
Responsibility of the HUB Lead Agency



Next Steps...

- ▶ HUB Workgroup
 - ▶ Select a lead agency
 - ▶ Complete/review Community Needs Assessment
 - ▶ Select a target population
 - ▶ Determine initial focus outcomes and related pathways
- ▶ Review Draft Charter
- ▶ Options for HUB lead agency

Planned approach for monitoring and continuous improvement



SECTION II: PROJECT-LEVEL

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

Transformation Project Description

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

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

Project Selection & Expected Outcomes

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

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

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

ACH Response

Our NCACH region's Community Health Needs Assessment (CHNA), which was released in December 2016, identified mental health care access and access to care as the top two community priorities. These health needs and issues were identified through systematic, comprehensive data collection and analysis, and benefited from participation of 39 community partners. As a follow up to this assessment, NCACH staff also gathered feedback from community members to assist with project selection through an online survey and using in-person presentations to all three of our Coalitions for Health Improvement. The Transitional Care Project was selected because it ranked high in terms of being relevant to all four counties, being able to improve outcomes during the Demonstration period, and being sustainable after the Demonstration.

During our project selection process, 169 community members were surveyed and some noted that this project had care coordination at its core, and that improved transitional care was well-aligned with the Pathways Community HUB, a care coordination system that will assist the medical community to connect their patients with the social services needed to address the health needs that cannot be met in the clinic.

One of our key sustainability strategies is to leverage our Pathways Community HUB (which provide a payment mechanism for services) to provide scaled transitional care services beyond the Demonstration. In addition, improvements to processes and systems through our Transitional Care Project, including more interoperable information technology platforms that facilitate efficient communication and care coordination, will have a broader impact on all people in transition from intensive settings of care or institutional settings. As mentioned in our sustainability section, one of our strategies is to target capacity building investments because improved infrastructure and processes will live beyond the Demonstration period.

To ensure the selected project is coordinated with, and does not duplicate, existing efforts in the region, we specifically recruited current providers of transitional care services for our Transitional Care and Diversion Interventions Workgroup (see Transitional Care Project - Attachment A). For example, we have a representative from Columbia Basin Hospital overseeing skilled nursing services in Grant County, a representative from Assured Home Health serving Medicare recipients in the Grant County area, and the Executive Director of Community Choice (the Health Homes Lead for Region 6 which encompasses the NCACH region). Our workgroup will be tasked with completing an inventory of transitional care services currently in play across our region. We know that transitional care is already a priority in the Health Homes programs offered in our region (eligible clients for Health Homes must have a risk score that exceeds a certain level). That said, we have an opportunity to reach a unique and complementary target population; those who are discharged from acute care but do not qualify for Health Homes.

Based on analysis of regional data, we believe our Transitional Care Project will target beneficiaries in transition from intensive settings of care or institutional setting, including beneficiaries discharged from acute care, beneficiaries with serious mental illness (SMI) discharged from inpatient care, or clients returning to the community from prison or jail. Our focus on people with behavioral health needs and those released from incarceration is supported by qualitative and quantitative data indicating areas of need and opportunities for impact. Based on preliminary data analysis, we hope to eventually reach all Medicaid adults and adolescents incarcerated in our

county jail and detention facilities (about 600 youth per year¹ and 6,500 adults per year²) and NCACH residents being released from emergency departments (EDs) and hospitals based on a primary diagnosis of mental and behavioral disorders (about 1,700)³. Process improvements have the potential to positively impact any resident needing transitional care, regardless of their insurance status.

Based on 323 people surveyed at three separate outreach events across our region, 49% of respondents identified drug and alcohol use as the biggest health problem in their community (the highest percentage) while 22% identified mental health/depression as the biggest problem (third highest rank after drug & alcohol use and obesity). This is corroborated by a Community Prevention and Wellness Initiative survey conducted by Together for Youth in Wenatchee. Youth were asked to identify how serious a problem alcohol use, marijuana use, prescription drug misuse, driving under the influence, tobacco use, depression and suicide were in their community. A higher percentage of youth in Wenatchee (our most populated city) ranked *all* of these issues as a “serious problem” compared to the statewide average⁴.

This feedback is supported by quantitative data, though data also shows areas of strength in terms of transitional care related to behavioral health issues. Mental and behavioral health disorders are the second most common cause of acute hospitalizations in the NCACH region⁵. After Better Health Together (BHT) and Greater Columbia, NCACH has the highest percentage of children hospitalized for mental and behavioral health disorders (17% compared to 11% statewide average). Mental and behavioral health disorders are the sixth leading cause of Outpatient ED utilization among Medicaid recipients⁶. In fact, Medicaid members who had three or more ED visits were 4.8 times more likely to have a drug dependence compared to those who did not have three or more ED visits. And they were 5.2 times more likely to have a co-occurring mental illness/substance use disorder⁷. For adults, Okanogan County’s rate of adults who reported poor mental health was higher than the statewide

¹ Washington State Center for Court Research. *Washington State Juvenile Detention 2016 Annual Report*.

² Washington State Statistical Analysis Center. *County Profiles*. Based on total adult arrests in 2016 for Chelan, Douglas, Grant and Okanogan counties combined. We will need to follow up with our local corrections partners to get more accurate data, since total arrests are not an accurate indicator of total adults incarcerated in county jails. However, jail bookings are also a poor indicator since other jurisdictions send inmates to Chelan County Jail. *Is this how you want this citation to look?*

³ Based on HCA data. Hospitalization data included in “Starter Kit” showed 171 counts of acute hospitalizations among Medicaid recipients for mental and behavioral disorders. ED utilization by Facility showed 1,554 ED visits among Medicaid recipients for mental and behavioral disorders.

⁴ WA DSHS DBHR 2016 Wenatchee CPWI Community Survey.

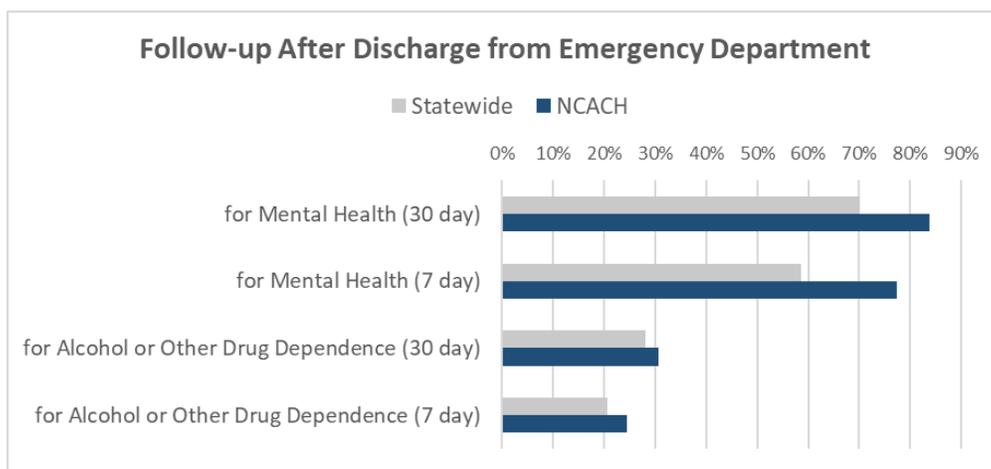
⁵ HCA RHNI “Starter-Kit” Delivery, “Top Ten Most Common Causes of Statewide Acute Hospitalizations Among Medicaid Recipients, Excluding Pregnancy and Child Delivery Related Hospitalizations, During Jan 1, 2015-Oct 31, 2015”.

⁶ AIM data product delivery, “ED Utilization of Medicaid Recipients Using Hospitals in North Central During Oct 1, 2015-Sep 30, 2016”

⁷ DSHS Research and Data Analysis, “Measure Decomposition Data” file. As indicated by RDA, likelihood ratios are “designed to identify demographic and health risk factor characteristics associated with favorable and adverse outcomes on selected metrics, to help inform ACH project planning. Demographic and health risk characteristics that are much more prevalent among persons experiencing adverse outcomes may identify high-opportunity populations for intervention”. *Flagging the long citation*.

average (15% compared to 11.3%⁸), and the rate of alcohol-impaired driving deaths was 13% higher compared to the state (48% compared to 35%)⁹.

The good news is that we are the top performing ACH based on *Follow-up After Discharge from ED for Mental Illness* measures (for both seven-day and 30-day measures), based on 2016 data for our region.¹⁰ While this indicates an area of strength relative to other ACHs, we have room for improvement when it comes to following up for alcohol and drug dependence. Those rates, compared to the mental health measures, are much lower, and they dropped between 2015 and 2016 (we were the top performing ACH in 2015 and ranked fourth in 2016.) Specifically, only 24.5% of Medicaid enrollees 18 years of age with a primary diagnosis of alcohol or other drug dependence received follow-up within 7 days of discharge from the ED for their alcohol and drug health issues (compared to 77.3% for enrollees with a primary diagnosis of mental health.) And only 30.6% of Medicaid enrollees with a primary diagnosis of alcohol or other drug dependence received follow up within 30 days (compared to 83.9% for mental health.) These areas of strength and weakness suggest some inconsistency in coordination of care as patients move across settings and an opportunity for our transitional care project to have a positive impact on these measures.



Source: DSHS Research and Data Analysis, “ACH Toolkit Historical Data” file. Based on 2016 data.

Criminal justice data for our region also highlights the importance of meeting health needs for youth and adults, both while they are incarcerated and as they transition back to their community from incarceration. Chelan and Douglas counties have higher arrest rates per 1,000 adolescents (ages 10-17) for drug law violations (5.4 and 6, respectively, compared to 2.3 statewide average)¹¹. Chelan and Okanogan counties have two-to-three times the rate of adult prisoners in state correctional

⁸ HCA RHNI “Starter-Kit”, *Prevalence Estimates – Overall* tab. Based on BRFSS measure for % adults who reported poor mental health during the past 30 days: 2013-2015.

⁹ Robert Wood Johnson Foundation, *County Health Rankings* (2017).

¹⁰ DSHS Research and Data Analysis, “ACH Toolkit Historical Data” file. Based on 2016 data.

¹¹ DSHS Risk and Protection Profiles for Substance Abuse Prevention Planning, retrieved at: <https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state>. Based on the 2015 measure for “Arrests of adolescents ages 10-17 for drug law violations, per 1,000 adolescents”.

systems (1412 and 1031, compared to 522 statewide average.)¹² Youth detention rates also highlight disparities. While the youth-level population-based rate of detention in 2016 was 9.3 per 1,000 youth, all four of our NCACH counties demonstrated higher rates with Okanogan County having the highest rate in the state (four times higher.)¹³ Racial disproportionalities in detention rates are prevalent across all four of our counties. For example, 43% of detained youth in Okanogan were Native American even though Native Americans make up 12.6% of the total population in that county, and 55% of detained youth in Chelan County were Latino/Hispanic even though Hispanics make up 28% of the total population in that county. Given our interest in transitional care for justice involved individuals, we specifically recruited justice system representatives for our Transitional Care and Diversion Interventions Workgroup. For example, we have a representative from the Okanogan County Juvenile Justice Department (who also sits on our Board), and a judge from the Okanogan District Court. There are also opportunities for staff to connect with justice system stakeholders from our opioid workgroup, including a Chelan County Jail representative and a Grant County Sheriff’s Department representative. The linkages are especially important where recovery services need to be part of a transition plan for incarcerated individuals who are struggling with opioid use.

A resolution passed by the National Congress of American Indians (NCAI) in June 2017 urged Congress to amend Medicaid to allow reimbursement for outpatient services that are provided to individuals incarcerated in Indian Country¹⁴. This resolution underscored the importance of providing sufficient funding to meet the healthcare needs of inmates, whether through medical staff available in tribal jails or by reimbursing transfers to local Indian Health Services (IHS) clinics. Medicaid benefits are also suspended in county jails and juvenile detention facilities, thus impacting continuity of health care services. Meeting the health care needs of people – during incarceration and as they are released from incarceration – will inherently involve addressing behavioral health issues contributing to criminal justice involvement. Medicaid members in the NCACH region (18-64 years of age) who were arrested were 2.6 or more times more likely to exhibit behavioral health risk factors compared to those who were not arrested, as shown in the table below¹⁵.

Risk Factor for Arrests	X times more likely to exhibit risk factor, if arrested
Substance abuse - low (drug abuse/dependence)	6.5
SUD treatment need	5.4
Co-occurring mental illness/substance use disorder	4.8
Substance abuse – very low (alcohol abuse/dependence)	3.4
Psychiatric – high (schizophrenia)	2.7
Psychiatric – medium (bipolar)	2.6

Source: DSHS Research and Data Analysis, “Measure Decomposition Data” file released October 27, 2017

Based on these potential target populations, we are gravitating towards the following evidence-based approaches as they specifically target people struggling with behavioral health issues:

¹² DSHS Risk and Protection Profiles for Substance Abuse Prevention Planning, retrieved at: <https://www.dshs.wa.gov/sesa/research-and-data-analysis/county-and-state>. Based on the 2015 measure for “Prisoners age 18+ in state correctional system, per 100,000 based on county of conviction”

¹³ Washington State Center for Court Research. *Washington State Juvenile Detention 2016 Annual Report*.

¹⁴ “Funding for Correctional Health Care in Tribal and BIA Facilities”. See <http://www.ncai.org/resources/resolutions/funding-for-correctional-health-care-in-tribal-and-bia-facilities>

¹⁵ DSHS Research and Data Analysis, “Measure Decomposition Data” file released October 27, 2017.

- Care Transitions Intervention;
- Care Transitions Interventions in Mental Health; and,
- Evidence-Informed approaches to transitional care for people with health and behavioral health needs leaving incarceration.

Our preliminary selected approaches dovetail with some ideas specific to our Transitional Care Project that one of our healthcare partners recently shared. Specifically, they suggested that social workers/community health workers placed in EDs would allow for direct intervention with frequent ED utilizers, who often have complex social needs. This would improve follow-up, education and scheduling while proactively addressing social determinants of health driving ED utilization.

Our Transitional Care and Diversion Interventions Workgroup had its first meeting on October 24, 2017, and will be meeting on a monthly basis to explore these approaches and guidelines in more detail as they formulate an implementation plan to improve care for these high-needs populations. We will continue to explore data, as we did at our first meeting (see Transitional Care Project - Attachment B), to guide our workgroup in data-driven planning. Beginning quarter 4 of 2017, we will work with our workgroup members to fill in a matrix outlining existing services in each county and illuminating gaps that the Demonstration could help fill. We will specifically ask them to consider Domain I issues, including workforce and Health Information Technology/Health Information Exchange (HIT/HIE) needs (see project implementation and timing worksheet for more details).

Over the next eight months, our workgroup will be tasked with narrowing the focus down to one or two approaches depending on available funding. They will further fine tune our target population with respect to initial implementation strategies and outline a plan for scaling approaches more broadly across our region. We will be asking the workgroup to draw on criteria to help them prioritize implementation options. In addition to considering need, impact, and feasibility, one of our criteria will be equity (to ensure that health and racial disparities are addressed). Sharing data broken out by specific demographic and geographic areas will ensure that our approaches are targeted and that no high-needs segment is lost in diluted averages. The juvenile detention data shared above, for example, is a perfect example of geographic and demographic variations within a specific measure that must be considered by our workgroup members.

Note that we intentionally created a combined workgroup for transition and diversion efforts because these efforts address very similar patient challenges, including barriers related to social determinants of health. As this workgroup becomes more involved in planning, it may decide to split into distinct workgroups. NCACH will respond to member recommendations on the workgroup's structure.

Though transitional care efforts may address a specific target population in the short term (e.g. demographic or geographic), NCACH maintains guiding principles in the development of all its project plans that will ensure that we do not only complete short-term projects that improve the lives of the targeted population, but transform systems that will lead to broader improvements lasting beyond the five years of the Demonstration. Some core principles include:

- **Sustainability:** It is NCACH's firm policy to not fund service delivery costs or other operations costs for service providers, or for other project activities, except in the context of a project plan leading to sustainability in the absence of Demonstration funds after 2021.

- **Embed Domain I activities into Projects:** Value-Based Payments (VBP), workforce and systems for population health management (HIT/HIE) improved through our Transitional Care Project will also enhance health system interoperability for all Medicaid beneficiaries who come into contact with partnering organizations.
- **Connection with all Demonstration Projects:** The Transitional Care Project will connect with the additional five NCACH selected projects. This alignment between all projects will ensure the work not only impacts the target population outlined in the final project plan, but connects across the different projects to create improvements for all Medicaid beneficiaries.
- **Social Service Connection:** To the greatest extent possible, our Transitional Care Project must connect patients to resources that proactively address social determinants of health.

Implementation Approach and Timing

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

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

Partnering Providers

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

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

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

Include:

- Organization name
- Organization type
- Organization phone number
- Organization e-mail address
- Brief description of organization

NCACH Transitional Care Project

- Employer Identification Number (EIN)
- Upload to Financial Executor portal

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

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
- Describe process for ensuring partnering providers commit to serving the Medicaid population.
- Describe the process for engaging partnering providers that are critical to the project's success, and ensuring that a broad spectrum of care and related social services is represented.

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

ACH Response

Given the overarching target population of the Demonstration, our workgroups know that they are charged with focusing on the Medicaid population. Their recommendations around project implementation and funding will target providers with a shared vision of serving this population, while also promoting broader improvements to processes and systems involved in transitional care. This is critical since it is the on-the-ground activities and practices of our healthcare providers and community-based organizations that will drive improvements to the Medicaid-specific metrics selected and measured by the Washington State Health Care Authority.

Members from our Transitional Care and Diversion Interventions Workgroup were vetted and recruited by our Board Executive Committee with a specific focus on sector representatives who serve a significant portion of the Medicaid population. For example, we have workgroup members representing therapeutic courts, juvenile courts, the housing authority, and law enforcement. These representatives work with many Medicaid beneficiaries in light of the strong overlap between these sectors and people impacted by poverty. In addition, partnering providers from our Whole Person Care Collaborative (WPCC), which is made of all major primary care and behavioral health care providers serving Medicaid beneficiaries in our four-county region, are engaged through our Governing Board and in our project workgroups. These medical providers all serve the Medicaid population, though the volume and proportion of Medicaid patients varies from provider to provider. On our Transitional Care and Diversion Interventions Workgroup, for example, we have a representative from Samaritan Hospital (1,233 Medicaid discharges in 2016) and Columbia Basin Hospital (25 Medicaid discharges in 2016) in Grant County. We also have a representative from Confluence which handles the largest volume of Medicaid discharges (3,129 in 2016) and has clinics in every county of NCACH. NCACH recently met with healthcare provider representatives (including two of our Governing Board members) who shared ideas for health system improvements that could have a broad regional impact and that would enhance the Demonstration projects we selected. We will share these ideas with our workgroups, and continue to be open to further suggestions and ideas from our healthcare and social service partners. As the list of partnering providers involved in implementation becomes clearer, we plan on asking them to assert their commitment to serving the Medicaid population in our funding agreements.

Our Transitional Care and Diversion Interventions workgroup charter specifically calls out composition that ensures representation from the social service and medical sectors, as well as other systems involved in transitions. This targeted workgroup composition ensures a balance of perspectives and

multi-faceted input during project planning. Composition was based in part on who could speak to the potential evidence-based approaches, which is why this workgroup has representatives from skilled nursing facilities, aging and adult care, law enforcement, and jails. As our workgroup continues to assess feasibility of specific approaches and target populations, reaching out to potential partnering providers will be critical, especially since getting a sense of buy-in across the entire NCACH region will inform the feasibility of scaling approaches beyond our initial targeted implementation.

Where additional input and expertise is needed, workgroups may bring in experts or reach out to potential partners that would be critical to project success. To ensure that our workgroup considers the broad spectrum of care and related social services critical to the project's success, NCACH staff are explicitly calling out questions about social determinants of health during project planning. For example, at our October 24, 2017 workgroup meeting, we discussed post-incarceration issues that would need to be addressed to promote successful transitions, including affordable housing to prevent homelessness and community and social supports for people returning to home environments stressed by poverty. At our next monthly meeting, we plan on asking them to think about why transitions fail, and to review inventories of social service resources across our region to identify gaps and opportunities that would increase the success of transitions.

To leverage Managed Care Organizations' (MCOs) expertise in project implementation, and ensure there is no duplication, all three MCOs operating in our region after January 2018 (when we transition to Fully-Integrated Managed Care) have a seat on every one of our project workgroups. They include Molina, Coordinated Care, and Amerigroup. This provides opportunities for them to share their expertise and data with the rest of the workgroup members to ensure the success of our selected approaches as we continue project planning and then move into project implementation. MCOs also have a seat on our Governing Board. Through mutual agreement among the MCOs active in our NCACH region, representatives take turns rotating as their sector representative and share notes from our Board meetings with all other MCOs. In addition, we initiated monthly meetings between NCACH staff and MCO partners to proactively anticipate where our Demonstration projects might support MCO system improvements, especially as they relate to Value-Based Payments. Our next meeting is scheduled for November 30, 2017. All of these engagement mechanisms with MCOs are critical. This is not just about avoiding duplication, it is about ensuring alignment and using Demonstration investments to help providers adapt to Value-Based Purchasing.

Regional Assets, Anticipated Challenges and Proposed Solutions

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

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

ACH Response

One of NCACH's greatest assets is the level of commitment and engagement of our health and social service partners. Our Whole Person Care Collaborative (WPCC) is made up of all major primary care and behavioral health care providers serving Medicaid beneficiaries in our region. The WPCC is well established as a result of a prior federal State Innovation Model grant, and is in the process of

developing a learning collaborative, with assistance from contractors at Centre for Collaboration, Motivation, and Innovation (CCMI) and CSI Solutions, Inc., that will significantly advance bi-directional integration as well as chronic care management. Other regions have reached out to us to learn more about this collaborative model, and Managed Care Organization (MCO) partners have noted that we are farther along in terms of integrating our health care providers into a cohesive whole. The WPCC will touch the rest of our projects and many of their agencies are involved in our other workgroups.

In addition, partnering providers from the criminal justice, emergency medical services, and social service sectors specifically recruited for Transitional Care and Diversion Interventions Workgroup are demonstrating their commitment by volunteering significant time to help plan and implement solutions for improving transitional care services. We plan on engaging workgroup members to assess efforts that are already underway in our communities that this project could leverage, while also addressing anticipated challenges voiced by community partners. For example, feedback from Coalitions for Health Improvement highlighted specific concerns with respect to transitional care; lack of affordable housing, rigid transitional housing rules and lack of wet shelters (for people with substance abuse issues), limitations options given our rural region, legal barriers for people with criminal records, and overwhelming systems that are difficult to navigate. They also noted the lack of interagency planning, though this is something that our selected approaches will explicitly address. Potential mitigation strategies to address these challenges and barriers include: working with partners, for example Our Valley Our Future who took the lead on a comprehensive action plan to address housing issues in our region, Upper Valley Mend, Okanogan Housing Authority (one of their representatives sits on our Board), the Homeless Task Force of Grant County (one of our Board members is its Chair); hosting focus groups that can help inform investments related to social determinants of health (housing and transportation are critical issues in our region); and working with Amerigroup, one of 3 MCOs in our region as of January 2018 who is also under contract with HCA to oversee the delivery of supportive housing and supported employment services under the Medicaid Demonstration. We will also work closely with one of our Board members (and CHI representative) who is a housing and community planner with the City of Wenatchee.

Earlier this year, NCACH recognized a gap in data and analytic capacity. Over the past several months, we have addressed this gap in a variety of ways: (1) hired a full-time data analyst to do in-house data analysis, (2) contracted with Center for Outcomes Research and Education (CORE) to provide technical assistance and consultation to assist NCACH with data-related needs for the project planning process (3) formed an HIT/HIE Workgroup to address regional population health management systems and information exchanges that can be expanded, enhanced, or initiated, and (4) contracted with CCMI and CSI Solutions, Inc. for technical support to develop a learning collaborative and performance monitoring software, tools, dashboards, and processes. The steps we have taken to address a previously identified weakness have not only turned data and analytic capacity into an area of strength for NCACH, but demonstrate that we can rapidly and systematically address future identified challenges.

NCACH also considers its other Demonstration projects regional assets, since projects will mutually reinforce one another and help address gaps. For example, we plan on leveraging the Pathways Community HUB to specifically address our target population's challenge with navigating systems and aligning social service supports. One of the realities given the rural and expansive nature of our region

is a weaker social service network. According to a report prepared by the Giving Practice¹⁶, studies highlight the fact that rural nonprofits tend to be smaller, isolated, and more reliant on volunteers. At the time this report was published, our four-county region had 92% fewer nonprofits than King County, excluding religious organizations, hospitals, and universities (252 compared to 3,137.) This is a challenge since transitions from acute care or incarceration can be improved through robust social service supports in the community.

County	Nonprofits	County	Nonprofits	County	Nonprofits
Adams	10	Grays Harbor	74	Pierce	955
Asotin	15	Island	102	San Juan	81
Benton	162	Jefferson	72	Skagit	136
Chelan	120	King	3,137	Skamania	8
Clallam	112	Kitsap	295	Snohomish	526
Clark	317	Kittitas	53	Spokane	490
Columbia	6	Klickitat	22	Stevens	36
Cowlitz	86	Lewis	75	Thurston	277
Douglas	10	Lincoln	13	Wahkiakum	4
Ferry	7	Mason	48	Walla Walla	83
Franklin	34	Okanogan	64	Whatcom	247
Garfield	1	Pacific	40	Whitman	50
Grant	58	Pend Oreille	5	Yakima	198

Figure 3 - Filing Nonprofits by County, excluding religious organizations, hospitals, and universities. (2007).

Source: An Assessment of Capacity Building in Washington State (December 2009)

NCACH is initiating a social services focus group to develop a strategic plan on how we can better align community-based organizations within the Demonstration project to address non-medical needs that can impact care (e.g., transportation). Additionally, NCACH staff will engage our workgroup members and partners to identify and prioritize weak or missing elements in both our health care and social service networks. In addition to monthly meetings with our workgroup members, we will connect with existing regional councils, including the North Central Regional Hospital Council, the North Central Emergency Care Council, and meetings of local law enforcement leaders. These groups are well connected with the NCACH and can bring together stakeholders from these sectors to evaluate project plans and distribute information about transitional care initiatives to the community.

While Demonstration investments will not be sufficient to fill all the gaps, we are committed to working with partners to identify creative solutions and other potential sources of funding. For example, we might leverage technology to promote a regional 24/7 nurse advice line or consider using outside consultants to provide technical assistance around accessing federal dollars available for HIT investments.

Monitoring and Continuous Improvement

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

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

¹⁶ The Giving Practice, a Consultancy of Philanthropy Northwest. (December 2009) *An Assessment of Capacity Building in Washington State*

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

ACH Response

The goal of NCACH’s monitoring plan is to use real-time or close to real-time data to support our transitional care implementation and continuous improvement (see Transitional Care Project - Attachment C). Largely pulling from existing data sources, NCACH will track operational, process, and outcomes measures for each project and for the ACH overall. These existing data sources include the Healthier Washington dashboard, the Department of Health Quarterly Drug Overdose Dashboard, the Department of Health Prescription Monitoring Program (PMP) Dashboard, the HCA DSRIP Dashboard, and other reports and products currently available from or under development by the state. We will work with workgroups to supplement this data with regional and partner data. Monitoring data will be used to drive shared learning, form the foundation of rapid-cycle continuous improvement processes, and support program evaluation efforts. This will allow the ACH and key partners to identify issues, barriers, and successes quickly. Key elements of this system include:

Convening key stakeholders. NCACH is convening the Transitional Care and Diversion Interventions Workgroup to guide decisions for our transitional care project. This group includes clinical and program subject matter experts who will make recommendations regarding project implementation, while also informing our Quality Improvement Plan (QIP). NCACH will work with stakeholder groups to monitor progress on a quarterly basis and triage issues that arise in implementation, such as access to data or recruitment and enrollment delays. Key stakeholders for this project includes criminal justice stakeholders (including law enforcement, juvenile justice, district court, and therapeutic courts), hospitals (individual hospitals serving a large portion of Medicaid beneficiaries, as well as a representative from the North Central Regional Hospital Council), and MCOs. A detailed list is included in our workbook’s partnering providers tab. The exact approach and tools to support partner reporting and rapid cycle monitoring and improvement will be developed in 2018 with guidance from our specific project workgroups (including the WPCC, Opioid Workgroup, Transitional Care and Diversion Interventions Workgroup, and Pathways Community HUB Workgroup). The development of continuous monitoring and improvement systems will be led by ACH staff with technical assistance from our consultants (e.g. CORE and CCMI/CSI).

Identifying monitoring metrics, data sources, benchmarks, and targets. Monitoring metrics will vary by project, and will include ACH toolkit pay-for-reporting and pay-for-performance metrics, as well as regional accountability and quality improvement plan metrics. In order to improve our project performance measures, it will be critical to identify proxy measures that we can track at a local-level and that are likely to impact the measures. This may involve process, output, and/or outcome measures (e.g., number of people reached broken out by year.) NCACH data staff will begin working with key contractors such as the Center for Outcomes Research and Education (CORE) beginning quarter 3 of 2018 to develop and recommend to the workgroup a detailed QIP that NCACH will support to monitor the health impact of our Transitional Care Project. NCACH staff will facilitate linkages where input from our regional HIT/HIE workgroup or the statewide HIT/HIE efforts led by the

HCA may be needed. NCACH also will ask MCOs to review quality metrics and agree on quality reporting for Value-Based Payment models. For the implementation phase, many metrics will be process or operational in focus. Using the toolkit as a guide, NCACH staff will engage workgroup members to help identify benchmarks and, where possible, improvement targets. Potential metrics for our Transitional Care Project are listed in the table below; final metrics will be identified in the implementation plan.

Potential Monitoring Metrics – Transitional Care Project

Implementation/Operational Measures – Regional monitoring metrics to track implementation progress

Measures TBD; examples may include:

- Partnering provider patient volume
- Number of providers receiving training and technical assistance on guidelines
- Number and percent of partners adopting HIE

Toolkit P4R Measures – Required metrics for ACH reporting

- Number of partners trained
- Number of partners implementing selected approaches
- Number of partners achieving certification
- Number of clients receiving transitional care plans prior to release
- Number and percent of partners sharing information via HIE to better coordinate care (cross-partner communication, including transitional care plans)
- Number of clients who meet with a Transitions Coach in the hospital
- Number of in-reach visits to jails

Toolkit P4P Measures – Incentive measures, which will be reported by HCA and tracked by the ACH

- Follow-up after Discharge from ED for:
 - Mental Health
 - Alcohol or other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization
- Outpatient Emergency Department Visits per 1000 member months
- Percent Homeless (Narrow Definition)
- Plan All-Cause Readmission Rate (30 Days)

Quality Improvement Plan Metrics – Regional performance metrics

QIP metrics will be identified by quarter 2 of 2019

Building data infrastructure to collect, aggregate, analyze, and report data for monitoring. NCACH plans to develop a data infrastructure to collect and aggregate project information, in order to support continuous analysis, monitoring and improvement. The potential data infrastructure to support monitoring and continuous improvement (see above) should be designed to complement existing data assets (such as the Fully-Integrated Managed Care Early Warning System, Healthier Washington Dashboard, other dashboards under development, and reporting from regional associations). An ideal system will be able to securely collect, combine, store, and report data. Through our Whole Person Care Collaborative, we are planning on using a customized web portal (Healthcare Communities) developed by one of our current contractors, CSI Solutions, Inc. Originally developed in 2005, this platform has grown to support nearly 70 communities, including CMS’s Transforming Clinical Practices Initiative. This portal would serve multiple functions, providing centralized access to resource sharing, document sharing, tracking of process measures through consistent form-fillable reporting templates and surveys, and tracking of measures through dashboards. Based on conversations with CSI Solutions, it seems very likely that we can leverage this web portal for monitoring progress and reporting associated with the rest of our projects. Ideally, partners would submit monthly reports through this online portal.

Reports from implementation partners will focus on project milestones and process details that can

be used to support overall monitoring, identify potential challenges or barriers that individual or multiple partners are experiencing, and identify potential champions and best practices. Reporting will be contractually required of project partners, though every effort will be made to keep these reports simple and streamlined in order to minimize the reporting burden for partners (one of our key design principles). Data from partner reporting will complement existing data resources, including the Healthier Washington Data Dashboard and the Department of Health Drug Overdose Dashboard, (both currently operational), as well as the Department of Health Prescription Monitoring Program (PMP) Dashboard and the HCA DSRIP Dashboard. Some of these data assets are currently under development by the State using a Tableau interface, with the hopes of being released in early 2018 and updated on a quarterly basis.

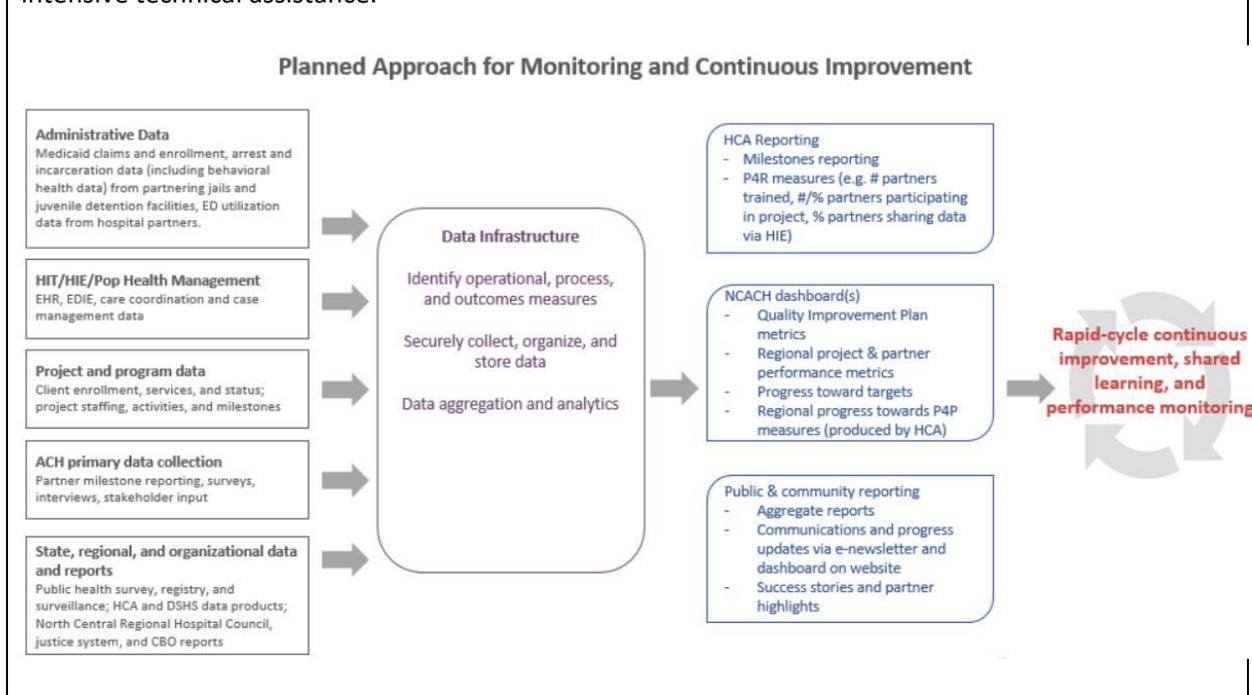
Other ACHs are also investigating options, and NCACH has participated in several webinars from vendors offering these types of solutions. For example, a webinar presented by one New York DSRIP provider with SpectraMedix, their data infrastructure partners; a webinar organized by the Washington Health Alliance regarding a healthcare quality improvement tool from 10xHealth; a webex on a Salesforce platform built by Persistent Systems which was designed for another New York DSRIP provider to see a 360 view of project management and progress; and a webinar with the Washington State Hospital Association on a specific quality benchmarking system they are interested in making available to ACHs. NCACH staff will continue exploring options, consult with other ACHs who may have investigated their own solutions, and solicit input from our regional HIT/HIE workgroup. We plan on identifying a strategy for collecting all of this data by the end of 2018. Ideally, we would find a way to use the same platform for most of our projects in order to minimize administrative costs.

As part of the data infrastructure work, NCACH will identify data sources and a plan for data collection, establish data use agreements with partnering providers (potentially including MCOs), establish data governance models, comply with relevant privacy and security regulations, implement processes for transferring data, and identify tools to collect, manage, store, analyze, visualize, and report data. Efforts will be made to minimize the reporting burden on partnering providers, leveraging existing data reporting where possible.

Implementing continuous improvement (CI) processes. Drawing on this data infrastructure, NCACH will develop continuous improvement (CI) processes based on best practices for clinical and health systems improvement, bringing in expertise from contractors (e.g., CORE or CCMI/CSI) where needed (see diagram below or Transitional Care Project - Attachment C for a larger version of this graphic). Drawing on monthly reports, and ad-hoc check-ins with partnering providers, staff will regularly monitor performance and understand, in real-time, whether we are on the path to reaching expected outcomes. Project workgroups also will be involved in project monitoring and course correction, through quarterly improvement cycles accompanied by collaborative peer learning sessions. With each cycle, NCACH and partners will adapt, test, and refine strategies, document learnings and results, and spread learnings across partners. These processes should allow for identification of barriers, challenges, and risks. If timelines still cannot be met, NCACH will communicate a plan back to the Health Care Authority regarding reasons why timelines weren't met, a plan for adapting the timeline, and prevention/risk mitigation strategies that will be shared with other partners and projects where appropriate.

Quality improvement efforts will be coordinated with existing local and statewide technical assistance providers, including Qualis, the Practice Transformation Support Hub, MCO initiatives, and HCA resources. For example, the HCA AIM team is planning on creating monitoring reports containing

specific project level detail (they anticipate that production of these reports would start in 2018). Information, reports, and assessments from other quality improvement efforts may also be helpful data sources to monitor ACH and partner progress (e.g. MCO assessments and measures). NCACH envisions supporting quality improvement in a variety of ways, ranging from connecting partnering providers to relevant resources to creating new opportunities for partnering providers. NCACH may provide training or technical assistance to providers around specific issues or barriers, such as HIT/HIE adoption or workforce development. NCACH’s goal is for partners to be as successful as possible in project implementation and will design quality improvement efforts that offer a flexible approach. If partners are identified as struggling in a particular area, or lagging behind, NCACH intends to determine what will be needed to ensure that partner’s success and determine whether existing or additional resources can be provided. This may involve extensions, and/or more comprehensive or intensive technical assistance.



Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

Attest that the ACH understands and accepts the responsibilities and requirements of identifying initiatives that partnering providers are participating in that are funded by the U.S. Department of Health and Human Services and other relevant delivery system reform initiatives, and ensuring these

initiatives are not duplicative of DSRIP projects. These responsibilities and requirements consist of:

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

YES	NO
X	

Project Sustainability

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

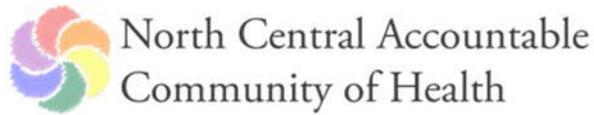
ACH Response

One of NCACH’s key strategies is to target Demonstration funds to support changes in systems and processes that can lay the ground work for long-term sustainability. Many of Washington State’s Medicaid Demonstration projects are ultimately about improving linkages to promote more effective coordination and holistic care. This kind of system transformation can be accelerated through capacity building investments, including facilitating cross-sector communication, making discrete capital investments, rethinking processes, or changing the way resources are allocated. By incentivizing these types of changes through Demonstration investments, we expect improved infrastructure and processes to live beyond the Demonstration period, especially where they show improvements in health and social outcomes for our target populations.

For example, new linkages and strengthened relationships that are created between criminal justice and health care representatives through our transitional care approaches are not contingent on continued funding. Laying the groundwork for a more robust and interoperable information technology (IT) systems or other coordination mechanisms between criminal justice, health care, and other sectors (e.g., strengthening the region’s Washington Information Network 211 (WIN211) infrastructure to facilitate linkages to social service and health care supports) will have lasting impacts. This kind of capacity building is critical to the continued efforts of our partners. These investments are part of our approach for expanding, using, supporting and maintaining population health management systems across all of NCACH’s selected projects. Specific to our Transitional Care Project, policies might be changed to allow social service providers access to clients while they are incarcerated (so that their needs can continue to be planned for.) It will be the workgroup’s charge to consider these and other capacity investments or policy changes that can facilitate smoother transitions between settings.

The NCACH Governing Board is open to supporting additional staff resources and direct services, but only where a strong path toward sustainability is articulated by our partnering providers (whether services can be sustained through Value-Based Payments or through other revenue generating

strategies, including demonstrated support from foundations or local jurisdictions). However, by focusing investments on strengthening our partnering providers' foundations (rather than specific programs), we hope to enhance their ability to achieve their mission and sustain their work. This guideline will be made clear to our workgroups as they dive deeper into project planning and make implementation and funding recommendations to the NCACH Governing Board.



Transitional Care and Diversion Interventions Workgroup Charter

Background

On January 9th, 2017 the Washington State Health Care Authority (HCA) signed an 1115 Waiver, now known as the Medicaid Transformation Demonstration Project. The goal of the Demonstration is to improve care, increase efficiency, reduce costs and integrate Medicaid contracting. To align clinical integration with payment integration within the Demonstration Project, HCA developed the [Medicaid Demonstration Project Toolkit](#). Two of the projects that were selected are Transitional Care and Diversion Intervention. The project objects, as described in the toolkit, are:

- Transitional Care – improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place
- Diversion Interventions – Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

Charge

The Transitional Care and Diversion Interventions Workgroup will ensure that the North Central region implements effective evidence based practices that align with the milestones and approaches described in the Toolkit. Specifically the Workgroup will complete the following:

- Provide recommendations to the NCACH Governing Board and staff on approaches to take for Transitional Care and Diversion Interventions projects.
- As much as possible, ensure Diversion Interventions and Transitional Care projects align with all six projects NCACH selected to implement.
- Collect, synthesize, and use stakeholder and community input on project planning and implementation.
- Work with NCACH partners to implement sustainable changes in the regional health care system (broadly conceived) that improve effective transitions for patients re-entering the community from intensive care settings or incarceration, and provide more effective alternatives to incarceration, inpatient treatment or emergency department care for patients whose needs can be better addressed in other ways.
- Determine how work completed through Transitional Care and Diversion Interventions are able to be financially sustainable past the Demonstration period.
- As much as possible, ensure projects effectively connect patients with resources to mitigate the negative consequences of the social determinants of health.
- Identify how IT, workforce, and value-based payment strategies can support this project.

Composition

The Transitional Care and Diversion Interventions Workgroup will include representatives from Grant, Chelan, Douglas, and Okanogan Counties. Workgroup membership is not a prerequisite to receiving funding through the Demonstration. The NCACH Executive Committee will recommend to the Governing Board workgroup members from a list of interested parties which may include representation from:

- Emergency Medical Services (EMS)
- Law Enforcement
- Legal Services
- Regional Justice Centers (Jails)

- Hospitals
- Skilled Nursing Facilities/Assisted living/Long-term Care Facility/Hospice
- Aging and Adult Care
- Managed Care Organizations (*Operating in all 4 NCACH counties after January 1st, 2018*)
- Behavioral Health Administrative Service Organization
- Behavioral Health Providers including Crisis providers
- Primary Care Providers
- Care Coordination agency/Case Managers
- Education
- Tribal

Additional representation will be added to the Workgroup by the Executive Director if it is deemed necessary. A Workgroup Chair will be appointed by the Executive Director. The Transitional Care and Diversion Interventions Workgroup is a sub-committee of the NCACH board and as such will be led by the Workgroup Chair and NCACH staff and must have a minimum of two board members serving on the Workgroup.

Meetings

Transitional Care and Diversion Interventions Workgroup meetings will be held once per month, with additional meetings scheduled as necessary. Meetings will be held in Chelan, Douglas, Grant, and Okanogan Counties; locations will vary and an effort will be made to hold meetings in each of the Local Health Jurisdictions throughout the year. Whenever possible, meetings will have an option to participate via teleconference or audioconference for those unable to attend in person, although in-person participation is encouraged. NCACH program staff and the Workgroup Chair shall be responsible for establishing the agendas. Notes for all meetings will be provided to the Workgroup by NCACH staff within two weeks of each meeting. Monthly meetings will be open meeting minutes and materials will be posted on the NCACH website (www.ncach.org).

Membership Roles and Responsibilities

1. Attend at least 75% of regular meetings of the Workgroup and actively participate in the work of the Workgroup.
2. Sign a Membership Agreement (attachment A)
3. Communicate with other members of your sector and/or community to ensure broader input into the design, planning, and implementation process.
4. Assess current state capacity to effectively deliver Transitional Care and Diversion Interventions.
5. Select initial target population and evidence-supported approaches informed by the regional health needs assessment and community data.
6. Review prepared data to recommend target population(s), to guide project planning and implementation, and to promote continuous quality improvement
7. Assist in identifying, recruiting, and securing formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.

8. Recommend to the Board a project implementation plan, including a financial sustainability model and how projects will be scaled to full region in advance of HCAs project implementation deadline.
9. Monitor project implementation plan, including scaling of implementation plan across region, and provide routine updates and recommended adjustments of the implementation plan to the NCACH Governing Board.
10. Develop and recommend a funding process to the NCACH Governing Board for non-primary care and outpatient behavioral health members involved in Transitional Care and Diversion Interventions projects
11. Collaborate with NCACH staff on data and reporting needs related to Demonstration metrics, and on the application of continuous quality improvement methods in this project.
12. Use strategies that are supported by regional data, to advance equity and reduce disparities in the development and implementation of the Transitional Care and Diversion Intervention Projects.

Authority

The Transitional Care and Diversion Interventions Workgroup is an advisory body that will inform decision-making by the NCACH Governing Board and ensure regional priorities and local considerations are incorporated in program design decisions. Recommendations and input developed by the Workgroup will be shared in regular monthly progress reports to the NCACH Governing Board.

**North Central Accountable Community of Health
Transitional Care and Diversion Interventions Workgroup
(Attachment A)**

Membership Agreement

I acknowledge by my signature of this membership agreement that I have read, understood, and agreed to follow the guidelines and policies outlined in the North Central Accountable Community of Health Transitional Care and Diversion Interventions Workgroup Charter.

I understand that continued membership in the Workgroup is contingent on following the requirements of membership that are outlined in the Charter. Not meeting the requirements for membership could result in the loss of my membership status in the Workgroup.

Dated: _____

Signed: _____

Print Name: _____

Title: _____



North Central Accountable
Community of Health

NCACH Transitional Care Project Plan – Attachment B

Transitional Care and Diversion Interventions Workgroup

October 24th, 2017

Healthier Washington

Healthier WA is a statewide initiative that is focused on achieving system wide change to link clinical and community factors that support health and spread integrated value based payment and care delivery models.

To achieve these goals, Healthier WA focuses on three goals:

1. Building healthier communities through a collaborative regional approach.
2. Integrating how we meet physical and behavioral health needs so that health care focuses on the whole person.
3. Improving how we pay for services by rewarding quality over quantity.

Locally, this work is accomplished through Regional Collaboratives such as the Accountable Communities of Health.



5 Years from now



Current system

- Fragmented care delivery
- Disjointed care transitions
- Disengaged clients
- Capacity limits
- Impoverishment
- Inconsistent measurement
- Volume-based payment



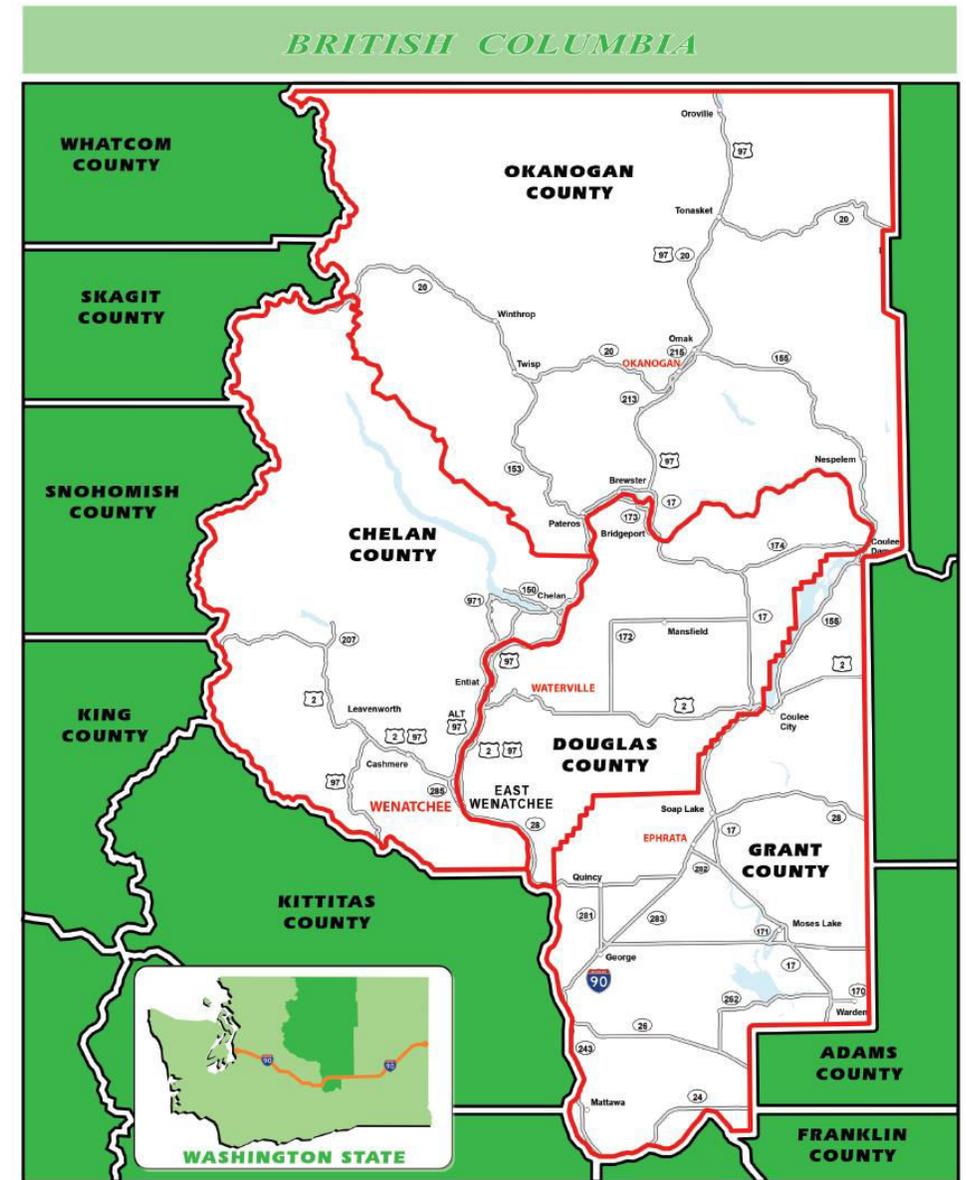
Transformed System

- Integrated, whole-person care
- Coordinated care
- Activated clients
- Access to appropriate services
- Timely supports
- Standardized measurement
- Value-based payment

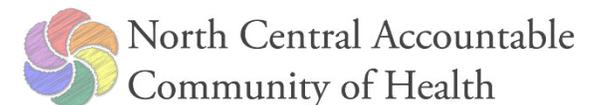


A Regional Approach

- ACHs play a critical role:
 - **Coordinate** and **oversee** regional projects aimed at improving care for Medicaid beneficiaries.
 - **Apply** for transformation projects, and incentive payments, on behalf of partnering providers within the region.
 - **Solicit** community feedback in development of Project Plan applications.
 - **Decide** on distribution of incentive funds to providers for achievement of defined milestones.



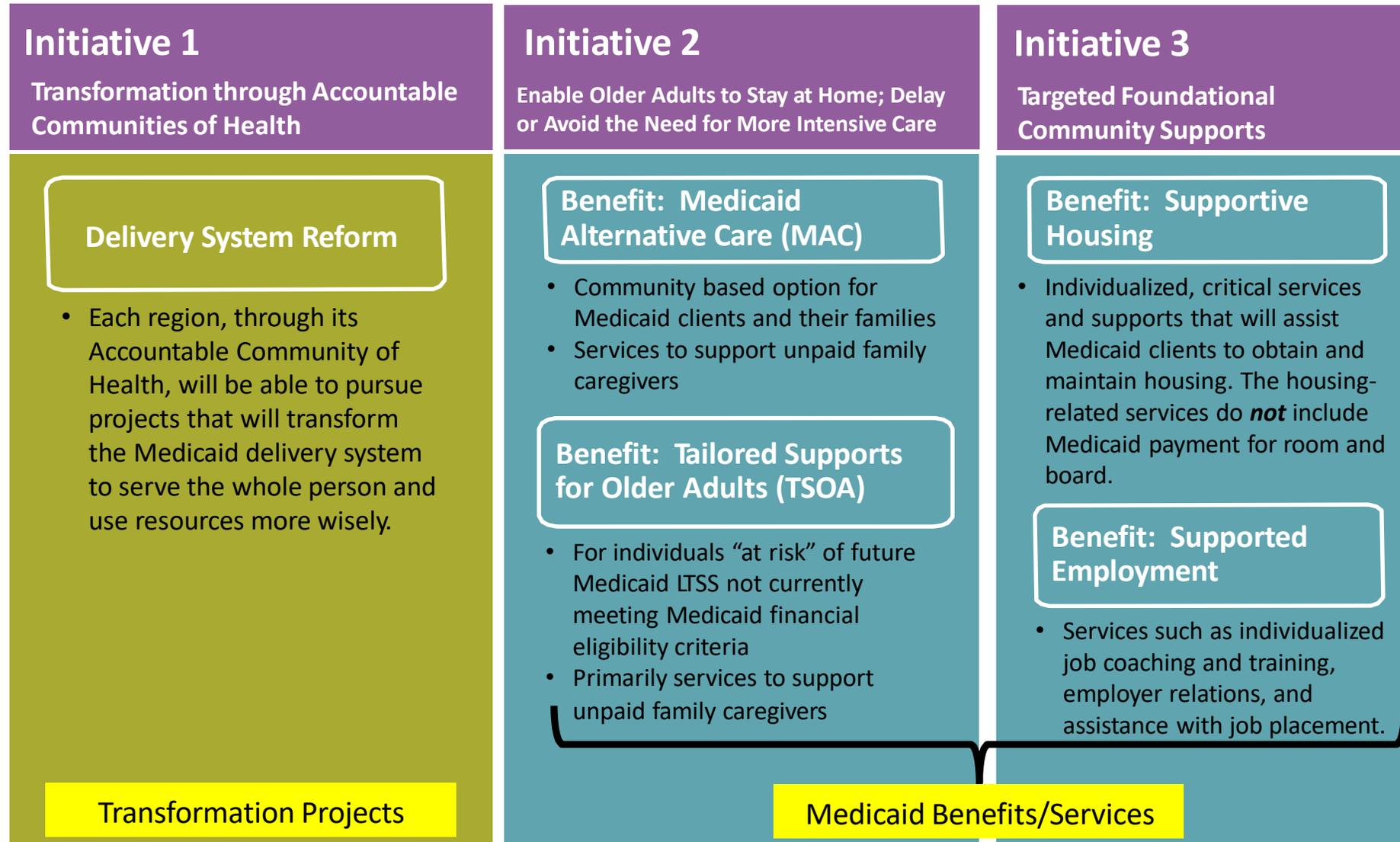
North Central Accountable Community of Health



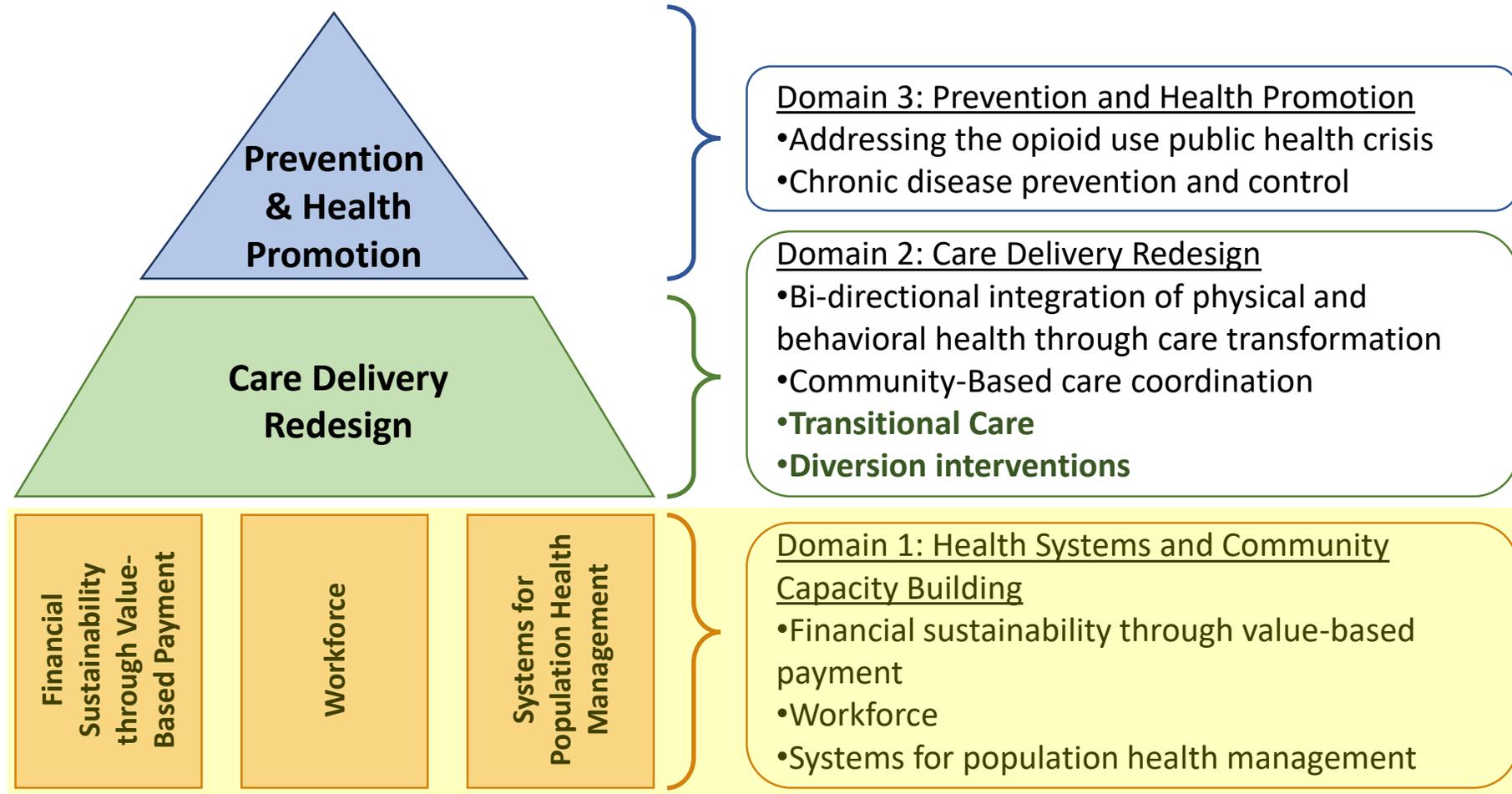
Medicaid Transformation Demonstration

- Through a five-year demonstration, Healthier WA will use up to \$1.5 Billion to address three initiatives aimed at transforming Medicaid to improve quality and control costs:
 - **Initiative 1: Transformation Through Accountable Communities of Health**
 - **Initiative 2: Long-term Services and Supports to Enable Older Adults to Live At Home Longer**
 - **Initiative 3: Supportive Housing and Supported Employment**
- Of the \$1.5Billion available through the Demonstration, **\$1.125Billion will be available to address Initiative 1.**

Medicaid Transformation Demonstration



Initiative 1: Care Transformation



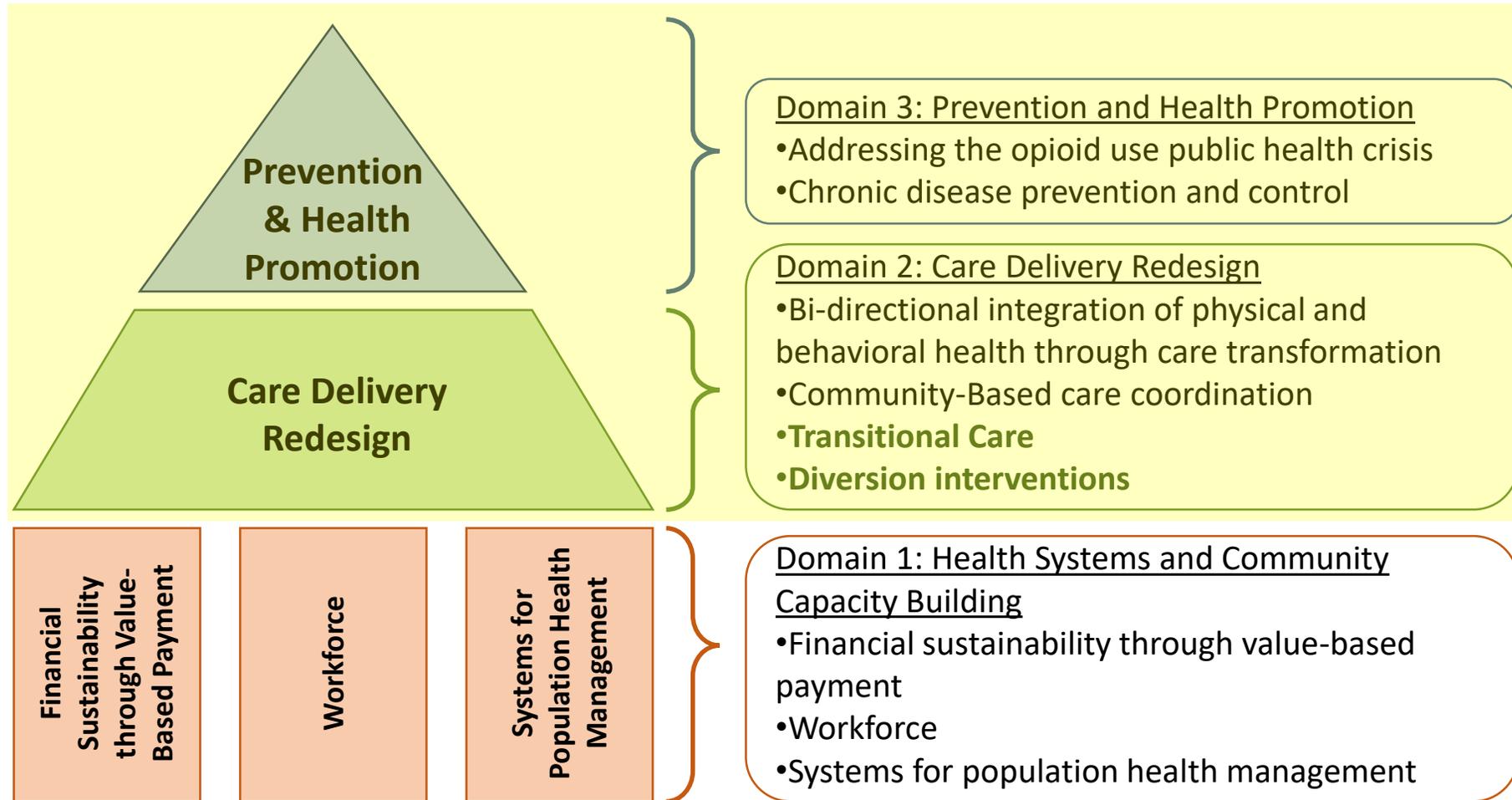
Domain 1: Health Systems and Community Capacity Building

Domain 1 addresses the core health system capacities to be developed and enhanced. Three required focus areas are to be implemented and expanded across the delivery system. Each of these areas will need to be addressed progressively throughout the five-year timeline. State agencies will provide leadership but the ACH will have a role in each focus area.

Focus Areas

1. Financial Sustainability through Value Based Payment
2. Workforce
3. Data Systems for Population Health Management

Initiative 1: Care Transformation



Projects and general target populations

Bi-Directional Integration

Community-Based Care Coordination (aka HUB)

Transitional Care

Diversion Interventions

Addressing the Opioid Use Public Health Crisis

Chronic Disease Prevention and Control

Objective

Integrate health system and community approaches to improve chronic disease management and control.

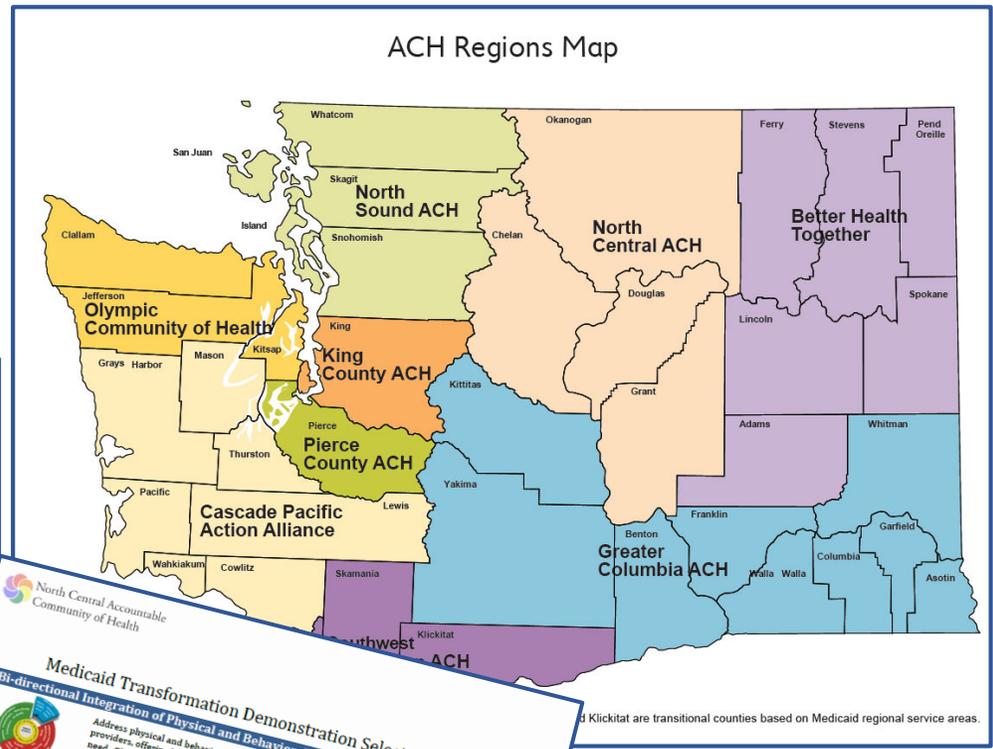
General target population (as defined by HCA)

Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a **focus on those populations experiencing the greatest burden of chronic disease(s) in the region.**

More Information



MEDICAID TRANSFORMATION APPROVED PROJECT TOOLKIT
June 2017



North Central Accountable Community of Health

Medicaid Transformation Demonstration Selected Projects
Chelan, Douglas, Grant, and Okanogan Counties

Bi-directional Integration of Physical and Behavioral Health through Care Transformation
Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through Managed Care Organizations, for people enrolled in Medicaid to address the whole person.

Community-Based Care Coordination
Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. This will rely on the development of the Pathways HUB infrastructure which will coordinate care coordinators and allow current care coordinators to provide more effective and efficient care coordination.

Transitional Care
Improve transitional care services of Medicaid beneficiaries moving from intensive medical care or institutional settings. This includes those discharged from acute care to home or to supportive housing, those with serious mental illness discharged from inpatient care, or client returning to the community from prison or jail. Improvement in these services will lead to a reduction in avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

Diversion Interventions
Implement diversion strategies to promote more appropriate use of emergency services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. Strategies targeted at Medicaid beneficiaries presenting at the Emergency Department for non-acute conditions. Medicaid beneficiaries who access the EMS system for emergency conditions, and Medicaid beneficiaries with mental health and substance use conditions coming into contact with law enforcement.

Addressing the Opioid Use Public Health Crisis
Reduce opioid-related morbidity and mortality through strategies to prevent opioid misuse and abuse, treatment of opioid use disorder, and long-term recovery, and whole-person care.

Chronic Disease Prevention and Control
Improve chronic disease management and control by using the Chronic Care Model in a primary care setting. The CCM identifies a health care system that encourage high-quality chronic disease management, the health system self-management support, decision support, and clinical information systems.

North Central Accountable Community of Health
10000 Parkway, East Wenatchee, WA 98802 | 509.886.6400 | www.ncaach.org

Selected Medicaid Demonstration Projects

Project Name	Objective	General target population (as defined by HCA)
Bi-Directional Integration	Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers.	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).
Community-Based Care Coordination (aka HUB)	Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.	Medicaid beneficiaries (adults and children) with one or more chronic disease by condition (such as, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke) mental illness/depressive disorders moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high ED utilization)
Transitional Care	Improve transitional care services to reduce avoidable hospital utilization and ensure Medicaid beneficiaries are getting the right care in the right place.	Medicaid beneficiaries in transition from intensive settings of care or institutional care, including: <ul style="list-style-type: none"> beneficiaries discharged from acute care and inpatient care to home or to supportive housing (including beneficiaries with serious mental illness (SMI)) beneficiaries discharged from the community from prison or jail client returning to the community from prison or jail
Diversion Interventions	Implement diversion strategies to promote more appropriate use of emergency care services, especially for medically underserved populations.	Medicaid beneficiaries presenting at the ED for non-acute conditions <ul style="list-style-type: none"> Medicaid beneficiaries with mental health and/or substance use conditions Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement
Addressing the Opioid Use Public Health Crisis	Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin
Chronic Disease Prevention and Control	Integrate health system and community approaches to improve chronic disease management and control.	Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region

North Central Accountable Community of Health

Medicaid Transformation Demonstration Selected Projects

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Addressing the Opioid Use Public Health Crisis
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Resources and Relationships

- Domains and Projects *should not* be implemented in isolation from one another.
 - Projects will be highly interrelated and interdependent
- Transformation projects must:
 - Be based on community-specific needs for the Medicaid population
 - Avoid redundancy and duplication
- Regional projects will be assessed based on achievement of defined milestones and metrics.

Funding the Demonstration Projects

Each project involves metrics

Funding will depend, in part, on our performance

- This is not a grant program. There will be up-front money for start-up, but much of the project funding must be earned by reaching performance targets.
- In the early years of the projects, we will be judged mainly on the progress we make in implementing project plans.
- In the later years of the projects, we will be judged mainly in terms of health care improvements such as reductions in unnecessary ER visits and hospitalization, and on clinical quality metrics such as the percent of Medicaid diabetes patients receiving HbA1c testing, percent receiving depression screening, and many others.
- It will be a heavy lift to measurably improve Medicaid clinical quality by the end of 2021.

Transitional Care & Diversion Workgroup

Workgroup will ensure that the region implements effective evidence based practices that align with the Toolkit. Specifically the following:

- Provide recommendations to the NCACH Governing Board and staff on approaches to take for Transitional Care and Diversion Interventions projects.
- Ensure projects align with all six projects NCACH selected to implement.
- Use stakeholder and community input on project planning and implementation.
- Work with NCACH partners to implement sustainable changes in the regional health care system & Criminal Justice System
- Ensure projects effectively connect patients with resources to mitigate the negative consequences of the social determinants of health.
- Identify how IT, workforce, and value-based payment strategies can support this project.

Evidence Based Approaches

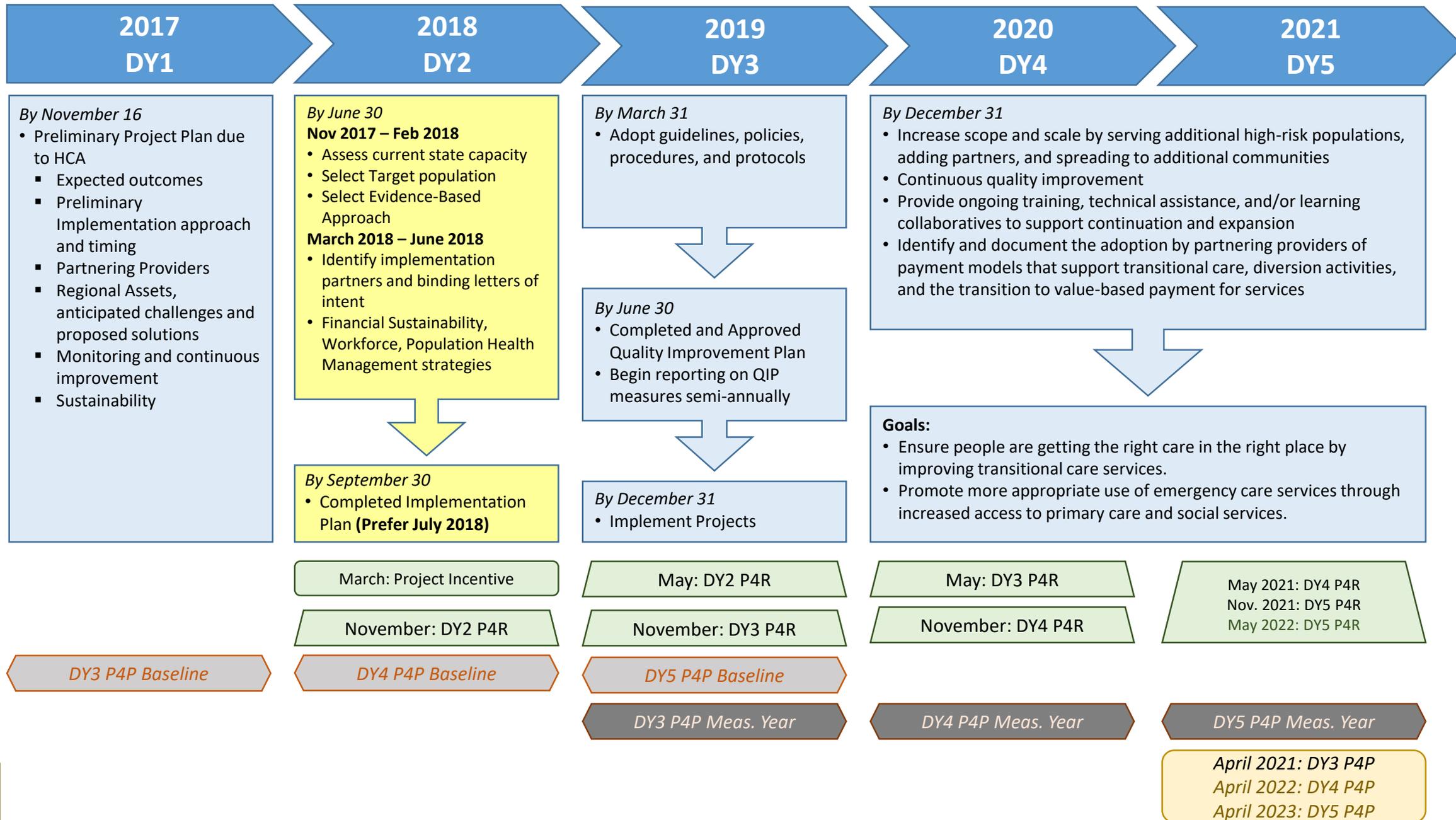
Evidence Based Approaches:

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0
2. Transitional Care Model (TCM)
3. Care Transitions Intervention® (CTI®)
4. Care Transitions Interventions in Mental Health
5. Transitional Care for People with Health and Behavioral Health Needs Leaving Incarceration

Diversion Intervention

1. Emergency Department (ED) Diversion
2. Community Paramedicine Model
3. Law Enforcement Assisted Diversion (LEAD)

Transitional Care and Diversion Interventions Implementation Timeline



Implementation Plan

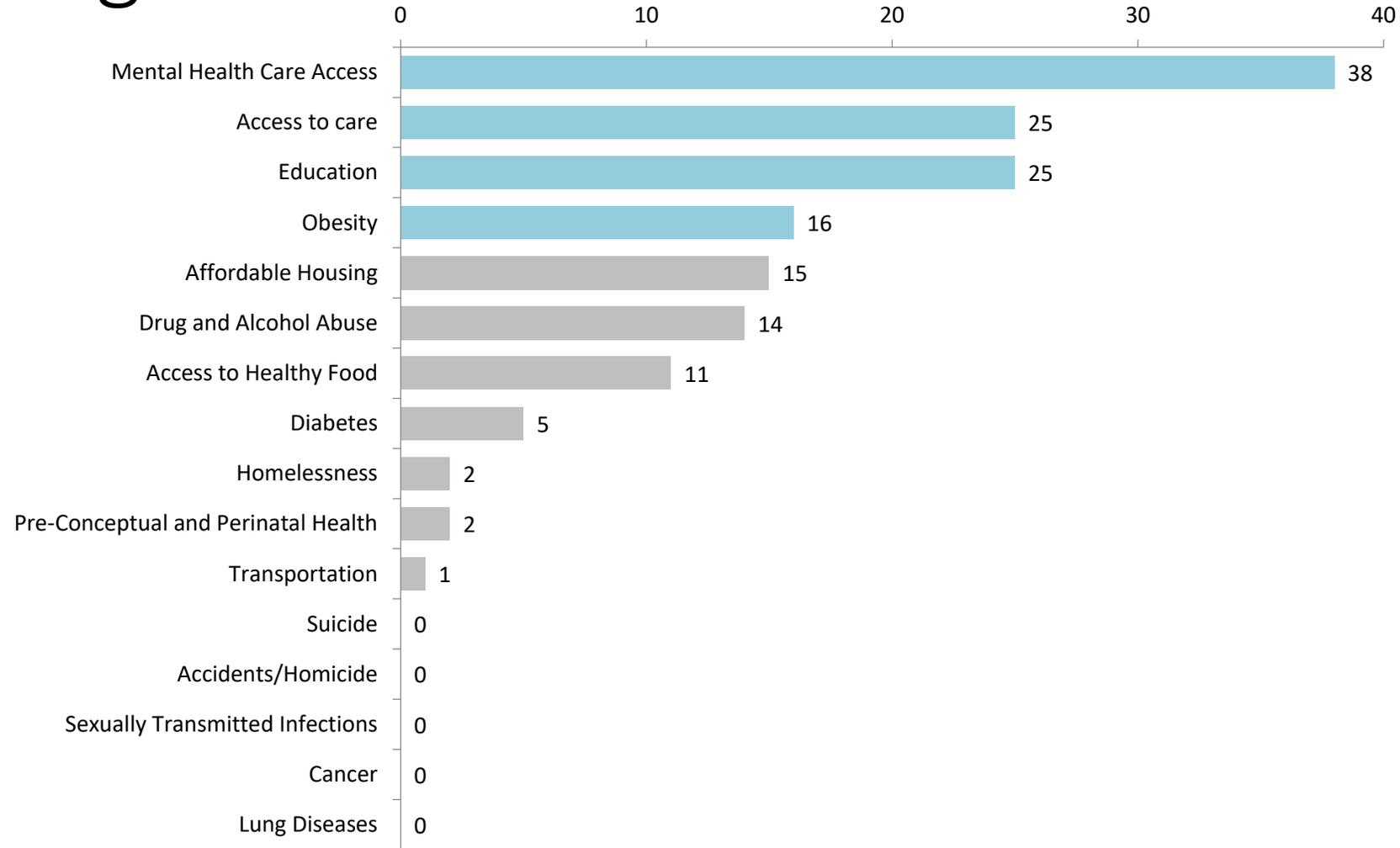
Minimum Requirements

- Implementation timeline.
- Description of selected evidence-based approach, target population, justification for how approach is responsive to specific needs in the region.
- If applicable, explanation of how the standard pathways selected in Project 2B (Pathways Community HUB) align with the target population and evidence-based approach selected in this project.
- Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts.
- Roles and responsibilities of implementation partners.
- List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely manner.
- Descriptions of service delivery mode, which may include home-based and/or telehealth options.
- Describe strategies for ensuring long-term project sustainability.

Data Preview

Transitional Care & Diversion Intervention Workgroup
10/24/2017 Meeting

Regional Health Needs



Medicaid Population Demographics

NCACH Region (N=94,009)

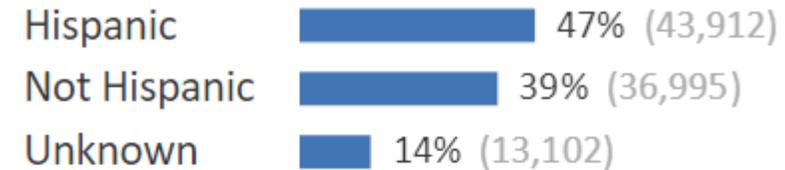
Age Group



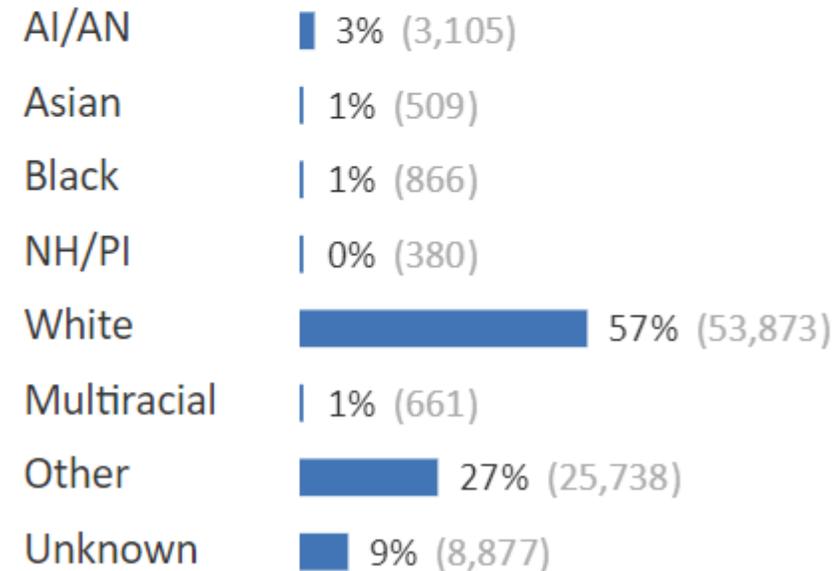
Gender



Ethnicity



Race



CHELAN

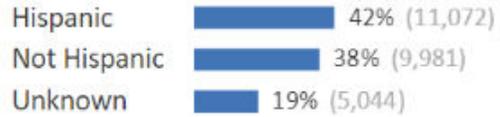
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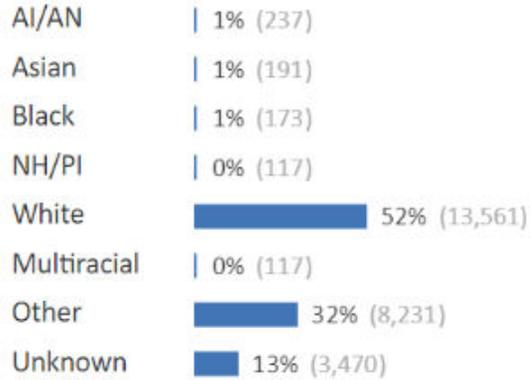
Gender



Ethnicity



Race



DOUGLAS

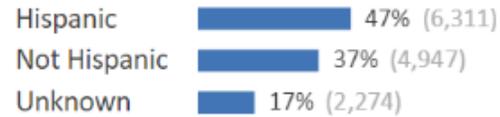
Age Group



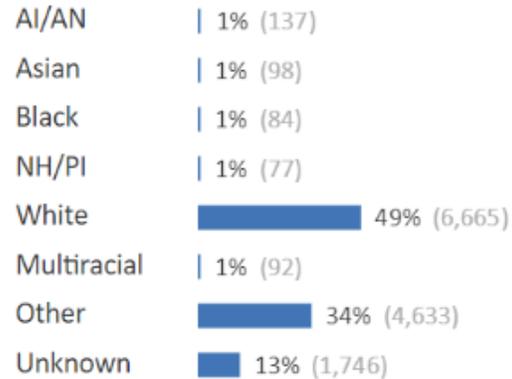
Gender



Ethnicity



Race



GRANT

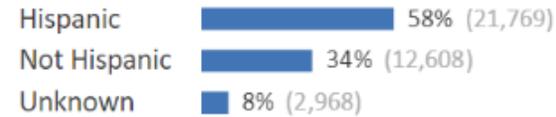
Age Group



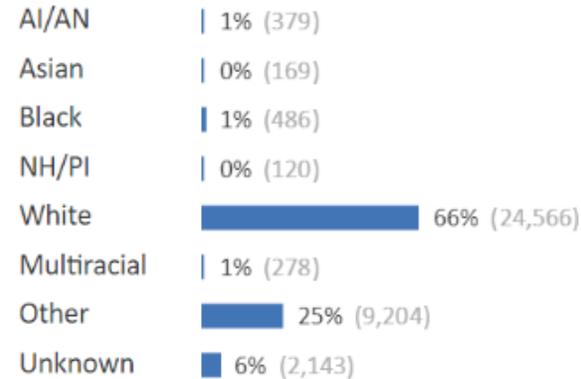
Gender



Ethnicity



Race



OKANOGAN

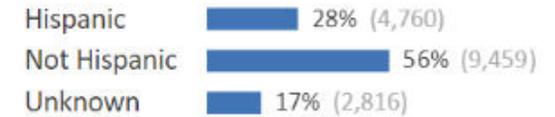
Age Group



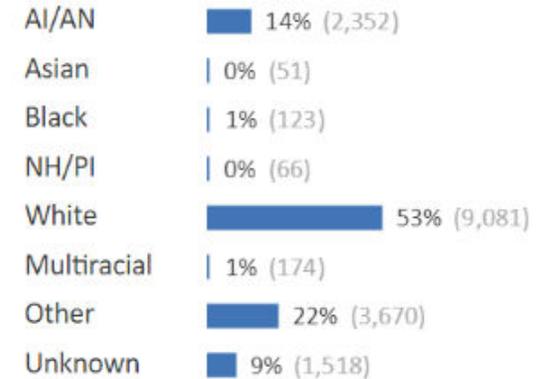
Gender



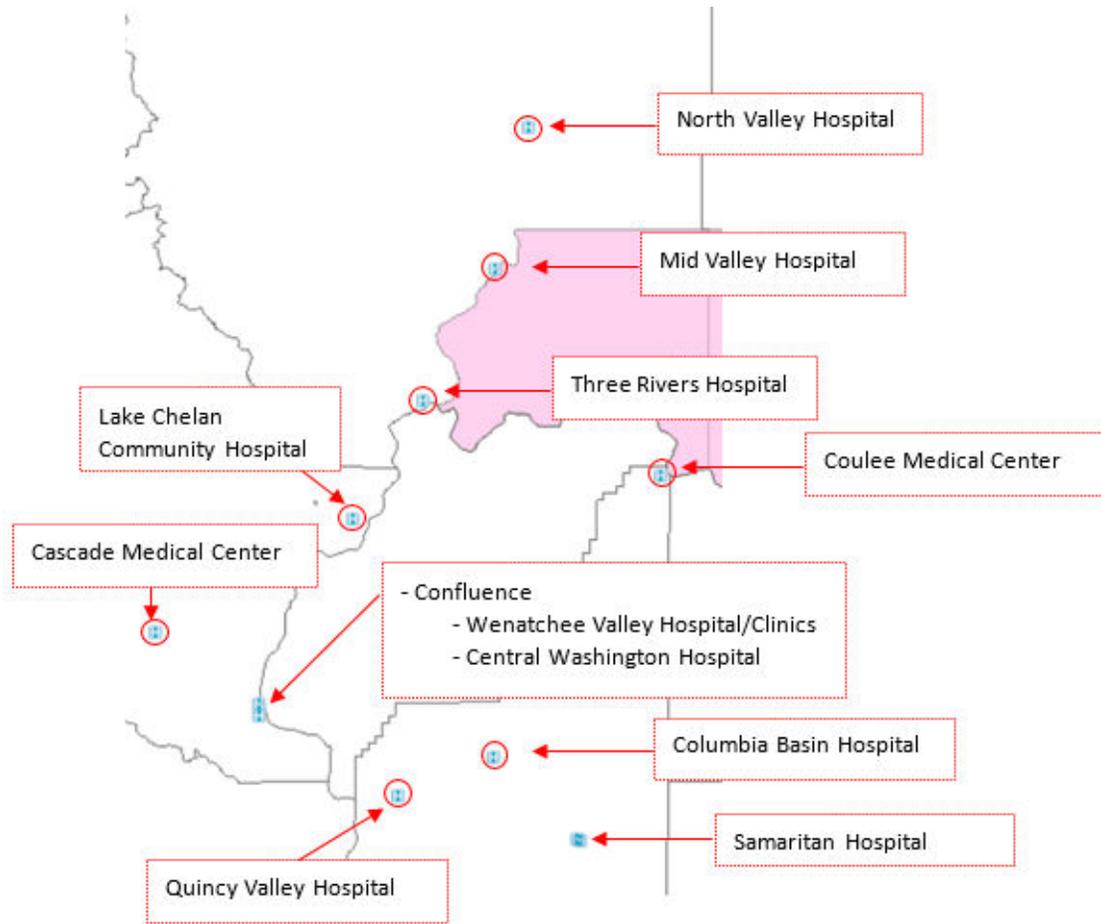
Ethnicity



Race



FY2016 Hospital Census



Hospital	# of Medicaid Discharges	Mean Length of Stay (days)
Cascade Medical Center	5	3.60
Columbia Basin Hospital	25	2.16
Confluence-Central WA Hospital	3,129	3.46
Confluence – Wenatchee Valley Hospital & Clinics	42	10.07
Coulee Medical Center	228	2.24
Lake Chelan Community Hospital	156	2.12
Mid-Valley Hospital	466	1.99
North Valley Hospital	175	2.35
Quincy Valley Medical Center	4	3.00
Samaritan Healthcare	1,233	1.98
Three Rivers Hospital	193	2.09

Source: Health Services and Resources (HRS) Map Tool
 Critical Access Hospitals circled in red

Source: Department of Health CHARS data | Measurement Period: 1/1/16 – 12/31/16

Top Ten Most Common Causes of Acute Hospitalizations Among Medicaid Recipients

Rank	Cause of Acute Hospitalization	Count	%	State Rank
1	Injury and Poisoning	266	12.1	2 (9.4%)
2	Mental and Behavioral Disorders	171	7.8	1 (18.2%)
3	Diseases of Heart	135	6.1	4 (5.7%)
4	Respiratory Infections	132	6.0	9 (3.6%)
5	Diseases of the Musculoskeletal System and Connective Tissue	115	5.2	5 (4.5%)
6	Substance Use Disorder	105	4.8	6 (4.6%)
7	Septicemia	105	4.8	3 (7.4%)
8	Cancer/Malignancies	102	4.6	8 (3.6%)
9	Diabetes	94	4.3	
10	Diseases of Liver, Biliary Tract, and Pancreas	84	3.8	7 (3.7%)

*Data for North Central ACH, Excluding Pregnancy and Child Delivery Related Hospitalizations (Jan 1, 2015 - Oct 31, 2015)
Source: Health Care Authority Starter Kit, determined by primary diagnosis field in HCA ProviderOne Medicaid Data System*

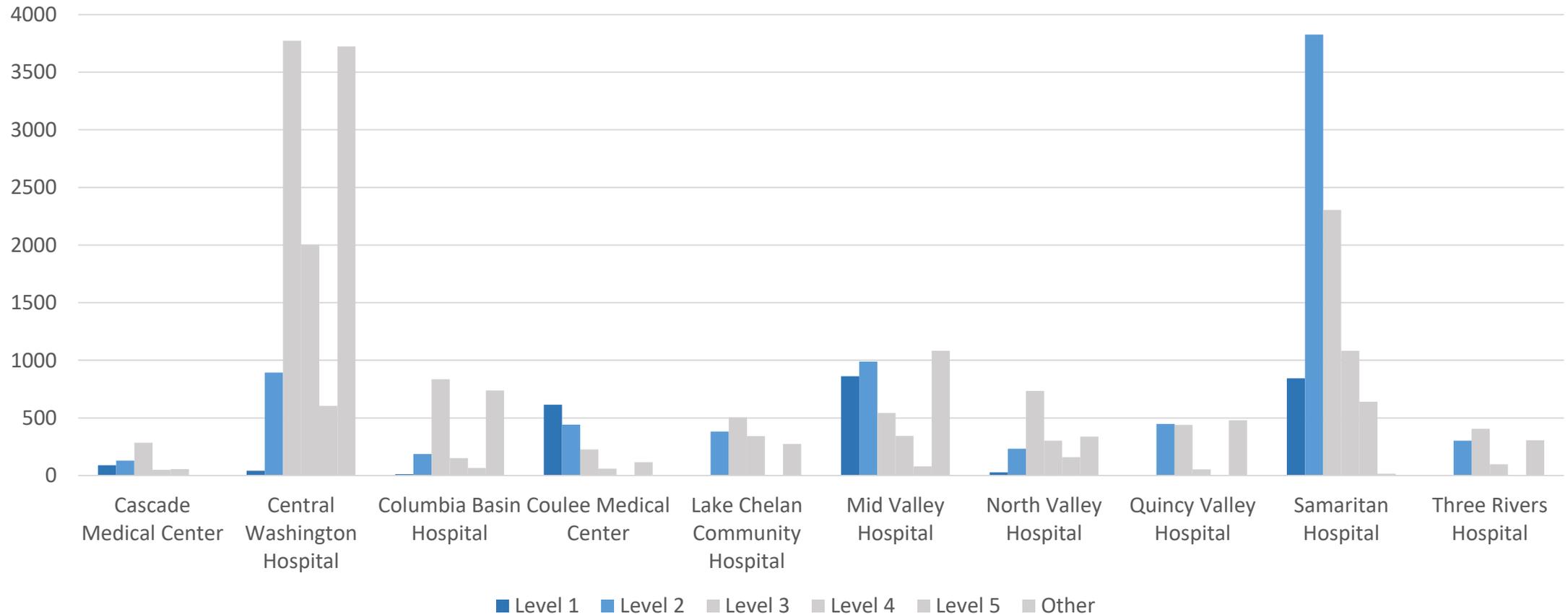
Top Ten Most Common Causes of Outpatient ED Utilization Among Medicaid Recipients

Rank	Cause of Acute Hospitalization	Count	%
1	Symptoms, signs & abnormal clinical and lab findings	8,007	24
2	Injury, poisoning, and certain other consequences of external causes	7,822	23
3	Diseases of the respiratory system	3,860	11
4	Diseases of the digestive system	2,169	6
5	Diseases of the musculoskeletal system and connective tissue	1,635	5
6	Mental and behavioral disorders	1,554	5
7	Diseases of the skin and subcutaneous tissue	1,423	4
8	Diseases of the genitourinary system	1,352	4
9	Pregnancy, childbirth and the puerperium	1,195	4
10	Infectious and parasitic diseases	1,104	3

*Source: Health Care Authority (ED utilization by Facility data set)
Data for North Central ACH (Oct 1, 2015 - Sep 30, 2016)*

ED utilization by Triage Levels

Counts by Hospital and Triage Level

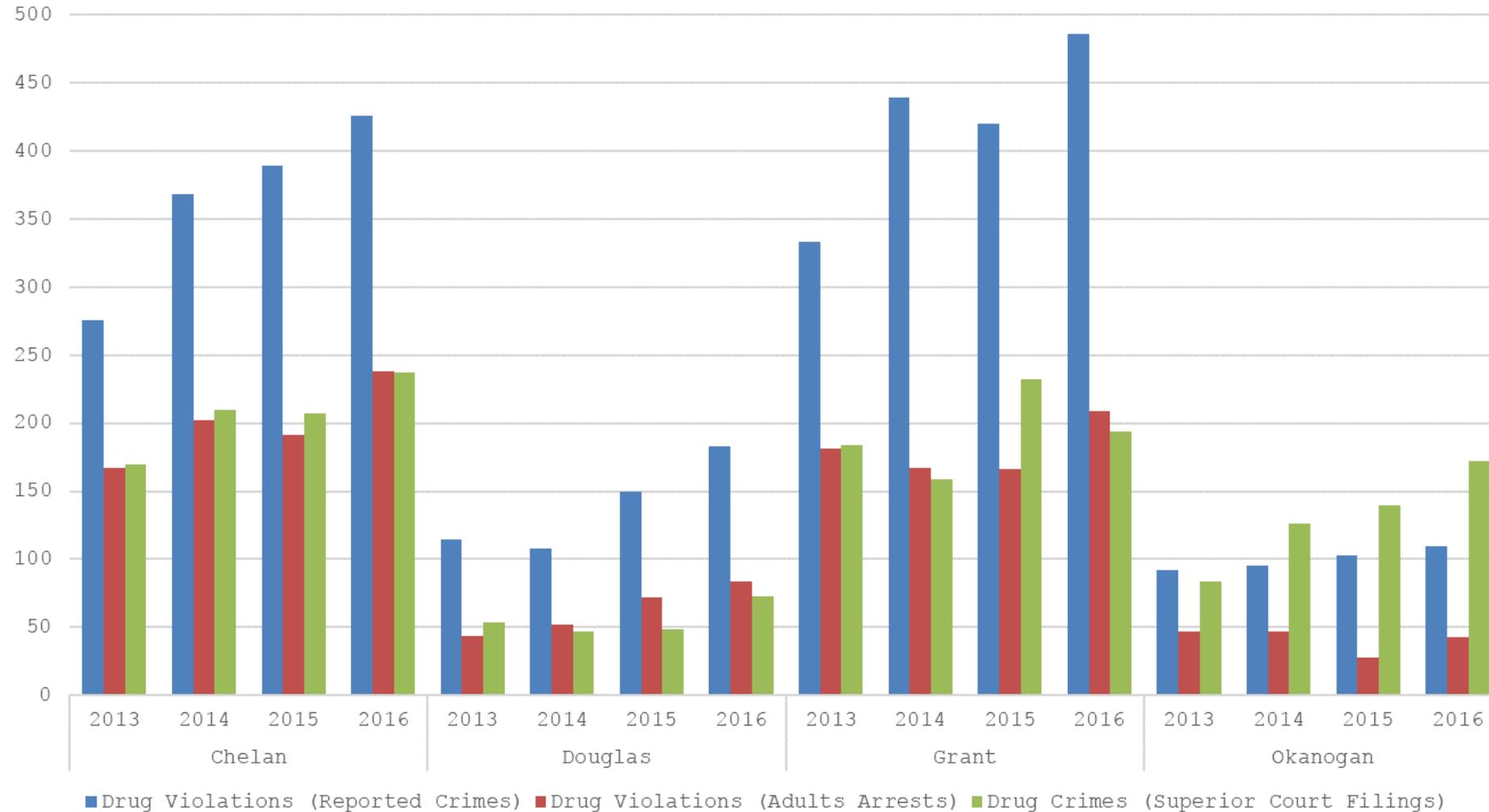


Source: Health Care Authority (ED utilization by Facility data set)

Note: Triage Levels based on CPT code groupings

Arrest/Incarceration Data

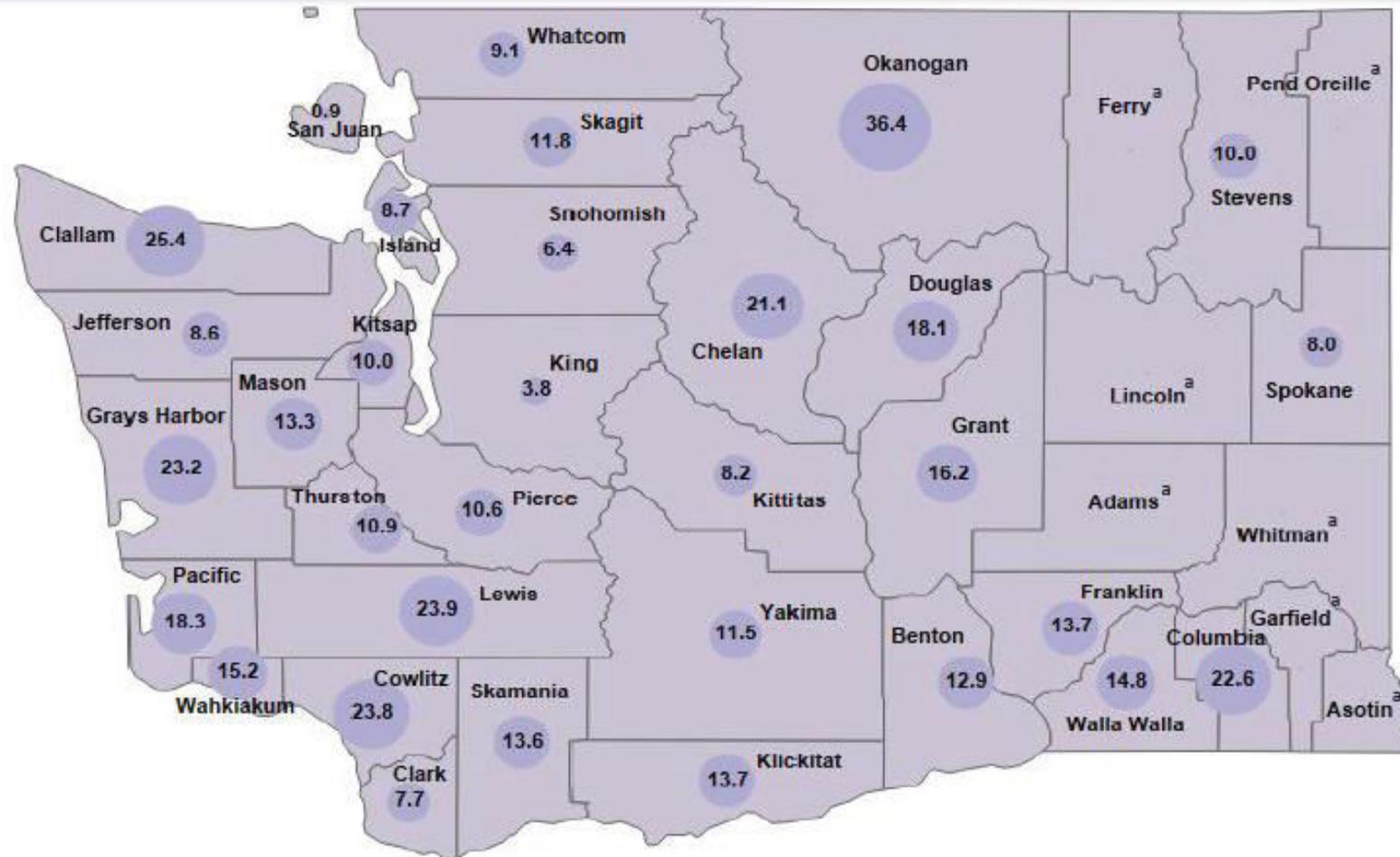
NCACH Criminal Justice Summary by County



Source: Washington State Statistical Analysis Center County Profiles

Youth Detention Rates

Figure 3. Youth-Level Detention Rates by County. This figure shows the number of youth (per 1,000 youth age 10-17 in the county) who had at least one detention stay in 2016.

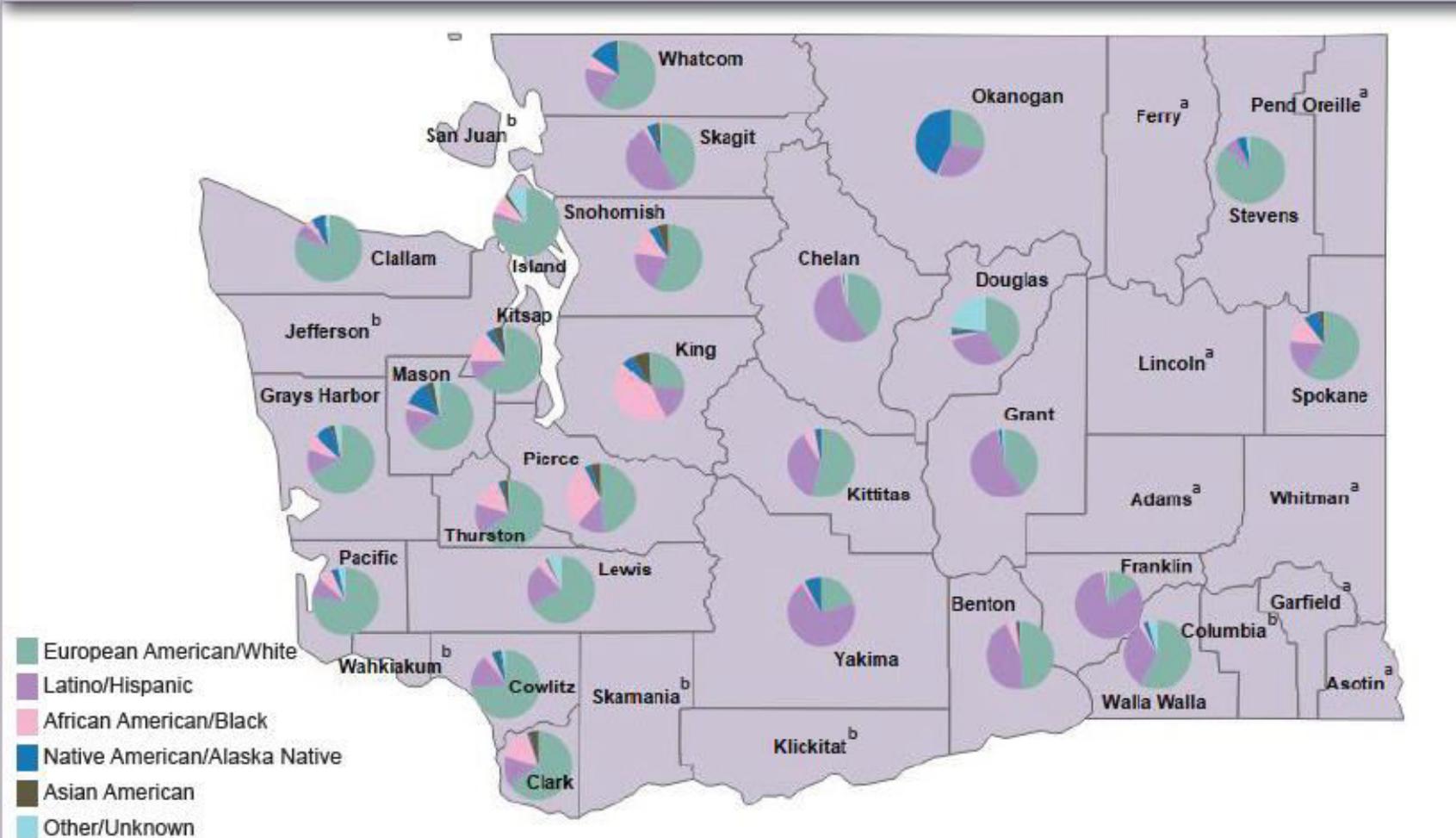


^aDetention data were not available for the full 2016 calendar year from these counties.

Source: Washington State Center for Court Research (Juvenile Detention 2016 Annual Report)

Youth Detention Rates

Figure 5. Youth in Detention in 2016 by Race/Ethnicity and County. This figure shows the racial/ethnic breakdown of youth who had at least one detention stay in 2016.

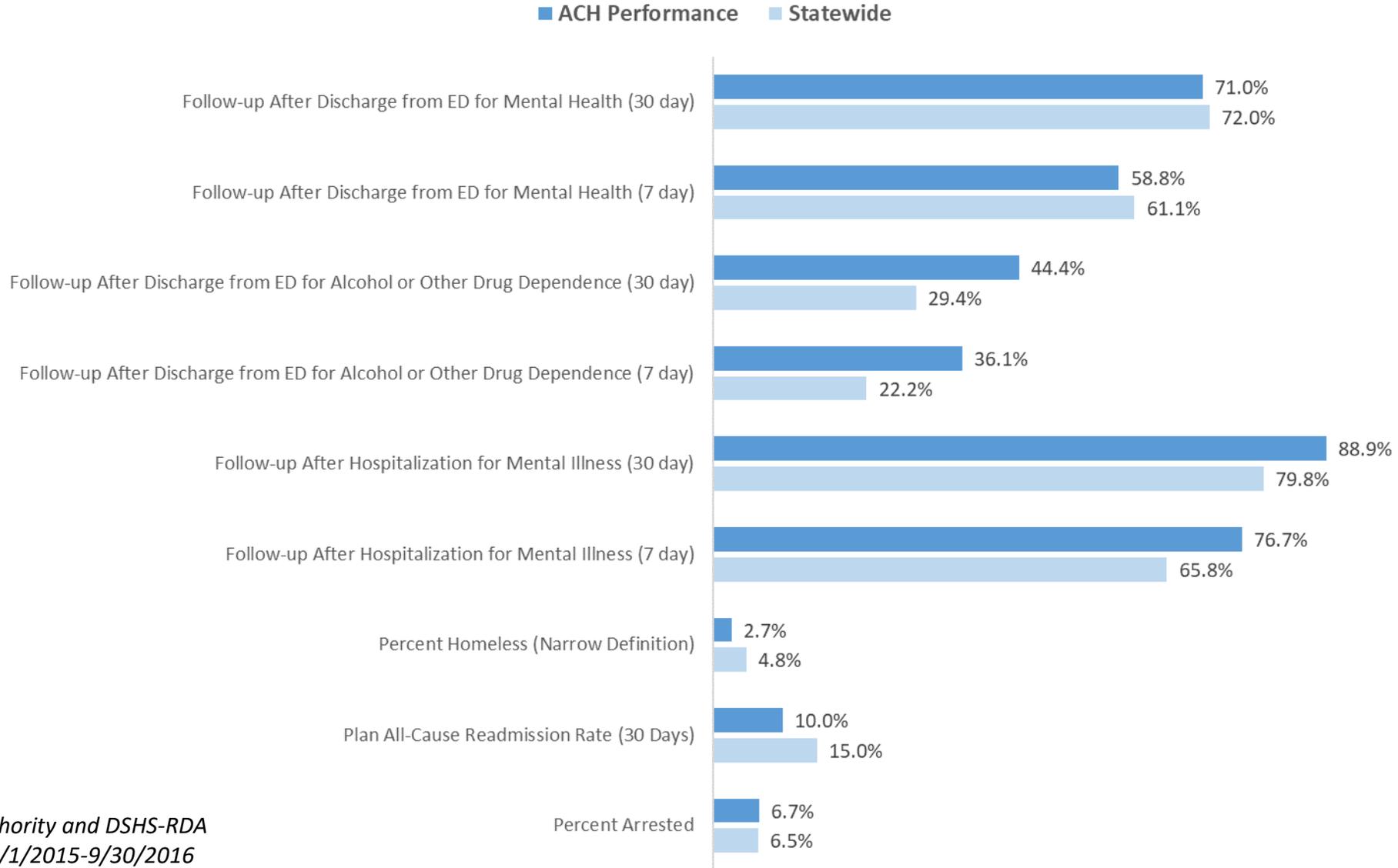


^aDetention data were not available for the full 2016 calendar year from these counties.
^bThese counties' rates are excluded because they had fewer than 30 youth in detention in 2016.

Source: Washington State Center for Court Research (Juvenile Detention 2016 Annual Report)

Accountability Measures

Transitional Care & Diversion Interventions



Source: Health Care Authority and DSHS-RDA
Measurement period 10/1/2015-9/30/2016

Risk Factors for ED Utilization

Risk Factor	X times more likely to exhibit risk factor, if have 3+ ED visits		
Hematological	8.85 (extra high)	4.3 (medium)	4.3 (low)
Type 1 diabetes (high)	7.2		
Pulmonary	6.8 (very high)		4.7 (medium)
Cardiovascular	6.6 (very high)		4.1 (medium)
Renal (extra high)	6.0		
Co-occurring mental illness/substance use disorder	5.2		
Substance abuse (low)	4.8		

Risk Factors for Arrests

Risk Factor	X times more likely to exhibit risk factor, if have 3+ ED visits
Substance abuse - low (drug abuse/dependence)	6.5
SUD treatment need	5.4
Co-occurring mental illness/substance use disorder	4.8
Substance abuse – very low (alcohol abuse/dependence)	3.4
HIV (asymptomatic infection)	3.0
Psychiatric – high (schizophrenia)	2.7
Psychiatric – medium (bipolar)	2.6

Feedback from CHIS

Implications for Transition Care	Implications for Diversion Interventions
Release to homelessness (lack of affordable housing, rigid transitional housing, lack of wet/low barrier shelters)	Ranked order of needs for client populations served by CHI members (both medical and social service providers) <ol style="list-style-type: none"> 1. Non-acute ER use (no same day appointments, nighttime access) 2. Mental health and substance abuse challenges a big issue 3. Inappropriate use of EMS
Need follow up post release (primary care, coaching, patient education, follow up phone calls)	Low health literacy
Referrals to other community resources (non-medical) – need to match to biggest issue	No access to care (in clients’ minds) – don’t know how to access services, lack system navigator, transportation
Legal barriers post incarceration	Lack of coordination of services
Lack of interagency planning	Contact with law enforcement often symptom of lack of engagement with social service network
Lack of system supports (overwhelming, systems not well explained)	
Discharge instructions should be written at 3 rd grade level	

Feedback from CHIs

Data Requests

- Where do ED utilizers (including high utilizers) live? (zip code frequencies and mapping)
- For *Outpatient ED visits* measure from HCA, could we get demographic breakouts?
- For top reasons for hospitalization, can we get data by county?
- Is there aggregate information we could request from WSHA (EDIE) that would help with project planning?
- Can we get measure rates for projects broken out by county?
- **What else would you like to add?**

Feedback from CHIs

Questions / Thoughts

- Is there a way to increase primary urgent care to avoid ER visits? Is there capacity with such few providers? (workforce implications)
- Need to recognize that rural areas with no urgent care clinics may have not other option than ER (e.g. Okanogan County)
- Provide more health literacy course for parents who are taking children to ER
- There is misuse of EMS for non-emergent transport to services
- **What other questions or thoughts do you have?**

Project Reporting Measures

- Report against QIP metrics
- Number of partners trained by selected model/approach: projected vs. actual and cumulative
- Number of partners participating and number implementing each selected model/approach
- % partnering provider organizations sharing information (via HIE) to better coordinate care
- % of partnering provider organizations with staffing ratios equal or better than recommended (Diversion only)
- VBP arrangement with payments/metrics to support adopted model (2021 only)

Project Performance Measures

Transitional Care

- Antidepressant Medication Management
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization
- Medication Management for People with Asthma (5 – 64 Years)
- Mental Health Treatment Penetration (Broad Version)
- **Outpatient ED Visits per 1000 Member Months**
- **Plan All-Cause Readmission Rate (30 Days)**
- Substance Use Disorder Treatment Penetration
- **Percent Homeless (Narrow definition)**
- Percent Arrested
- Medication Assisted Therapy (MAT): With Buprenorphine or Methadone
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
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- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

Project Performance Measures

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Next Steps – Project Planning

Project Plan Application Due November 16th

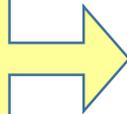
- Preliminary Evidence based Approaches and Target Populations
- Signed Membership Agreement (email to john.Schapman@cdhd.wa.gov)

Project Implementation Planning Timeline

- Read Evidence Based Approaches & review data for Target Populations
- Ensure Alignment with other Demonstration Projects

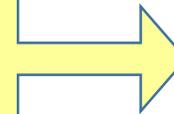
Nov 2017 – Feb 2018

- Assess current state capacity
- Select Target population
- Select Evidence-Based Approach



March 2018 – June 2018

- Identify implementation partners and binding letters of intent
- Financial Sustainability, Workforce, Population Health Management strategies



June 2018 – Sept 2018

Completed
Implementation Plan
***Prefer completion by
July 2018***



North Central Accountable
Community of Health

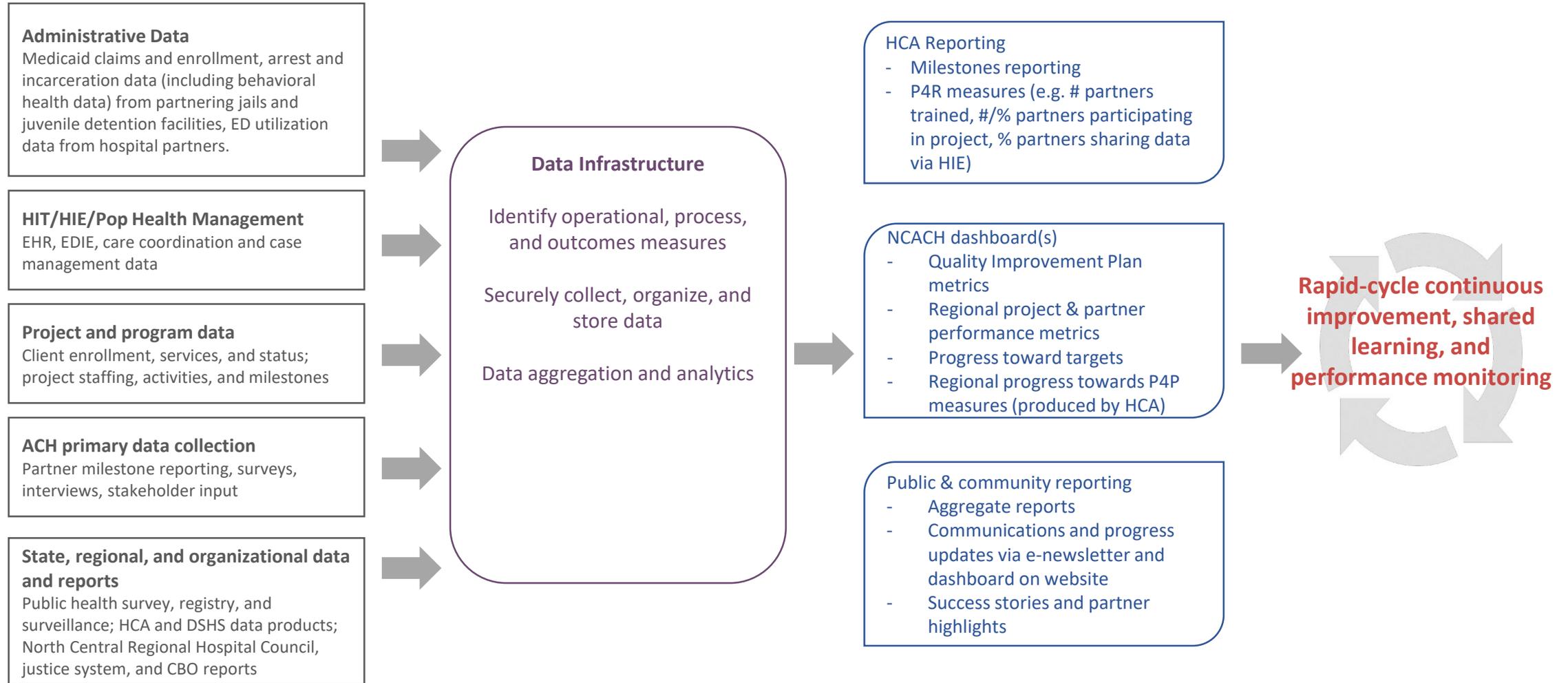
Contact

John Schapman

Transitional Care and Diversion Interventions Project Lead

email: john.Schapman@cdhd.wa.gov

Planned Approach for Monitoring and Continuous Improvement



SECTION II: PROJECT-LEVEL – Diversion Interventions

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

Transformation Project Description

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

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

Project Selection & Expected Outcomes

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

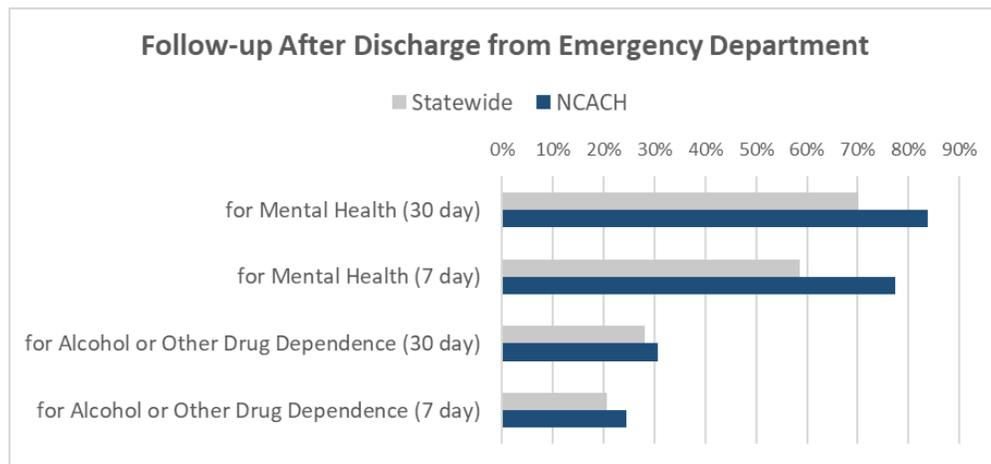
Describe the rationale for project selection, and the expected outcomes. In the narrative response, address the following: (2,000 words)

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

ACH Response

Rationale:

Data for the North Central Accountable Community of Health (NCACH) region in 2016 showed that only 24.5% of Medicaid enrollees 18 years of age with a primary diagnosis of alcohol or other drug dependence received follow-up within seven days of discharge from the emergency department for their alcohol and drug health issues (compared to 77.3% for enrollees with a primary diagnosis of mental health), and only 30.6% of Medicaid enrollees with a primary diagnosis of alcohol or other drug dependence received follow up within 30 days (compared to 83.9% for mental health)¹. While these are not direct performance measures for our Diversion Interventions Project, they do indicate inconsistency in coordination of care as patients move across settings and an opportunity for our diversion efforts to target areas of need.



Source: DSHS Research and Data Analysis, "ACH Toolkit Historical Data" file. Based on 2016 data.

In addition, access to behavioral health care is a challenge. There are no designated psychiatric inpatient beds in the NCACH region, despite the fact that mental and behavioral health diagnoses are the second leading cause of acute hospitalizations². The region's 2015 rates of mental health treatment penetration (40.5%) and substance use disorder treatment penetration (22.2%) are below the state averages (42.9% and 26.7%, respectively)³. This suggests that there are Medicaid members who need treatment yet do not have adequate access to care.

¹ DSHS Research and Data Analysis, "ACH Toolkit Historical Data" file. Based on 2016 data.

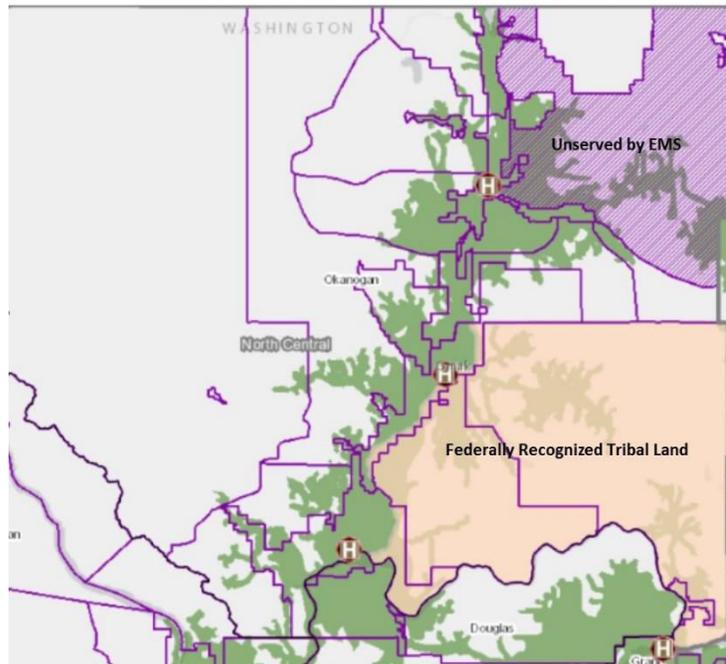
² HCA RHNI Starter-Kit, "Top Ten Most Common Causes of Statewide Acute Hospitalizations Among Medicaid Recipients, Excluding Pregnancy and Child Delivery Related Hospitalizations, During Jan 1, 2015-Oct 31, 2015".

³ DSHS Research and Data Analysis, "ACH Toolkit Historical Data" file. Based on 2015 data.

The information above highlights why access to care has been identified as a priority for NCACH in multiple assessments and community surveys, including the regional Community Health Needs Assessment (CHNA) completed in December 2016. The CHNA identified insufficient numbers of providers, travel distance to health care providers, and lack of providers willing to accept Medicaid and Medicare (especially among dentists) as key barriers to accessing care. In fact, many low-income and Department of Social and Health Services clients live in more rural and distant parts of the four counties included in the NCACH’s large and agricultural region. For example, in Chelan and Douglas counties, lower density, outlying areas (including un-incorporated parts of the counties) contain a disproportionately large share of the disabled and elderly⁴. Due to inflated housing costs, lower income families move further out into the more distant/affordable areas of the county where they have to travel longer distances for work and social or medical services. The need to serve low-income, disabled, and elderly populations residing outside of established public transit services is a challenge identified in all of three of our regions’ Human Services Transportation Plans⁵.

These access barriers are further highlighted in the Health Resources and Services Administration (HRSA) workforce data. HRSA data shows three out of four counties in our ACH region are designated as Medically Underserved Areas/Populations (Okanogan, Douglas, and Grant), and our entire region is designated as a Health Professional Shortage Area (HPSA) for dental health, mental health, and primary care⁶. This is further highlighted by the fact that there are large gaps within our region where residents live greater than 30 minutes from a hospital entity⁷.

However, NCACH has a number of Emergency Medical Service (EMS) providers that are spread



Okanogan County provides is an example of where there are large amounts of county land that is further than 30 minutes from a hospital (Green space = 30 minute drive time). A majority of tribal land in NCACH falls into this category.

Source: Washington State Department of Health, “EMS and Trauma Hospital Designations and Responses Areas.”

<https://fortress.wa.gov/doh/eh/maps/EMS/index.html>

⁴ Human Services Transportation Coordination Plan for Chelan & Douglas Counties (2014 Update).

⁵ Based on Human Services Transportation Plans released in 2014 by the three Regional Transportation Planning Organizations (RTPOs) in our region. Prominent needs and gaps highlighted in all three plans involve rural non-emergent medical service transportation and cross jurisdictional transportation for employment and medical services.

⁶ NCACH Community Health Needs Assessment: http://www.cdhd.wa.gov/Health%20Data/Docs/2016_Chelan-Douglas_Health_District_CHNA.pdf

⁷ Washington State Department of Health, “EMS and Trauma Hospital Designations and Responses Areas.” Retrieved from <https://fortress.wa.gov/doh/eh/maps/EMS/index.html>

across the region. This is a pre-established group of staff and volunteers that could be trained to provide additional support to residents in rural setting. Specifically, EMS providers in the NCACH region have 1390 EMTs, first responders and paramedics (389 staff and 1001 volunteers) that are located in the following areas⁸:

- 48 EMS agencies in Chelan/South Douglas counties
- 17 EMS agencies Okanogan/North Douglas counties
- 17 EMS agencies Grant County

There are opportunities to promote more appropriate use of emergency care services and person-centered care. For example, in the last three year interval (2014-2016), total 911 calls in the Methow Valley ranged from 543 to 612 with 157 to 222 (~29-36%) being non-transports. In the majority of these non-transport cases, the patient's needs could readily be managed at home via consult with the emergency department physician, home healthcare nurse, or their primary provider. In addition, in 2015 and 2016, Aero Methow Rescue Service ambulances had multiple responses for 50 patients, ranging from four to 15 total responses per patient. With an expanded and structured Community Paramedicine program, EMS staff could better care for these patients within their home and increase the likelihood of EMS providers receiving reimbursement for these services.

Coordinated processes for emergency department (ED) diversion, in collaboration with both an established Pathways Community HUB (Care Coordination Project) and a Community Paramedicine program will assist in reducing the likelihood of continued ED utilization for the patients within the NCACH region. The Diversion Interventions Project will also work directly to address Domain I workforce development strategies and access to care issues by training an already existing workforce in the regions (paramedics) to provide patient care in traditionally underserved regions where primary care workforce shortages exist. Improved ED diversion will also train existing ED staff to link well with the Pathways Community HUB (Care Coordination Project) to reduce readmission rates.

Coordinated Services:

To ensure there is no duplication in services, NCACH will share project details with the major regional provider councils that directly provide diversion intervention services and coordinate with our local coalitions to gain a better understanding of what is occurring in each community. In NCACH, the four main councils/coalitions we will work with include:

1. North Central Regional Hospital Council

A council of all hospital CEOs that meet every other month to address pressing needs of each hospital and areas where the region can collaborate on patient care. This group will help NCACH directly connect with ED managers in all the regional hospitals.

2. North Central Emergency Care Council

A regional council of the EMS providers, this group meets monthly to address the projects that are occurring with EMS providers across the region. NCACH will stay connected with this group to help identify agencies currently completing community paramedicine programs and agencies who are interested in initiating programs in the region.

⁸ North Central Emergency Care Council Presentation, September 24th, 2014 (<http://ncecc.net/wp-content/uploads/2012/03/NCECC-Presentation-2014-09-241.pdf>)

3. Behavioral Health Law Enforcement Meeting

This is a meeting of all law enforcement (police chiefs and sheriffs) within the current North Central Washington Behavioral Health Organization's service area. This group meets approximately every two months to address law enforcement issues related to mental health. NCACH staff plans to attend meetings to share details on the Diversion Interventions Project (specifically as they address law enforcement) to ensure we can enhance the current work occurring within this sector.

4. NCACH's Coalitions for Health Improvement (CHIs)

The Transitional Care and Diversion Interventions Workgroup will continue to work with NCACH staff and the local Coalitions for Health Improvement (CHIs) to ensure duplication does not occur. The CHIs are local coalitions, started by NCACH, in each of the three local health jurisdictions (Chelan-Douglas, Grant, and Okanogan). These broad-based CHIs are open to all members in the community and serve two main functions associated with the work of the Diversion Interventions Project:

1. Provide input on the selected and approved approaches chosen in the Medicaid Demonstration Project Toolkit including identifying areas within their community where existing efforts exist.
2. Collaborate with the Transitional Care and Diversion Interventions Workgroup to better engage local providers in the work of diversion interventions and utilize the Demonstration to enhance diversion efforts in the community.

Working with these coalitions and councils, NCACH will develop a status report in quarter 3 of 2018 of what initiatives are currently occurring in the region, what initiatives organizations plan to implement in the next two to three years, and how the Diversion Interventions Project can enhance the work that is occurring in the region. NCACH will also develop a matrix of how all Demonstration projects connect to each other to ensure that we do not duplicate services across the six NCACH selected projects.

Anticipated Scope of the Project:

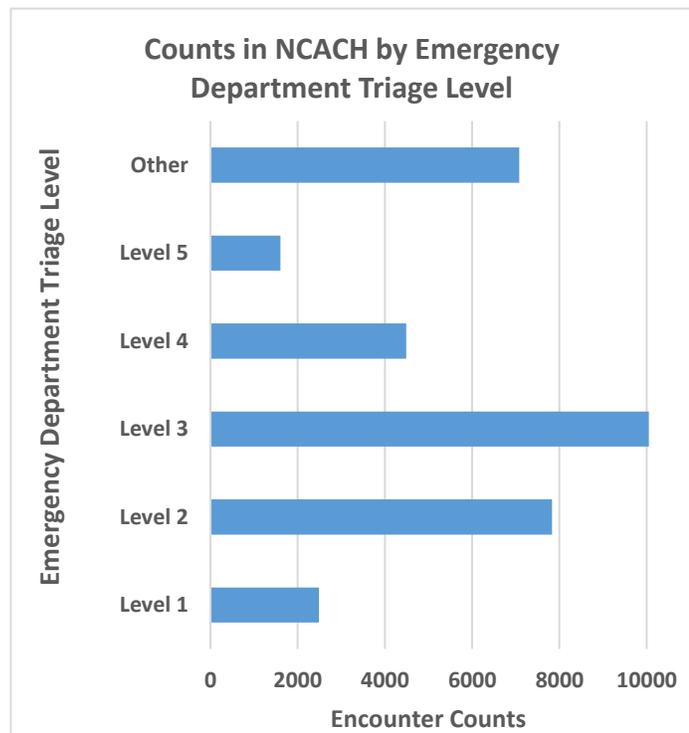
Currently, NCACH has a wide range of partnering providers. Specific to the charter, NCACH has representation on its Transitional Care and Diversion Interventions Workgroup from the following sectors:

- Emergency medical services
- Law enforcement
- Legal and court services
- Regional justice centers (jails)
- Hospitals
- Skilled nursing facilities/assisted living/long-term care facility/hospice
- Aging and adult care
- Care coordination agencies
- Managed care organizations (*Operating in all four NCACH counties after January 1, 2018*)
- Behavioral Health Administrative Service Organization
- Behavioral health providers including crisis providers
- Primary care providers
- Care coordination agency/case managers
- Education
- Tribal

- Transportation
- Housing

These providers all have direct interactions and ability to improve the metrics of patients who go in and out of the EDs for non-acute reasons, or for acute reasons that could have been avoided by providing proper coordination of health services. An example of this is the criminal justice system. Discussing incarceration transitions in coordination with ED diversion will ensure inmates leaving the criminal justice system can be connected with appropriate services (potentially through the Care Coordination Project), to ensure they are receiving the medical care and social services they need to maintain their health. Social service providers, such as housing and transportation, provide insight on the additional issues patients are facing to taking better care of their health. Stable housing and adequate transportation to preventative appointments will help reduce the likelihood of an individual being readmitted to the ED.

NCACH chose two initial evidence-based approaches (ED diversion and community paramedicine) and two target populations for our “preliminary target groups” that we will review further with our Transitional Care and Diversion Interventions Workgroup from quarter 4 of 2017 to quarter 2 of 2018, prior to finalizing the exact approach our region will choose when we submit our project implementation plans in quarter 3 of 2018. Specific to ED utilization, NCACH’s preliminary target population is Medicaid beneficiaries presenting to the ED for non-acute conditions. Specific to community paramedicine, NCACH’s preliminary target population is Medicaid beneficiaries who access EMS services for non-acute issues. To consider how NCACH will further outline the level of impact from these potential target populations over the course of the next eight months, NCACH’s Transitional Care and Diversion Interventions Workgroup will look at data across the region. In October 2017, the workgroup looked at initial data on ED utilization by triage levels (see Diversion Interventions Project - Attachment A). In 2016, 10,320 visits were listed as level 1 and level 2 triage levels when they were admitted to local hospitals in the NCACH region. The largest portion of these admits occurred in the Grant County area (5,925 or 57%)⁹. Level 1 and 2 triages are considered ED visits that could have been treated in a less intensive care setting. NCACH will utilize these populations as overall populations that will be further refined as we plan



Source: HCA-AIM data product delivery, “ED Utilization of Medicaid Recipients Using Hospitals in North Central During Oct 1, 2015-Sep 30, 2016”

⁹ HCA-AIM data product delivery, “ED Utilization of Medicaid Recipients Using Hospitals in North Central During Oct 1, 2015-Sep 30, 2016”

and implement projects.

The good news is that we are the top performing ACH based on *Follow-up After Discharge from ED for Mental Illness* measures (for both seven-day and 30-day measures)¹⁰. While this indicates an area of strength relative to other ACHs, we have room for improvement when it comes to following up for alcohol and drug dependence. Those rates, compared to the mental health measures, are much lower, and they dropped between 2015 and 2016 (we were the top performing ACH in 2015 and ranked fourth in 2016). In 2016 in the NCACH region, only 24.5% of Medicaid enrollees 18 years of age and older with a primary diagnosis of alcohol or other drug dependence received follow-up within seven days of discharge from the emergency department for their alcohol and drug health issues (compared to 77.3% for enrollees with a primary diagnosis of mental health). And only 30.6% of Medicaid enrollees with a primary diagnosis of alcohol or other drug dependence received follow up within 30 days (compared to 83.9% for mental health)¹¹. NCACH will initially review targeting the alcohol and drug dependence primary diagnoses patients in the region. This population can provide NCACH with a targeted population within this work of approximately 200 individuals, and NCACH will further identify if there are any alcohol or drug related ED visits where the secondary diagnose is alcohol or other drug dependence. Though NCACH is above the state average for follow-up after discharge from the ED for mental illness in comparison to statewide measures, NCACH regional partners believe that mental health is a major regional issue and NCACH will also review ED diversion intervention strategies for follow up for people with mental illness at the ED.

Specific to Community Paramedicine, NCACH gathered data from six EMS agencies in the NCACH region (Aero Methow, American Medical Response in Grant County, Ballard Ambulance, Cascade EMS, Lake Chelan EMS, and Moses Lake Fire). Those agencies reported 12,863 total 911 calls in 2016, with 5,467 (43%) of those calls classified as non-emergent. When NCACH further broke down the non-emergent calls, 2,572 (47%) of those calls were non-emergent transports and 2,895 (53%) of those calls were non-transports. When we evaluate this data geographically, Chelan and Douglas counties had the largest percentage of non-emergent calls (75%). The NCACH preliminary target population are those individuals who utilize the EMS system for non-emergent situations (5,467). This initial number will likely increase as NCACH connects with additional EMS facilities within the region in quarter 1 of 2018 and gather additional data on the number of non-emergent calls to EMS providers.

Finally, as NCACH develops the final project design, NCACH workgroups will ensure that health equity is considered in the project plans and implementation. More Medicaid enrollees in the region identify as Hispanic compared to the state average (47% and 21%, respectively). In Okanogan County, 14% of the Medicaid population identify as Native American¹². As we review data to refine each project's target populations, we will review where geographically we can implement projects that will help close gaps in health disparities, what projects we can initiate that will specifically target those identified health disparities, and how we include cultural considerations into the direct implementation and planning of those targeted populations. A specific example is a regional 24/7 nurse call line to reduce non-acute ED visits. NCACH will review how this service can be staffed with individual staff and/or translation services to assist non-English

¹⁰ DSHS Research and Data Analysis, "ACH Toolkit Historical Data" file. Based on 2016 data.

¹¹ Ibid.

¹² Healthier Washington Dashboard, Population Explorer Tab. Measurement Period Oct 2015 – Sept 2016.

speaking residents.

NCACH maintains guiding principles in the development of all their project plans that will ensure that we do not only complete short-term projects that improve the lives of a small population, but transform systems that will last past the five years of the Demonstration. Some of those core principles are:

- **Sustainability:** It is NCACH's firm policy not to fund service delivery costs or other operations costs for service providers, or for other project activities, except in the context of a project plan leading to sustainability in the absence of Demonstration funds after 2021.
- **Embed Domain I Activities into Projects:** Value-Based Payment (VBP), workforce and systems for population health management improved through the Diversion Interventions Project will also enhance health system interoperability for all Medicaid beneficiaries who come into contact with diversion intervention organizations partnering providers.
- **Connection with all Demonstration Projects:** The Diversion Interventions Project will connect with the additional five NCACH selected projects. This alignment between all projects will ensure Diversion Interventions Project work does not only impact the narrow population outlined in the project plan, but interrelates to all Medicaid beneficiaries across the different projects.
- **Social Service Connection:** To the greatest extent possible, Diversion Interventions Project must connect patients with resources to mitigate the negative consequences of the social determinants of health.

Implementation Approach and Timing

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

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

Partnering Providers

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

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

implementation of the project.

Based on the ACH's selected projects, fill in the appropriate **Partnering Providers tab of the ACH Project Plan Supplemental Data Workbook**. Suggested sub-section word count does not pertain to partnering provider list. Include:

- Organization name
- Organization type
- Organization address
- Organization phone number
- Organization website (if applicable)
- Organization e-mail address
- Brief description of organization
- Employer Identification Number (EIN)
- Medicaid Provider ID (if applicable)

Describe engagement with partnering providers. In the narrative response, address the following: (500 words)

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

ACH Response

Partner Engagement:

Given the overarching target population of the Demonstration, our workgroups know that they are charged with focusing on the Medicaid population. Their recommendations around project implementation and funding will target providers with a shared vision of serving this population, while also promoting broader improvements to processes and systems involved in transitional care. This is critical, since it is the on-the-ground activities and practices of our healthcare providers and community-based organizations that will drive improvements to the Medicaid-specific metrics selected and measured by the Washington State Health Care Authority.

NCACH has established a Transitional Care and Diversion Interventions Workgroup to develop a comprehensive implementation plan for the Diversion Interventions Project. In this process, NCACH has engaged Federally Qualified Health Centers (FQHCs), physical health care providers, behavioral health providers, Managed Care Organizations (MCOs), skilled nursing facilities, home health, education, public health, hospitals (large systems and Critical Access Hospitals), the criminal justice system, law enforcement, community-based organizations, and local government. We have ensured that each of the above mentioned sectors are a part of the Transitional Care and Diversion Interventions Workgroup. However, NCACH staff will routinely connect with additional partners serving the Medicaid population through key informant interviews and regional meetings. As the list of partnering providers involved in implementation becomes clearer, we plan on asking them to assert

their commitment to serving the Medicaid population in our funding agreements.

Through the local CHIs the Transitional Care and Diversion Interventions Workgroup will also utilize local leadership to identify those partners in each jurisdiction, especially community-based organizations that serve the Medicaid population. Additional work will need to be done during planning and implementation to ensure partnering providers are consistently engaged in each of the counties through local implementation efforts.

In terms of medical and behavioral health providers, NCACH is actively working with the partnering providers that serve the majority of Medicaid clients. Through our work to become a mid-adopter for Fully-Integrated Managed Care (FIMC) and the Whole Person Care Collaborative (WPCC), NCACH has developed close relationships with our partnering providers that we are able to leverage in the Diversion Interventions Project efforts. The WPCC is made up of all major primary care and behavioral health care providers serving Medicaid beneficiaries in our region. In addition to the clinical providers, NCACH has engaged many community-based organizations and local governmental agencies that, based on their mission or nature of their work, tend to serve the Medicaid population in higher proportion than the general public. As implementation progresses, it will be imperative for NCACH to ensure that these partners continue to serve the Medicaid population, verified through claims data collection provided by the Washington State Health Care Authority's Analytic, Interoperability, and Measurement (AIM) team and analyzed by NCACH staff, if we are going to positively impact the Medicaid population and reach our performance targets.

Partners Who Serve Medicaid Clients:

Specific to Diversion Interventions Project programs, the major partnering providers (EDs and EMS) are required to treat any patient that that comes into the ED or calls 911. As we move into the outpatient medical setting, funding for primary care and behavioral health outpatient providers will go through the WPCC. This collaborative of primary care and behavioral health outpatient providers will be the only mechanism where these providers can receive funding through the Demonstration. Funding for these providers is contingent on how they address all six Demonstration projects and the number of Medicaid enrollees they serve in their organizations. NCACH is able to review claims data from the state to identify the number of Medicaid encounters that hospitals, primary care providers, and behavioral health organizations (BHO) have completed in previous years

To ensure the community-based organizations that are engaged in the Demonstration continue to serve Medicaid beneficiaries, NCACH will select partners using the following guidelines:

- Organizations whose mission and vision is to address low-income populations and therefore, the Medicaid population.
- Funding that goes to these organizations through the Demonstration are contingent on them serving Medicaid beneficiaries.
- A part of the agreements signed between NCACH and these organizations will outline the requirement to continue serving Medicaid beneficiaries.

To ensure we continue to maintain engagement of providers for project success, we will reach out to providers in multiple formats:

- Representative Workgroups: Carefully selected sectors were chosen to be represented on the Transitional Care and Diversion Interventions Workgroup. A charter (see Diversion Interventions Project - Attachment B) was created for the workgroup that addresses the Diversion Interventions Project and NCACH staff worked with the Board Executive Committee to ensure each slot was filled. One key element of this outreach was to connect with the

regional councils for each sector (public health, BHO, FQHCs, Regional Hospital Council, and Regional EMS Council) to fill the workgroups positions. As the project implementation plans develop, the Transitional Care and Diversion Interventions Workgroup will review workgroup membership to ensure the appropriate sectors are represented. The Transitional Care and Diversion Interventions Workgroup will also evaluate the need for a more focused sub-group that will be formed for a short period of time to gather targeted information from key organizations in the region.

- Key informant interviews: For agencies that are active in the work but unable to attend the Transitional Care and Diversion Interventions Workgroup, NCACH staff will perform key informant interviews for information gathering. These in-person meetings will be used to gather information that can then be brought back to the workgroup for further consideration in project planning.
- Identifying additional organizations: As we move into project implementation, the CHIs will continue to work with the partners in the local community to identify additional organizations that need to be at the table for successful implementation

MCO Engagement:

To leverage MCO partnerships, NCACH has made MCOs an integral part of NCACH’s formation from the beginning. The MCO sector holds a voting seat on the NCACH Governing Board. Each MCO has a representative on the Transitional Care and Diversion Interventions Workgroup. To hold more focused meetings, NCACH leadership holds monthly meetings with the three MCOs who will be operating in all four counties in region after the transition to FIMC on January 1, 2018 to directly address topics such as shared savings and VBP. To ensure that we maintain consistency with Medicare and commercial insurance, NCACH will work with providers through the WPCO to identify which metrics our region needs to focus on so providers are able to gain financial incentives through all payment methods.

Regional Assets, Anticipated Challenges and Proposed Solutions

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

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

ACH Response

Assets:

NCACH is extremely fortunate to have highly motivated and engaged clinical and community-based partners in the Diversion Interventions Project work. One of our greatest assets is the partnering providers who are dedicated enough that they are volunteering significant time to helping NCACH plan and implement solutions for improving diversion services. NCACH will engage Transitional Care and Diversion Interventions Workgroup members to assess efforts that are already underway in our communities that this project could leverage, while also addressing anticipated challenges voiced by community partners.

As well, there are a number of long standing regional councils already organized around sectors that will be key partners in this work. Specifically, this includes the North Central Regional Hospital Council

(comprised of all hospitals in the NCACH region) and the North Central Emergency Care Council (all EMS organizations in the NCACH region). These groups are well connected with the NCACH and can bring together stakeholders from these sectors to evaluate project plans and distribute information about the Diversion Interventions Project to the community.

Specific to the North Central Regional Emergency Care Council, goal five of the Council's strategic plan for July 1, 2017 to June 30, 2019 is to work toward sustainable emergency care funding and enhancing workforce development to optimize patient outcomes includes the development and utilization of community paramedicine programs in the North Central region¹³.

Specific to criminal justice and law enforcement. The North Central Behavioral Health Organization currently convenes local law enforcement leaders (police chiefs and sheriffs) every two months to address mental health issues their officers come into contact with. Due to the busy schedules of law enforcement, it is normally very difficult to get dedicated time from their staff. This pre-established meeting is a venue that NCACH can use to gain input from all major law enforcement leaders across the region. It is expected that the Behavioral Health Administrative Service Organization in the region will maintain this meeting under FIMC.

NCACH has well-established CHIs, broad based coalitions in each local health jurisdiction, who can highlight specific barriers with respect to diversion intervention. These barriers include lack of affordable housing, rigid transitional housing rules, lack of wet shelters (for people with substance abuse issues), limitations in our rural region, legal barriers for people with criminal records, and overwhelming systems that are difficult to navigate. Both the Transitional Care and Diversion Interventions Workgroup and the CHIs will work with local partners to come up with creative solutions to these problems.

Earlier this year, NCACH recognized a gap in data and analytic capacity. Over the past several months, we have addressed this gap in a variety of ways: hired a full-time data analyst to do in-house data analysis; contracted with Center for Outcomes Research and Education (CORE) to provide technical assistance and consultation to assist NCACH with data-related needs for the project planning process; formed a Health Information Technology/Health Information Exchange (HIT/HIE) workgroup to address regional population health management systems and information exchanges that can be expanded, enhanced, or initiated; and contracted with Centre for Collaboration, Motivation, and Innovation (CCMI) and CSI Solutions, Inc. for technical support in developing a learning collaborative, as well as performance monitoring software, tools, dashboards, and processes. The steps we have taken to address a previously identified weakness have not only turned data and analytic capacity into an area of strength for NCACH, but demonstrate that we can rapidly and systematically address future identified challenges.

Finally, NCACH considers its other Demonstration projects regional assets, since projects will mutually reinforce one another and help address gaps. For example, we plan on leveraging the Pathways Community HUB to specifically address our target population's challenge with navigating systems and aligning social service supports.

Barriers:

¹³ North Central Emergency Care Council Strategic Plan July 2017 – June 2019
(<https://www.doh.wa.gov/portals/1/Documents/2900/ncrplan.pdf>)

In the paramedic sector, there are multiple entities that provide EMS services (e.g., firefighters, private for-profit companies, hospitals, and non-profit companies). Each of these sectors have a different business model and flexibility around how they can deliver community paramedic services to patients in the region. Developing reimbursement models for community paramedicine that align with each service provider's business model will be difficult and could limit the number of EMS providers that we can work with under the Demonstration.

As well, the North Central Emergency Care Council completed a regional system evaluation in November 2010 that identified the following challenges:

- Funding streams through DOH contracts decreasing;
- Work required for existing EMS / Community training needs increasing;
- Work required by DOH for existing system maintenance increasing;
- Additional responsibilities added:
 - Participation in regional "Public Health Emergency Preparedness and Response" program;
 - New Cardiac / Stroke system development; and,
- Long term survival depends upon financial stability and sustainability.

Reinvestment of shared savings into this project will require some thoughtful planning. Specific to ED utilization, a number of Critical Access Hospitals will rely on ED revenue to help maintain their operating budget. With small departments outside of hospital services, any work completed that reduces ED use and inpatient hospitalization will put those organizations at significant risk of financial instability, especially since some of our Critical Access Hospitals are already on warrants given their limited tax base. NCACH will have to evaluate how Critical Access Hospitals can work with the NCACH to mitigate the risk associated with a reduction in funds due to decreased ED utilization.

Any shared savings realized in the criminal justice, judicial, and law enforcement systems will be hard to reinvest into the private non-profit sector, since the original funding for this work comes from local taxpayer dollars. Therefore, as programs are created that support reduced cost of our governmental agencies, it will require including all levels of government in the discussion of the Demonstration. This will ensure that we are aware of how we can implement projects that save our community members' dollars, but are also able to work with governmental agencies to create sustainable funding for these programs.

The NCACH region is an extremely rural region with only 19.4 persons per square mile¹⁴. Okanogan County, our largest county by geography (5315 square miles), is even more rural with only 7.8 people per square mile¹⁵. The rural nature of our region is one of the factors that led mental health care access and access to health care to be identified as our top two needs in our 2016 Regional CHNA. Our rural geography leads to transportation barriers for patients to make preventative appointments leading to higher ED utilization or using the EMS system for non-emergent transport needs.

Finally, NCACH is also concerned about data issues. The most pressing need is to develop or obtain solid baseline data on important project metrics. Without this baseline, any subsequent data collection may be meaningless. One option is to use our current state assessments as a mechanism to gather baseline data. Data challenges also include the ability to share data between criminal justice,

¹⁴ US Census Bureau, 2010-14.

¹⁵ US Census Bureau, 2010-14.

law enforcement, and medical communities that maintain patient confidentiality. We are not convinced that the state will be able to provide such data and are looking at options for developing this capacity within the region. Data sharing issues surfaced through our various project workgroups will be communicated with our HIT/HIE Workgroup. This workgroup will be launched in early 2018 and one of its tasks is to identify, review, and recommend potential solutions and articulate a regional HIT/HIE strategy that will provide a path for integrated care. They may recommend regional capacity investments that could be supported through our funds flow strategy which includes funds for HIT/HIE investments.

Strategies for Mitigating Risk:

NCACH plans to work with the North Central Emergency Care Council to meet with all EMS providers and develop plans to institute the community paramedicine program across all forms of EMS services. NCACH will likely form a subgroup of the Transitional Care and Diversion Interventions Workgroup focused on developing strategies specific to this evidence-based approach.

Sustainable funding will be a key initial first step in mitigating any barriers associated with projects. NCACH has initiated routine meetings with our MCO partners to further refine this strategy and will further enhance these discussions with a regional VBP workgroup. The VBP workgroup will also discuss how we address those organizations (e.g., hospitals) that are at risk of losing money due to improved patient care. Both the VBP and Transitional Care and Diversion Interventions Workgroup discussions will also include how we can work with governmental agencies around shared savings to ensure any projects associated with the criminal justice system are able to be sustained. Braided funding will also be a key strategy to support projects that provide strong value to our community members, but will not be sustained 100% by value-based contracting arrangements.

For Critical Access Hospital reimbursement structures, NCACH will connect providers with the Healthier Washington Rural Multi-Payer Payment Model plan that will work to transform payment to Washington's most critical providers toward methodologies that embrace value-based payment reform, sustainability, delivery system transformation, and true patient engagement. As that plan is developed, NCACH will assist those provider organizations in identifying technical assistance expertise that will help CAHs refine their business model to align with both Medicare and Medicaid value based payment streams. As well, a number of Critical Access Hospitals in the region are currently working with a consultant Caravan Health to develop Accountable Care Organizations (ACOs). NCACH has attended meetings of Caravan Health and our local CAHs, and NCACH has also held additional conversations with Caravan Health to determine how both the ACO model and the Demonstration can complement each other.

Specific to the EMS Business Model, NCACH can work with existing Community Paramedicine providers in the regions and Managed Care Organizations to collect data and demonstrate where savings has been made in the process and develop a reimbursement model for that shared savings that can be reinvested back into the Community Paramedicine programs.

To assist in the collection of data, NCACH will also leverage our Care Coordination Project (Pathways Community Hub) to help record and address some of the non-emergent reasons individuals interact with EMS providers. This system will also provide a path for those patients to get care outside of the acute setting. A similar process could be constructed for those individuals leaving the Regional Justice System. The CCS platform could be one additional tie for both Paramedicine and Criminal Justice to also link back to the medical sector. As well, where appropriate, NCACH can see where there is a need to create interoperability between these systems and medical providers.

Finally, NCACH is going to initiate a social services focus group to develop a strategic plan on how we can better align community-based organizations within the Demonstration to address non-medical needs that can impact care (e.g., transportation). NCACH realizes that there are a number of factors that will impact the social service agencies' ability to participate and this focus group will come up with initial recommendations our region can use in quarter 2 of 2018.

Monitoring and Continuous Improvement

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

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

ACH Response

The goal of NCACH's monitoring plan is to use real-time or close to real-time data to support project implementation and continuous improvement. Largely pulling from existing data sources, NCACH will track operational, process, and outcomes measures for each project and for the ACH overall. These existing data sources include the Healthier Washington dashboard, the Department of Health Quarterly Drug Overdose Dashboard, the Department of Health Prescription Monitoring Program (PMP) Dashboard, the HCA DSRIP Dashboard, and other reports and products currently available from or under development by the state. We will work with workgroups to supplement this data with regional and partner data. Monitoring data will be used to drive shared learning, form the foundation of rapid-cycle continuous improvement processes, and support program evaluation efforts. This will allow the ACH and key partners to identify issues, barriers, and successes quickly. Key elements of this system include:

Convening key stakeholders. NCACH has convened the Transitional Care and Diversion Interventions Workgroup to guide decisions for the Diversion Interventions Project. This group includes clinical and program subject matter experts and will make recommendations regarding project implementation. NCACH will work with stakeholder groups to monitor progress on a regular basis and triage issues that arise in implementation, such as access to data or recruitment and enrollment delays. Key stakeholders for this project includes criminal justice stakeholders (including law enforcement, juvenile justice, district court, and therapeutic courts), hospitals (individual hospitals serving a large portion of Medicaid beneficiaries, as well as a representative from the North Central Regional Hospital Council), and MCOs. A detailed list is included in our workbook's partnering providers tab. The exact approach and tools to support partner reporting and rapid cycle monitoring and improvement will be developed in 2018 with guidance from our specific project workgroups (including the WPCC, Opioid Workgroup, Transitional Care and Diversion Interventions Workgroup, and Pathways Community HUB Workgroup). The development of continuous monitoring and improvement systems will be led by ACH staff with technical assistance from our consultants (e.g.

CORE and CCMI/CSI).

Identifying monitoring metrics, data sources, benchmarks, and targets. Monitoring metrics will vary by project, and will include ACH toolkit pay-for-reporting and pay-for-performance metrics, as well as regional accountability and quality improvement plan metrics. In order to improve our project performance measures, it will be critical to identify proxy measures that we can track at a local level and that are likely to impact the measures. This may involve process, output, and/or outcome measures (e.g., number of people reached broken out by year). NCACH data staff will begin working with key contractors, such as CORE, beginning quarter 3 of 2018 to develop and recommend to the workgroup a detailed quality improvement plan that NCACH will support to monitor the health impact of our Diversion Interventions Project. NCACH staff will facilitate linkages where input from our regional Health Information Technology/Health Information Exchange (HIT/HIE) Workgroup or the statewide HIT/HIE efforts led by the HCA may be needed. NCACH also will ask MCOs to review quality metrics and agree on quality reporting for VBP models. For the implementation phase, many metrics will be process or operational in focus. Using the toolkit as a guide, NCACH staff will engage workgroup members to help identify benchmarks and, where possible, improvement targets. Potential metrics for Diversion Interventions Project are listed in the table below; final metrics will be identified in the implementation plan.

Potential Monitoring Metrics – Diversion Interventions Project

Implementation/Operational Measures – Regional monitoring metrics to track implementation progress

Measures TBD; examples may include:

- Type of non-emergent ED and 911 encounters
- Number of paramedics trained in community paramedicine
- Number/percent of non-emergent 911 calls
- Number of level 1 and 2 ED visits

Toolkit P4R Measures – Required metrics for ACH reporting

- Number of partners trained
- Percent of partnering provider organizations with staffing ratios equal or better than recommended
- Number of partners implementing selected approaches
- VBP arrangement with payments/metrics to support adopted model
- Percent of partnering provider organizations sharing information (via HIE) to better coordinate care

Toolkit P4P Measures – Incentive measures, which will be reported by HCA and tracked by the ACH

- Outpatient Emergency Department Visits per 100 member months
- Percent Arrested
- Percent Homeless (Narrow Definition)

Quality Improvement Plan Metrics – Regional performance metrics

QIP metrics will be identified by Demonstration Year 3, quarter 2

Building data infrastructure to collect, aggregate, analyze, and report data for monitoring. NCACH plans to develop a data infrastructure to collect and aggregate project information, in order to support continuous analysis, monitoring and improvement. The potential data infrastructure to support monitoring and continuous improvement (see figure on following page) should be designed to complement existing data assets (such as the Fully-Integrated Managed Care Early Warning System, Healthier Washington Dashboard, other dashboards under development, and reporting from regional associations). NCACH will also pull data from local partners in the Emergency Medical Services (EMS) profession that provide all 911 emergent and non-emergent calls, and gather emergency department data for each major Hospital in NCACH through the Washington State Analytics, Interoperability, and Measurement (AIM) Team and local provider quality improvement departments.

An ideal system will be able to securely collect, combine, store, and report data. Through our Whole Person Care Collaborative, we are planning on using a customized web portal (Healthcare Communities) developed by one of our current contractors, CSI Solutions, Inc. Originally developed in 2005, this platform has grown to support nearly 70 communities, including CMS's Transforming Clinical Practices Initiative. This portal would serve multiple functions, providing centralized access to resource sharing, document sharing, tracking of process measures through consistent form-fillable reporting templates and surveys, and tracking of measures through dashboards. Based on conversations with CSI Solutions, it seems very likely that we can leverage this web portal for monitoring progress and reporting associated with the rest of our projects. Ideally, partners would submit monthly reports through this online portal.

Reports from implementation partners will focus on project milestones and process details that can be used to support overall monitoring, identify potential challenges or barriers that individual or multiple partners are experiencing, and identify potential champions and best practices. Reporting will be contractually required of project partners, though every effort will be made to keep these reports simple and streamlined in order to minimize the reporting burden for partners (one of our key design principles). Data from partner reporting will complement existing data resources, including the Healthier Washington Data Dashboard and the Department of Health Drug Overdose Dashboard, (both currently operational), as well as the Department of Health Prescription Monitoring Program (PMP) Dashboard and the HCA DSRIP Dashboard. Some of these data assets are currently under development by the State using a Tableau interface, with the hopes of being released in early 2018 and updated on a quarterly basis.

Other ACHs are also investigating options, and NCACH has participated in several webinars from vendors offering these types of solutions. For example, a webinar presented by one New York DSRIP provider with SpectraMedix, their data infrastructure partners; a webinar organized by the Washington Health Alliance regarding a healthcare quality improvement tool from 10xHealth; a webex on a Salesforce platform built by Persistent Systems which was designed for another New York DSRIP provider to see a 360 degree view of project management and progress; and a webinar with the Washington State Hospital Association on a specific quality benchmarking system they are interested in making available to ACHs. NCACH staff will continue exploring options, consult with other ACHs who may have investigated their own solutions, and solicit input from our regional HIT/HIE workgroup. We plan on identifying a strategy for collecting all of this data by the end of 2018. Ideally, we would find a way to use the same platform for most or all of our projects in order to minimize administrative costs.

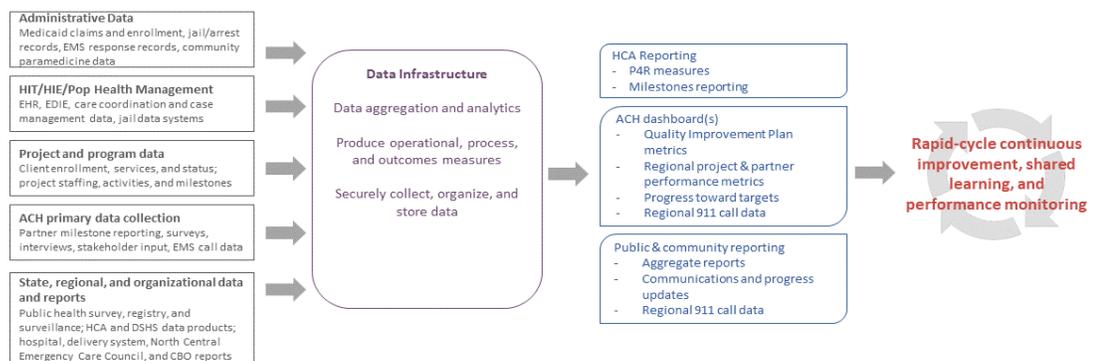
As part of the data infrastructure work, NCACH will identify data sources and a plan for data collection; establish data use agreements with partnering providers (potentially including MCOs); establish data governance models; comply with relevant privacy and security regulations; implement processes for transferring data; and identify tools to collect, manage, store, analyze, visualize, and report data. Efforts will be made to minimize the reporting burden on partnering providers, leveraging existing data reporting where possible.

Implementing continuous processes. Drawing on this data infrastructure, NCACH will develop continuous improvement (CI) processes based on best practices for clinical and health systems improvement, bringing in expertise from contractors (e.g., CORE or CCMI/CSI) where needed (diagram below or Diversion Interventions Project - Attachment C for a larger version of this graphic). Drawing

on monthly reports, and ad-hoc check-ins with partnering providers, staff will regularly monitor performance and understand, in real-time, whether we are on the path to reaching expected outcomes. Project workgroups also will be involved in project monitoring and course correction, through quarterly improvement cycles accompanied by collaborative peer learning sessions. With each cycle, NCACH and partners will adapt, test, and refine strategies, document learnings and results, and spread learnings across partners. These processes should allow for identification of barriers, challenges, and risks. If timelines still cannot be met, NCACH will communicate a plan back to the state regarding reasons why timelines weren't met, a plan for adapting the timeline, and prevention/risk mitigation strategies that will be shared with other partners and projects where appropriate.

Quality improvement efforts will be coordinated with existing local and statewide technical assistance providers, including Qualis, the Practice Transformation Support Hub, MCO initiatives, and HCA resources. For example, the HCA AIM team is planning on creating monitoring reports containing specific project level detail (they anticipate that production of these reports would start in 2018). Information, reports, and assessments from other quality improvement efforts may also be helpful data sources to monitor ACH and partner progress (e.g. MCO assessments and measures). NCACH envisions supporting quality improvement in a variety of ways, ranging from connecting partnering providers to relevant resources to creating new opportunities for partnering providers. NCACH may provide training or technical assistance to providers around specific issues or barriers, such as HIT/HIE adoption or workforce development. NCACH's goal is for partners to be as successful as possible in project implementation and will design quality improvement efforts that offer a flexible approach. If partners are identified as struggling in a particular area, or lagging behind, NCACH intends to determine what will be needed to ensure that partner's success and determine whether existing or additional resources can be provided. This may involve extensions, and/or more comprehensive or intensive technical assistance.

Diversion Intervention Planned Approach for Monitoring and Continuous Improvement



Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

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

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

YES	NO
X	

Project Sustainability

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

ACH Response
<p>One of NCACH’s key strategies is to target Demonstration funds to support changes in systems and processes that can lay the ground work for long-term sustainability. Many of Washington State’s Medicaid Demonstration projects are ultimately about improving linkages to promote more effective coordination and holistic care. This kind of system transformation can be accelerated through capacity building investments, including facilitating cross-sector communication, making discrete capital investments, rethinking processes, or changing the way resources are allocated. By incentivizing these types of changes through Demonstration investments, we expect improved infrastructure and processes to live beyond the Demonstration period, especially where they show improvements in health and social outcomes for our target populations. For example, new linkages and strengthened relationships that are created between criminal justice and health care representatives through our transitional care approaches are not contingent on funding to continue. Laying the groundwork for a more robust and interoperable IT systems or other coordination</p>

mechanisms between criminal justice, health care, and other sectors (e.g., strengthening the region's Washington Information Network 211 infrastructure to facilitate linkages to social service and health care supports) will have lasting impacts. This kind of capacity building is critical to the continued efforts of our partners. These investments are part of our approach for expanding, using, supporting and maintaining population health management systems across all of NCACH's selected projects.

Specific to our Diversion Interventions Project, policies might be changed to allow social service providers access to clients while they are incarcerated (so that their needs can continue to be planned for) and connect those individuals who leave EDs with systems of care coordination to reduce the possibility of readmission. As well, the Transitional Care and Diversion Interventions Workgroup will review how we can expand the scope of work of current medical professionals such as Emergency Medical Service providers who currently only provide acute services (911 calls). These services can further expand into community paramedicine programs that will provide both better patient care and utilize the current staffing models in place more efficiently. When not responding to emergencies, Community Paramedics can help people manage chronic disease such as diabetes, high blood pressures, cholesterol, and prevent disease and illness through immunizations and screenings. They can provide information and counseling about ways to care for themselves and their families. Community paramedicine will also link well to the Community Care Coordination (Pathways Hub Model) to ensure those individuals who utilize 911 services inappropriately receive the care they need through care coordination to better improve their health.

As care improves, acute care facilities will see a decrease in patient visits and therefore revenue. The Transitional Care and Diversion Interventions Workgroup will need to work closely with MCOs to ensure that demonstrated improvement in care can be rewarded through direct contracting if we want to be able to maintain strong services for acute care facilities. It will be the Transitional Care and Diversion Interventions Workgroup's charge to consider these and other capacity investments.

The NCACH Governing Board is open to supporting additional staff resources and direct services, but only when a strong path toward sustainability is articulated by our partnering providers. Sustainability of services can be done through Value-Based Payments or through other revenue generating strategies, including demonstrated support from foundations or local jurisdictions.) However, by focusing investments on strengthening our partnering providers' capacities (rather than specific programs), we hope to enhance their ability to achieve their mission and sustain their work. Transitional Care and Diversion Interventions Workgroup members will ensure they fund systems changes with our partners as they dive deeper into project planning and make implementation and funding recommendations to the NCACH Governing Board.



North Central Accountable
Community of Health

NCACH Diversion Interventions Project Plan – Attachment A

Transitional Care and Diversion Interventions Workgroup

October 24th, 2017

Healthier Washington

Healthier WA is a statewide initiative that is focused on achieving system wide change to link clinical and community factors that support health and spread integrated value based payment and care delivery models.

To achieve these goals, Healthier WA focuses on three goals:

1. Building healthier communities through a collaborative regional approach.
2. Integrating how we meet physical and behavioral health needs so that health care focuses on the whole person.
3. Improving how we pay for services by rewarding quality over quantity.

Locally, this work is accomplished through Regional Collaboratives such as the Accountable Communities of Health.



5 Years from now



Current system

- Fragmented care delivery
- Disjointed care transitions
- Disengaged clients
- Capacity limits
- Impoverishment
- Inconsistent measurement
- Volume-based payment



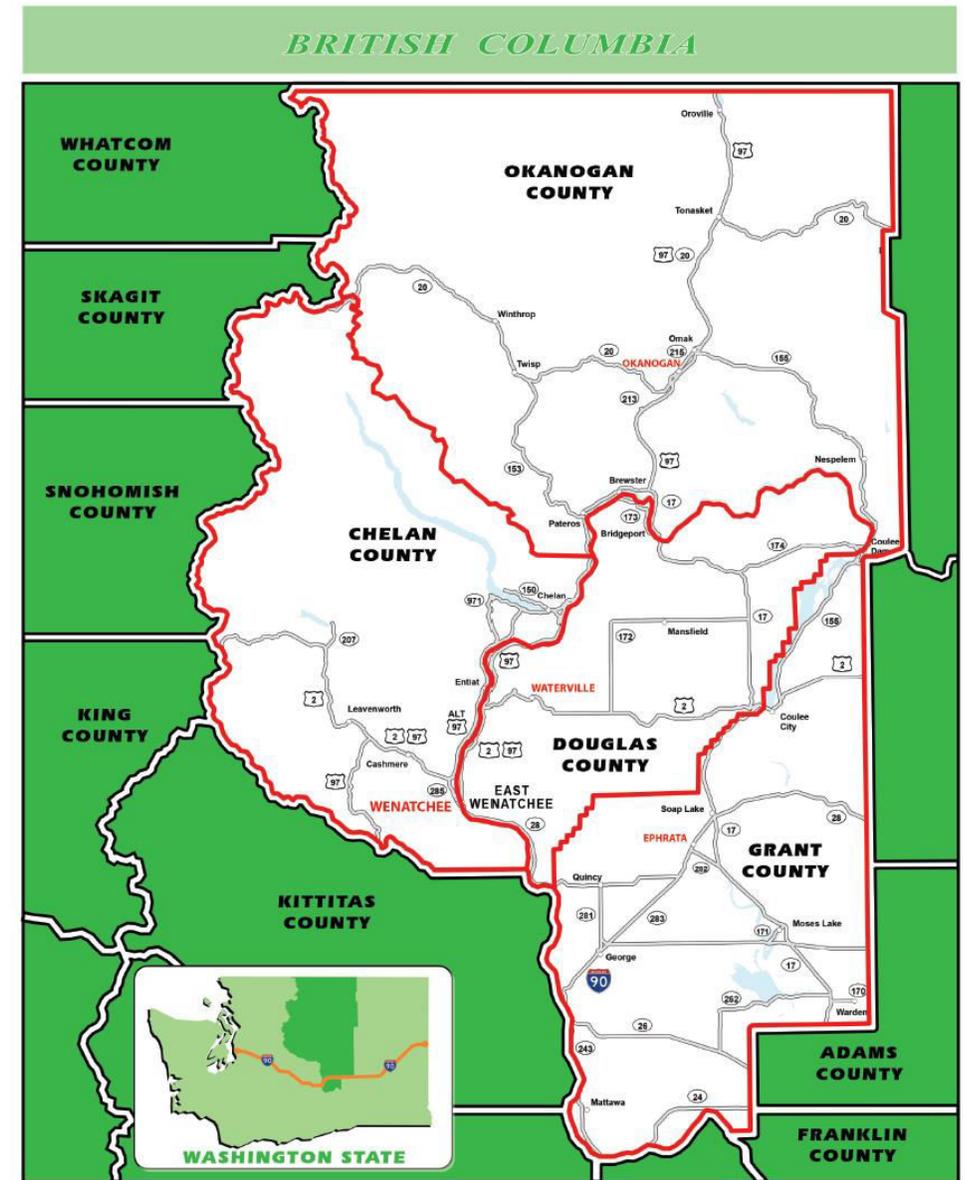
Transformed System

- Integrated, whole-person care
- Coordinated care
- Activated clients
- Access to appropriate services
- Timely supports
- Standardized measurement
- Value-based payment

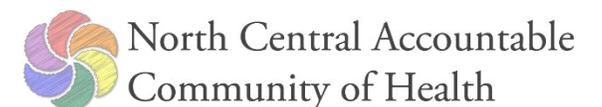


A Regional Approach

- ACHs play a critical role:
 - **Coordinate** and **oversee** regional projects aimed at improving care for Medicaid beneficiaries.
 - **Apply** for transformation projects, and incentive payments, on behalf of partnering providers within the region.
 - **Solicit** community feedback in development of Project Plan applications.
 - **Decide** on distribution of incentive funds to providers for achievement of defined milestones.



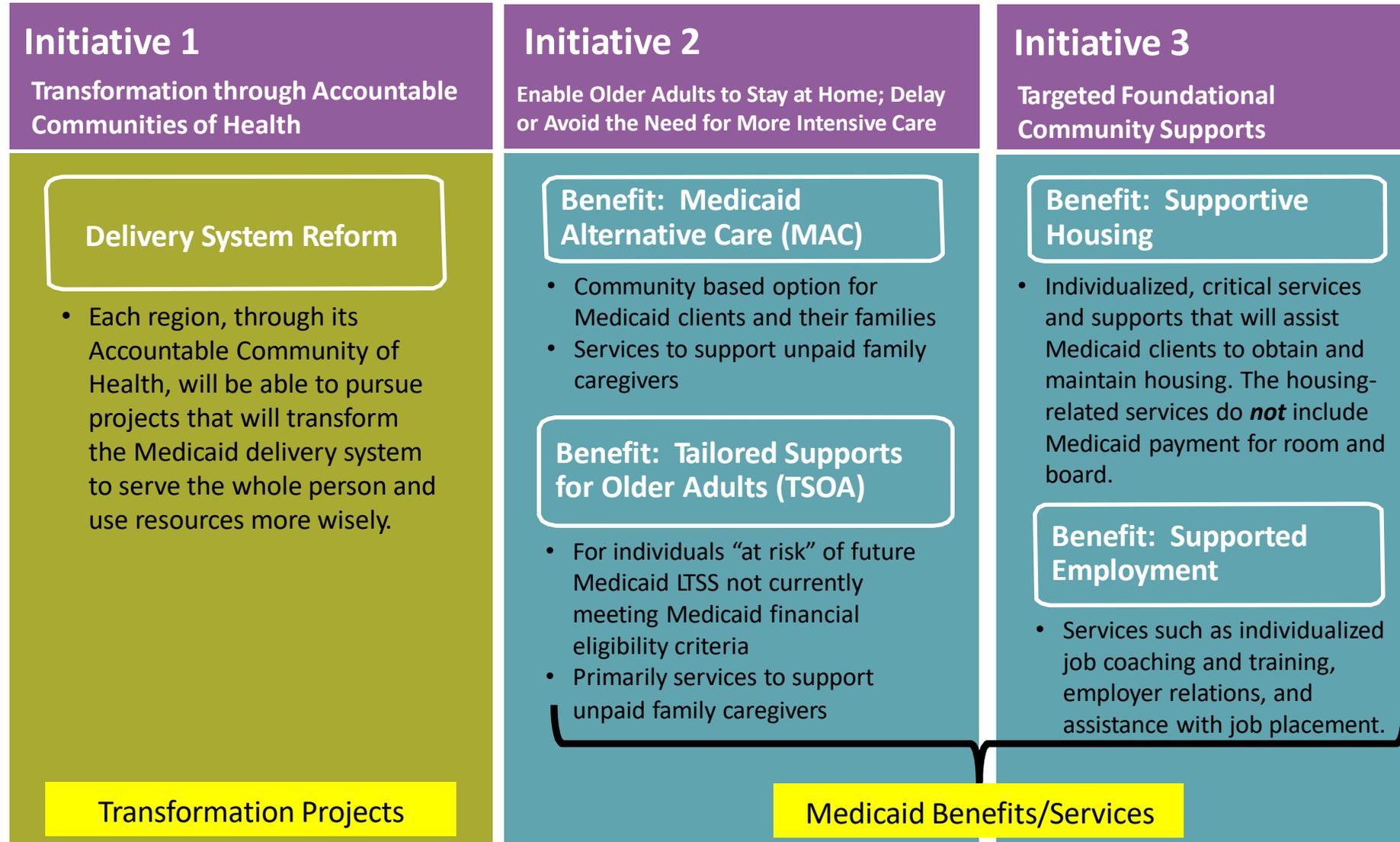
North Central Accountable Community of Health



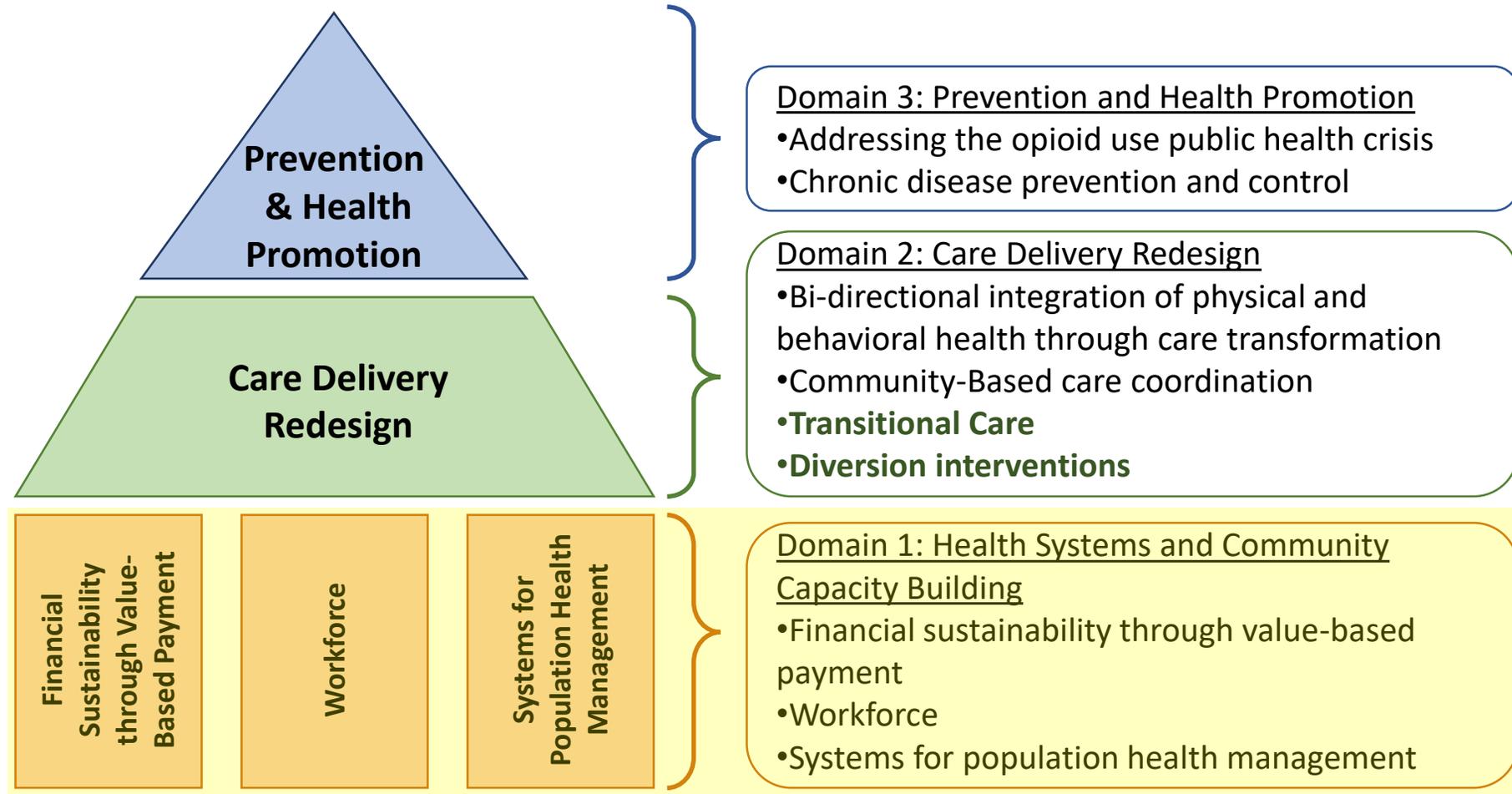
Medicaid Transformation Demonstration

- Through a five-year demonstration, Healthier WA will use up to \$1.5 Billion to address three initiatives aimed at transforming Medicaid to improve quality and control costs:
 - **Initiative 1: Transformation Through Accountable Communities of Health**
 - **Initiative 2: Long-term Services and Supports to Enable Older Adults to Live At Home Longer**
 - **Initiative 3: Supportive Housing and Supported Employment**
- Of the \$1.5Billion available through the Demonstration, **\$1.125Billion will be available to address Initiative 1.**

Medicaid Transformation Demonstration



Initiative 1: Care Transformation



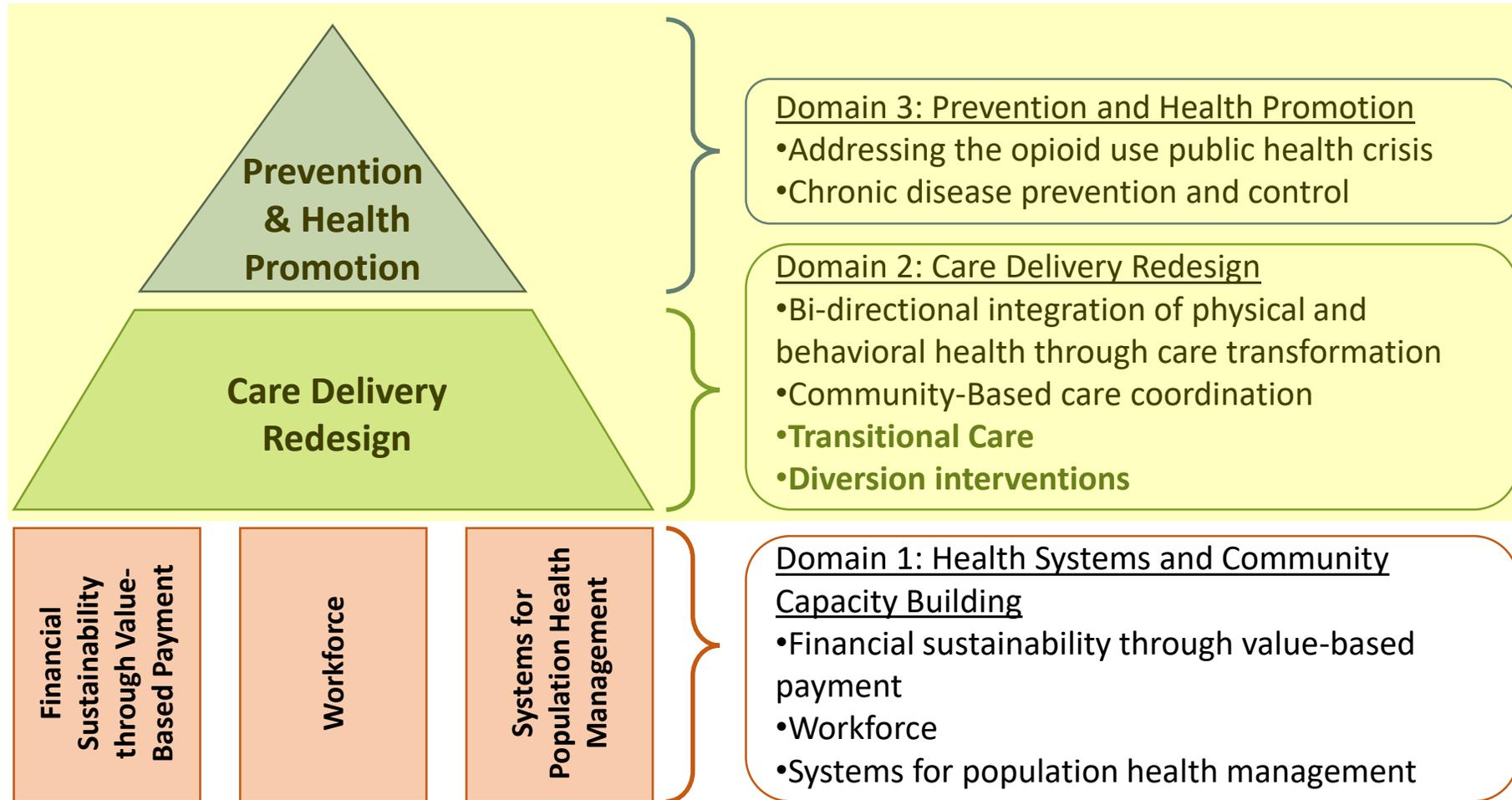
Domain 1: Health Systems and Community Capacity Building

Domain 1 addresses the core health system capacities to be developed and enhanced. Three required focus areas are to be implemented and expanded across the delivery system. Each of these areas will need to be addressed progressively throughout the five-year timeline. State agencies will provide leadership but the ACH will have a role in each focus area.

Focus Areas

1. Financial Sustainability through Value Based Payment
2. Workforce
3. Data Systems for Population Health Management

Initiative 1: Care Transformation



Projects and general target populations

Bi-Directional Integration

Community-Based Care Coordination (aka HUB)

Transitional Care

Diversion Interventions

Addressing the Opioid Use Public Health Crisis

Chronic Disease Prevention and Control

Objective

Integrate health system and community approaches to improve chronic disease management and control.

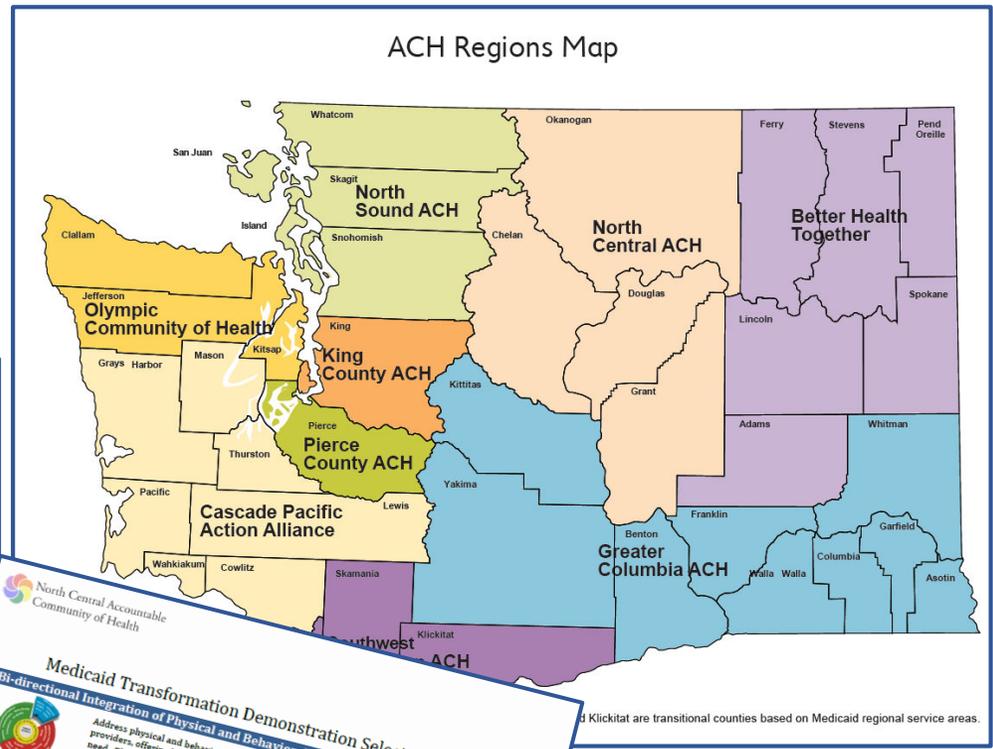
General target population (as defined by HCA)

Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a **focus on those populations experiencing the greatest burden of chronic disease(s) in the region.**

More Information



MEDICAID TRANSFORMATION APPROVED PROJECT TOOLKIT
June 2017



North Central Accountable Community of Health

Medicaid Transformation Demonstration Selected Projects
Chelan, Douglas, Grant, and Okanogan Counties

Bi-directional Integration of Physical and Behavioral Health through Care Transformation
Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through Managed Care Organizations, for people enrolled in Medicaid to address the whole person.

Community-Based Care Coordination
Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. This will rely on the development of the Pathways HUB infrastructure which will coordinate care coordinators and allow current care coordinators to provide more effective and efficient care coordination.

Transitional Care
Improve transitional care services of Medicaid beneficiaries moving from intensive medical care or institutional settings. This includes those discharged from acute care to home or to supportive housing, those with serious mental illness discharged from inpatient care, or client returning to the community from prison or jail. Improvement in these services will lead to a reduction in avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

Diversion Interventions
Implement diversion strategies to promote more appropriate use of emergency services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. Strategies targeted at Medicaid beneficiaries presenting at the Emergency Department for non-acute conditions, Medicaid beneficiaries who access the EMS system for emergency conditions, and Medicaid beneficiaries with mental health and substance use conditions coming into contact with law enforcement.

Chronic Disease Prevention and Control
Reduce opioid-related morbidity and mortality through strategies to prevent opioid misuse and abuse, treatment of opioid use disorder, and long-term recovery, and whole-person care.

Chronic Disease Prevention and Control
Improve chronic disease management and control by using the Chronic Care Model in a primary care setting. The CCM identifies a health care system that encourage high-quality chronic disease management, the health system self-management support, decision support, and clinical information systems.

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10000 1st Mall Parkway, East Wenatchee, WA 98802 | 509.886.6400 | www.ncaach.org

Selected Medicaid Demonstration Projects

Bi-Directional Integration	Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through Managed Care Organizations, for people enrolled in Medicaid to address the whole person.
Community-Based Care Coordination (aka HUB)	Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. This will rely on the development of the Pathways HUB infrastructure which will coordinate care coordinators and allow current care coordinators to provide more effective and efficient care coordination.
Transitional Care	Improve transitional care services to reduce avoidable hospital utilization and ensure Medicaid beneficiaries are getting the right care in the right place. This includes those discharged from acute care to home or to supportive housing, those with serious mental illness discharged from inpatient care, or client returning to the community from prison or jail. Improvement in these services will lead to a reduction in avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
Diversion Interventions	Implement diversion strategies to promote more appropriate use of emergency services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. Strategies targeted at Medicaid beneficiaries presenting at the Emergency Department for non-acute conditions, Medicaid beneficiaries who access the EMS system for emergency conditions, and Medicaid beneficiaries with mental health and substance use conditions coming into contact with law enforcement.
Addressing the Opioid Use Public Health Crisis	Reduce opioid-related morbidity and mortality through strategies to prevent opioid misuse and abuse, treatment of opioid use disorder, and long-term recovery, and whole-person care.
Chronic Disease Prevention and Control	Improve chronic disease management and control by using the Chronic Care Model in a primary care setting. The CCM identifies a health care system that encourage high-quality chronic disease management, the health system self-management support, decision support, and clinical information systems.

North Central Accountable Community of Health

Medicaid Transformation Demonstration Selected Projects

Bi-directional Integration of Physical and Behavioral Health through Care Transformation
Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through Managed Care Organizations, for people enrolled in Medicaid to address the whole person.

Community-Based Care Coordination
Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. This will rely on the development of the Pathways HUB infrastructure which will coordinate care coordinators and allow current care coordinators to provide more effective and efficient care coordination.

Transitional Care
Improve transitional care services to reduce avoidable hospital utilization and ensure Medicaid beneficiaries are getting the right care in the right place. This includes those discharged from acute care to home or to supportive housing, those with serious mental illness discharged from inpatient care, or client returning to the community from prison or jail. Improvement in these services will lead to a reduction in avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

Diversion Interventions
Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. Strategies will be targeted at Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for emergency conditions, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Chronic Disease Prevention and Control
Reduce opioid-related morbidity and mortality through strategies to prevent opioid misuse and abuse, treatment of opioid use disorder, and long-term recovery, and whole-person care.

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Resources and Relationships

- Domains and Projects *should not* be implemented in isolation from one another.
 - Projects will be highly interrelated and interdependent
- Transformation projects must:
 - Be based on community-specific needs for the Medicaid population
 - Avoid redundancy and duplication
- Regional projects will be assessed based on achievement of defined milestones and metrics.

Funding the Demonstration Projects

Each project involves metrics

Funding will depend, in part, on our performance

- This is not a grant program. There will be up-front money for start-up, but much of the project funding must be earned by reaching performance targets.
- In the early years of the projects, we will be judged mainly on the progress we make in implementing project plans.
- In the later years of the projects, we will be judged mainly in terms of health care improvements such as reductions in unnecessary ER visits and hospitalization, and on clinical quality metrics such as the percent of Medicaid diabetes patients receiving HbA1c testing, percent receiving depression screening, and many others.
- It will be a heavy lift to measurably improve Medicaid clinical quality by the end of 2021.

Transitional Care & Diversion Workgroup

Workgroup will ensure that the region implements effective evidence based practices that align with the Toolkit. Specifically the following:

- Provide recommendations to the NCACH Governing Board and staff on approaches to take for Transitional Care and Diversion Interventions projects.
- Ensure projects align with all six projects NCACH selected to implement.
- Use stakeholder and community input on project planning and implementation.
- Work with NCACH partners to implement sustainable changes in the regional health care system & Criminal Justice System
- Ensure projects effectively connect patients with resources to mitigate the negative consequences of the social determinants of health.
- Identify how IT, workforce, and value-based payment strategies can support this project.

Evidence Based Approaches

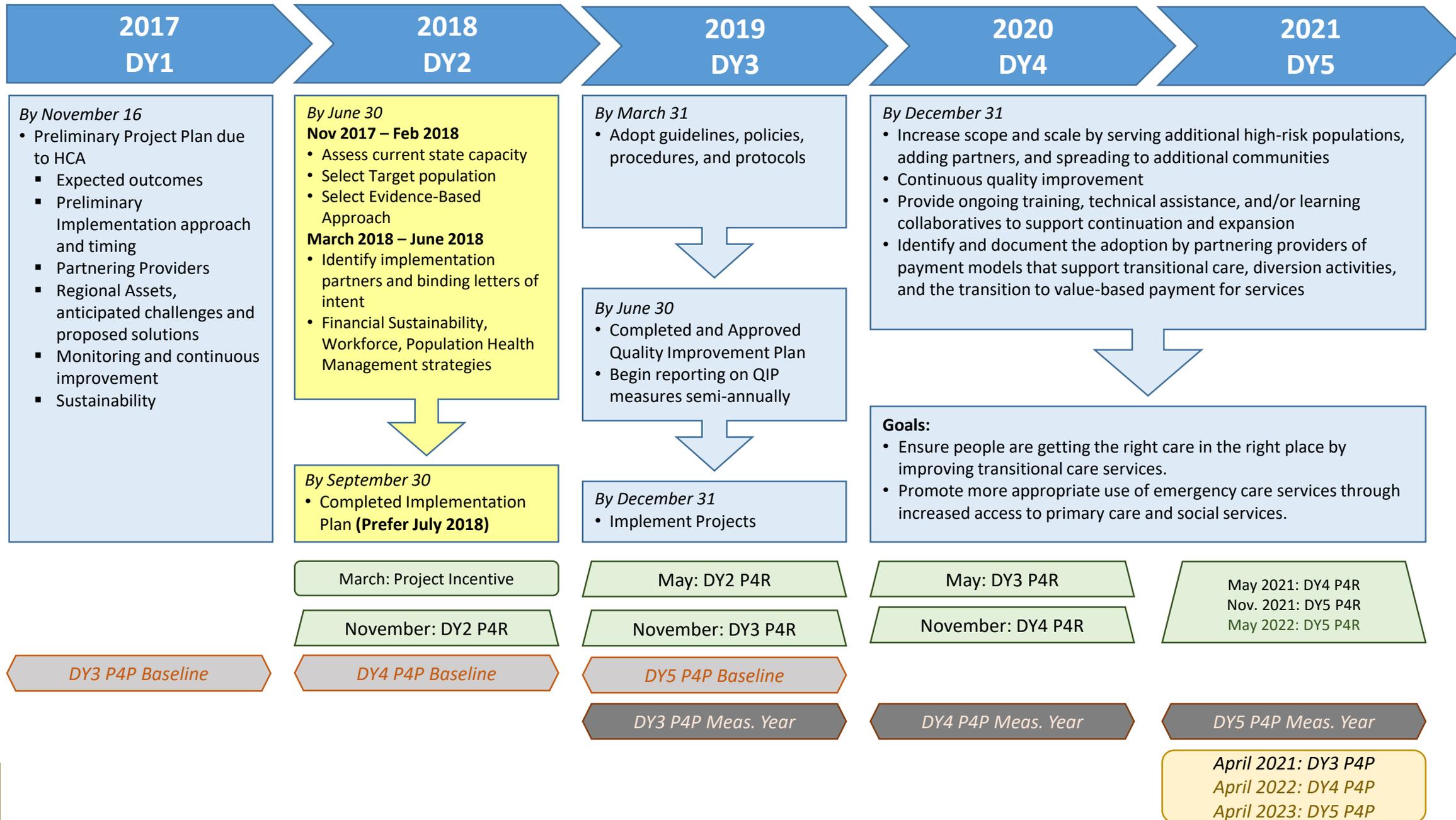
Evidence Based Approaches:

1. Interventions to Reduce Acute Care Transfers, INTERACT™4.0
2. Transitional Care Model (TCM)
3. Care Transitions Intervention® (CTI®)
4. Care Transitions Interventions in Mental Health
5. Transitional Care for People with Health and Behavioral Health Needs Leaving Incarceration

Diversion Intervention

1. Emergency Department (ED) Diversion
2. Community Paramedicine Model
3. Law Enforcement Assisted Diversion (LEAD)

Transitional Care and Diversion Interventions Implementation Timeline



Implementation Plan

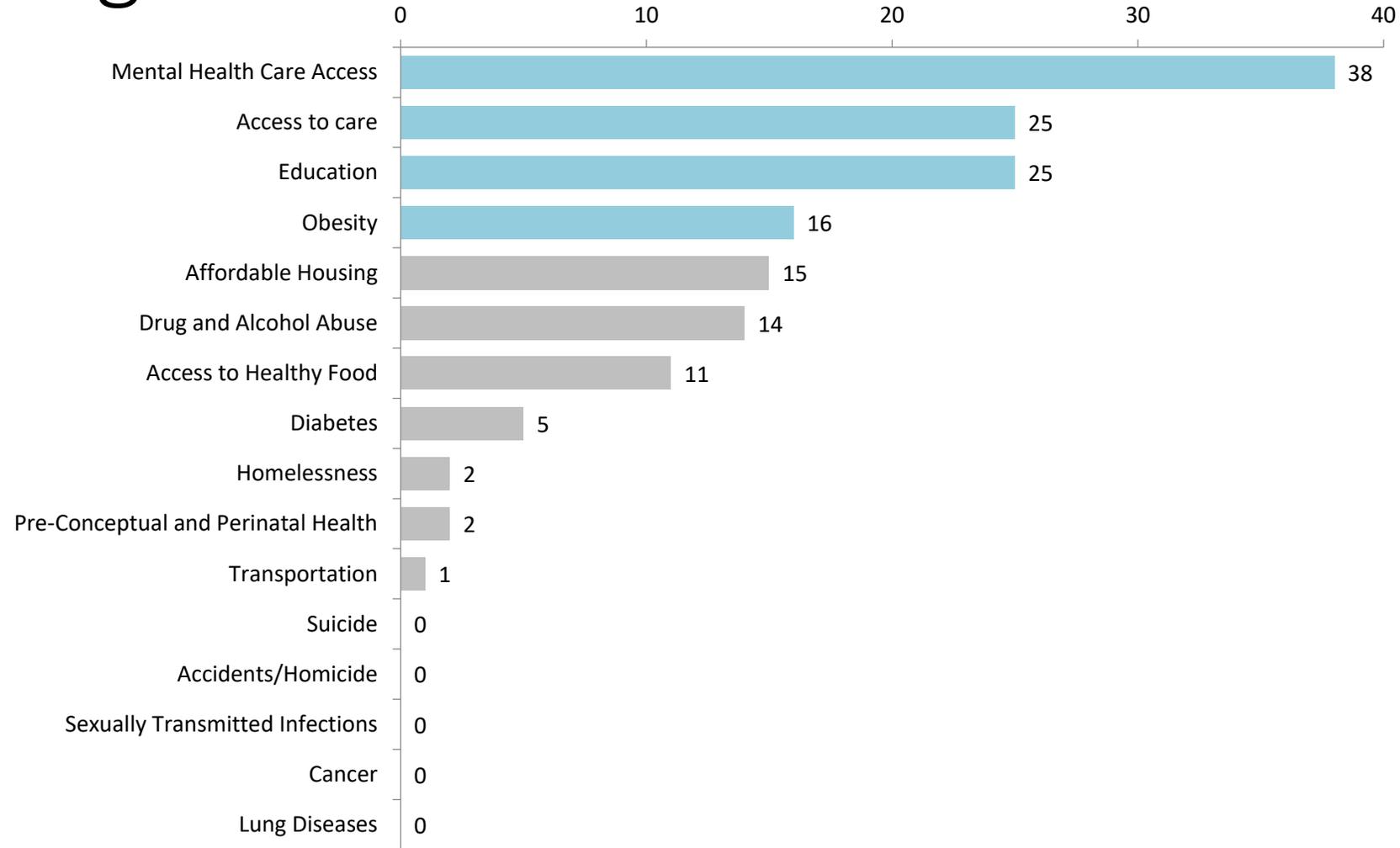
Minimum Requirements

- Implementation timeline.
- Description of selected evidence-based approach, target population, justification for how approach is responsive to specific needs in the region.
- If applicable, explanation of how the standard pathways selected in Project 2B (Pathways Community HUB) align with the target population and evidence-based approach selected in this project.
- Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts.
- Roles and responsibilities of implementation partners.
- List of committed implementation partners and potential future partners that demonstrates sufficient initial engagement to implement the approach in a timely manner.
- Descriptions of service delivery mode, which may include home-based and/or telehealth options.
- Describe strategies for ensuring long-term project sustainability.

Data Preview

Transitional Care & Diversion Intervention Workgroup
10/24/2017 Meeting

Regional Health Needs



Medicaid Population Demographics

NCACH Region (N=94,009)

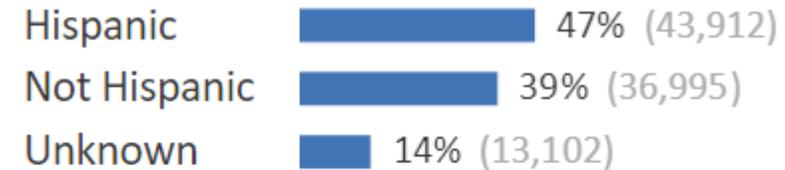
Age Group



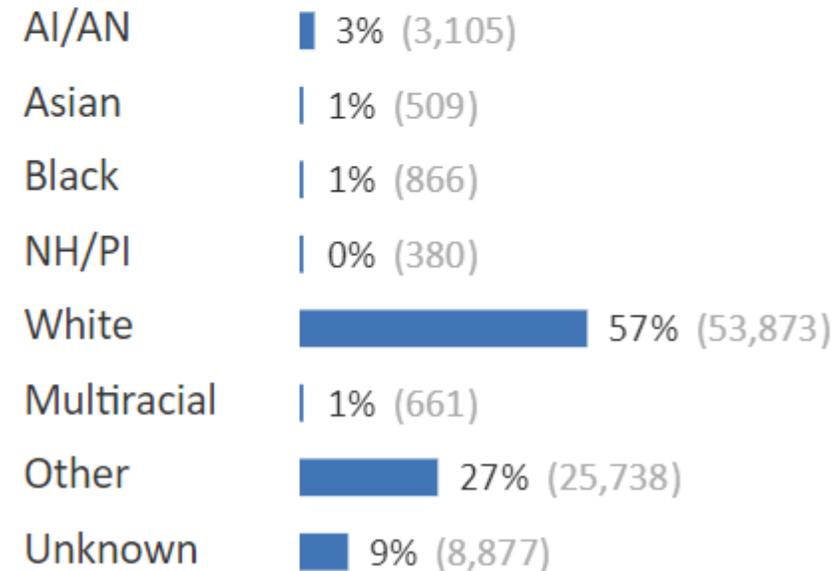
Gender



Ethnicity



Race



CHELAN

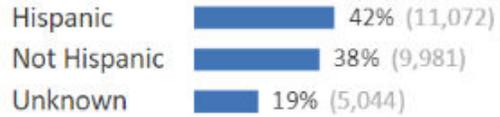
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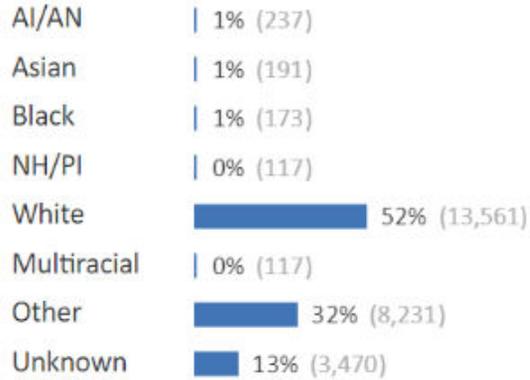
Gender



Ethnicity



Race



DOUGLAS

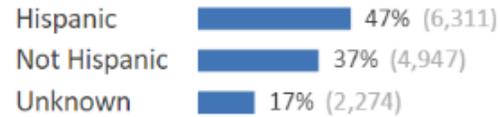
Age Group



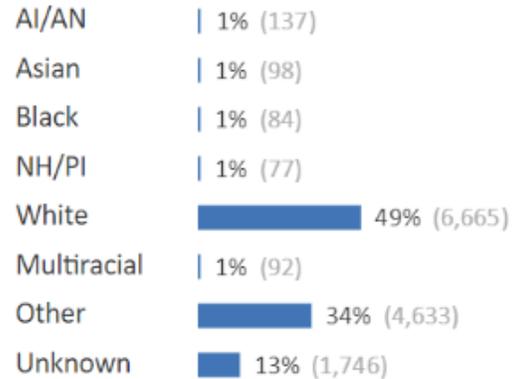
Gender



Ethnicity



Race



GRANT

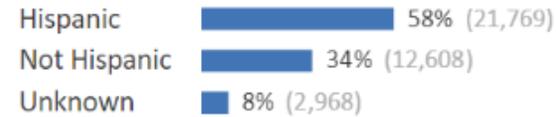
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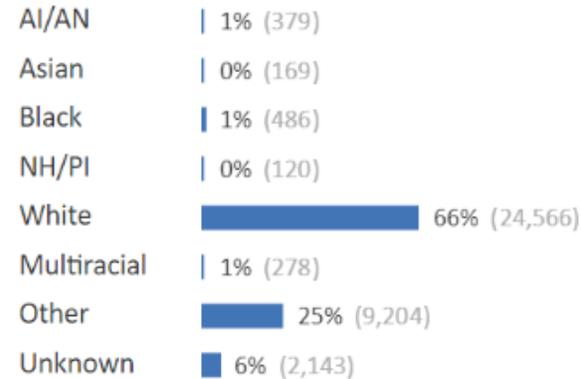
Gender



Ethnicity



Race



OKANOGAN

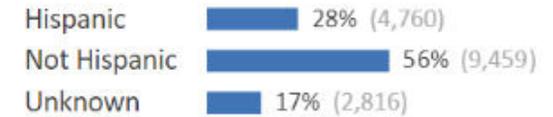
Age Group



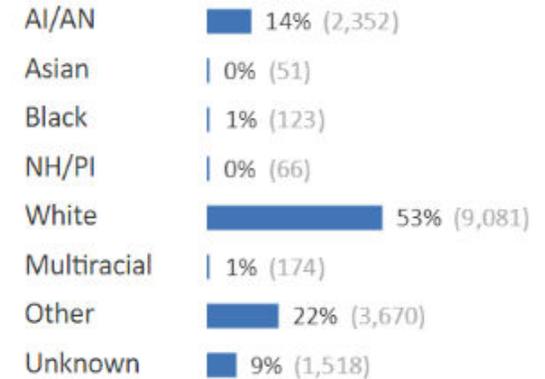
Gender



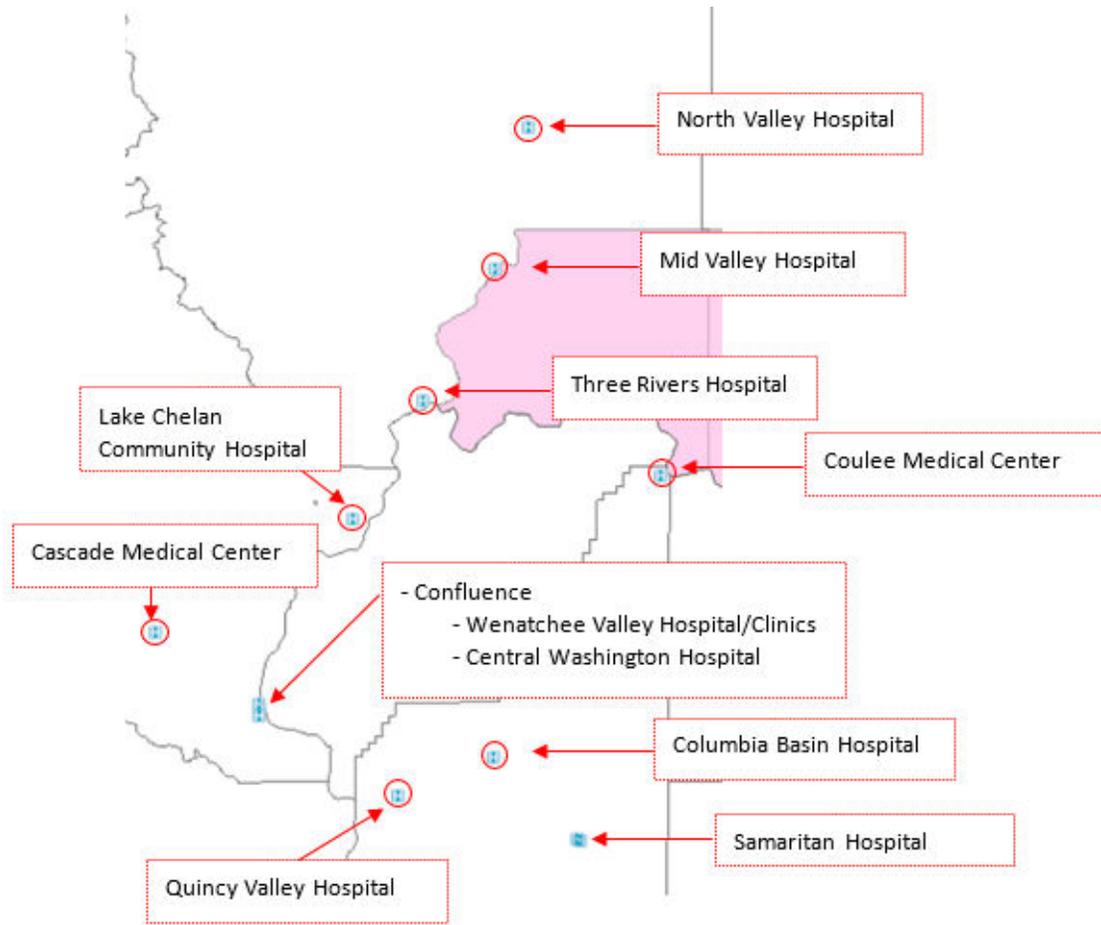
Ethnicity



Race



FY2016 Hospital Census



Hospital	# of Medicaid Discharges	Mean Length of Stay (days)
Cascade Medical Center	5	3.60
Columbia Basin Hospital	25	2.16
Confluence-Central WA Hospital	3,129	3.46
Confluence – Wenatchee Valley Hospital & Clinics	42	10.07
Coulee Medical Center	228	2.24
Lake Chelan Community Hospital	156	2.12
Mid-Valley Hospital	466	1.99
North Valley Hospital	175	2.35
Quincy Valley Medical Center	4	3.00
Samaritan Healthcare	1,233	1.98
Three Rivers Hospital	193	2.09

Source: Health Services and Resources (HRSA) Map Tool
 Critical Access Hospitals circled in red

Source: Department of Health CHARS data | Measurement Period: 1/1/16 – 12/31/16

Top Ten Most Common Causes of Acute Hospitalizations Among Medicaid Recipients

Rank	Cause of Acute Hospitalization	Count	%	State Rank
1	Injury and Poisoning	266	12.1	2 (9.4%)
2	Mental and Behavioral Disorders	171	7.8	1 (18.2%)
3	Diseases of Heart	135	6.1	4 (5.7%)
4	Respiratory Infections	132	6.0	9 (3.6%)
5	Diseases of the Musculoskeletal System and Connective Tissue	115	5.2	5 (4.5%)
6	Substance Use Disorder	105	4.8	6 (4.6%)
7	Septicemia	105	4.8	3 (7.4%)
8	Cancer/Malignancies	102	4.6	8 (3.6%)
9	Diabetes	94	4.3	
10	Diseases of Liver, Biliary Tract, and Pancreas	84	3.8	7 (3.7%)

*Data for North Central ACH, Excluding Pregnancy and Child Delivery Related Hospitalizations (Jan 1, 2015 - Oct 31, 2015)
Source: Health Care Authority Starter Kit, determined by primary diagnosis field in HCA ProviderOne Medicaid Data System*

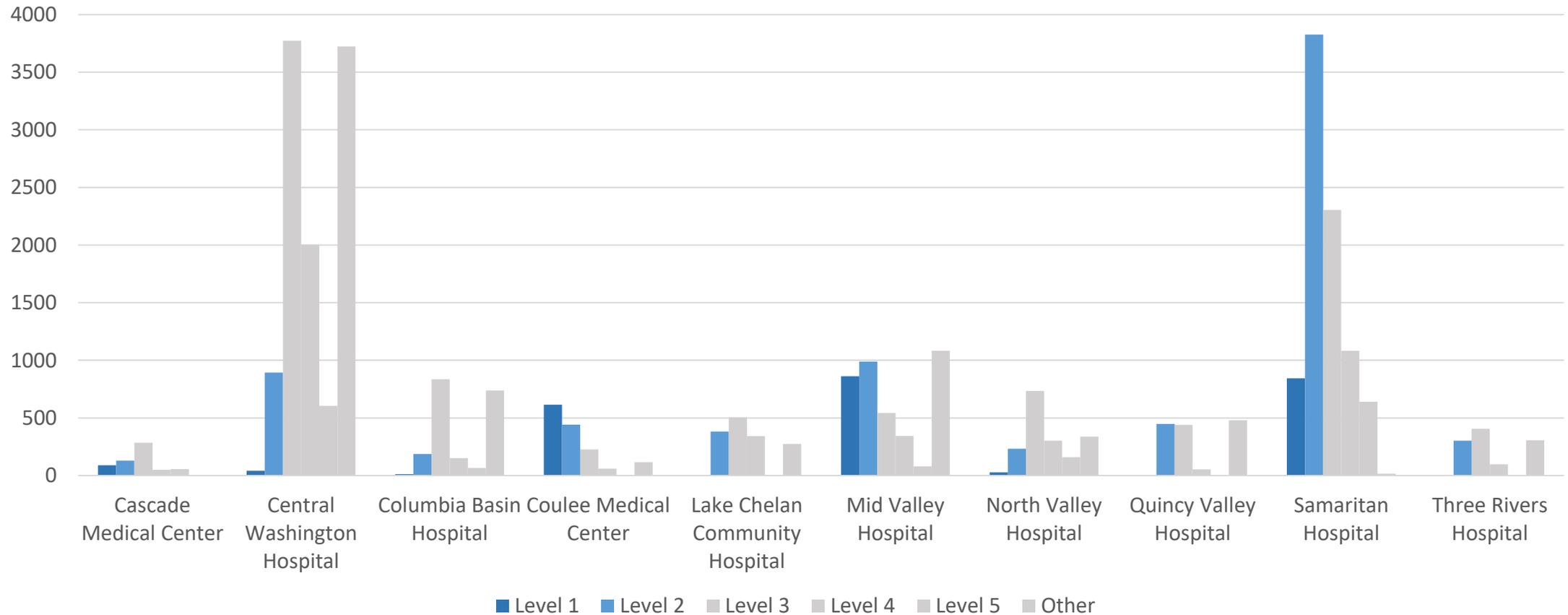
Top Ten Most Common Causes of Outpatient ED Utilization Among Medicaid Recipients

Rank	Cause of Acute Hospitalization	Count	%
1	Symptoms, signs & abnormal clinical and lab findings	8,007	24
2	Injury, poisoning, and certain other consequences of external causes	7,822	23
3	Diseases of the respiratory system	3,860	11
4	Diseases of the digestive system	2,169	6
5	Diseases of the musculoskeletal system and connective tissue	1,635	5
6	Mental and behavioral disorders	1,554	5
7	Diseases of the skin and subcutaneous tissue	1,423	4
8	Diseases of the genitourinary system	1,352	4
9	Pregnancy, childbirth and the puerperium	1,195	4
10	Infectious and parasitic diseases	1,104	3

*Source: Health Care Authority (ED utilization by Facility data set)
Data for North Central ACH (Oct 1, 2015 - Sep 30, 2016)*

ED utilization by Triage Levels

Counts by Hospital and Triage Level

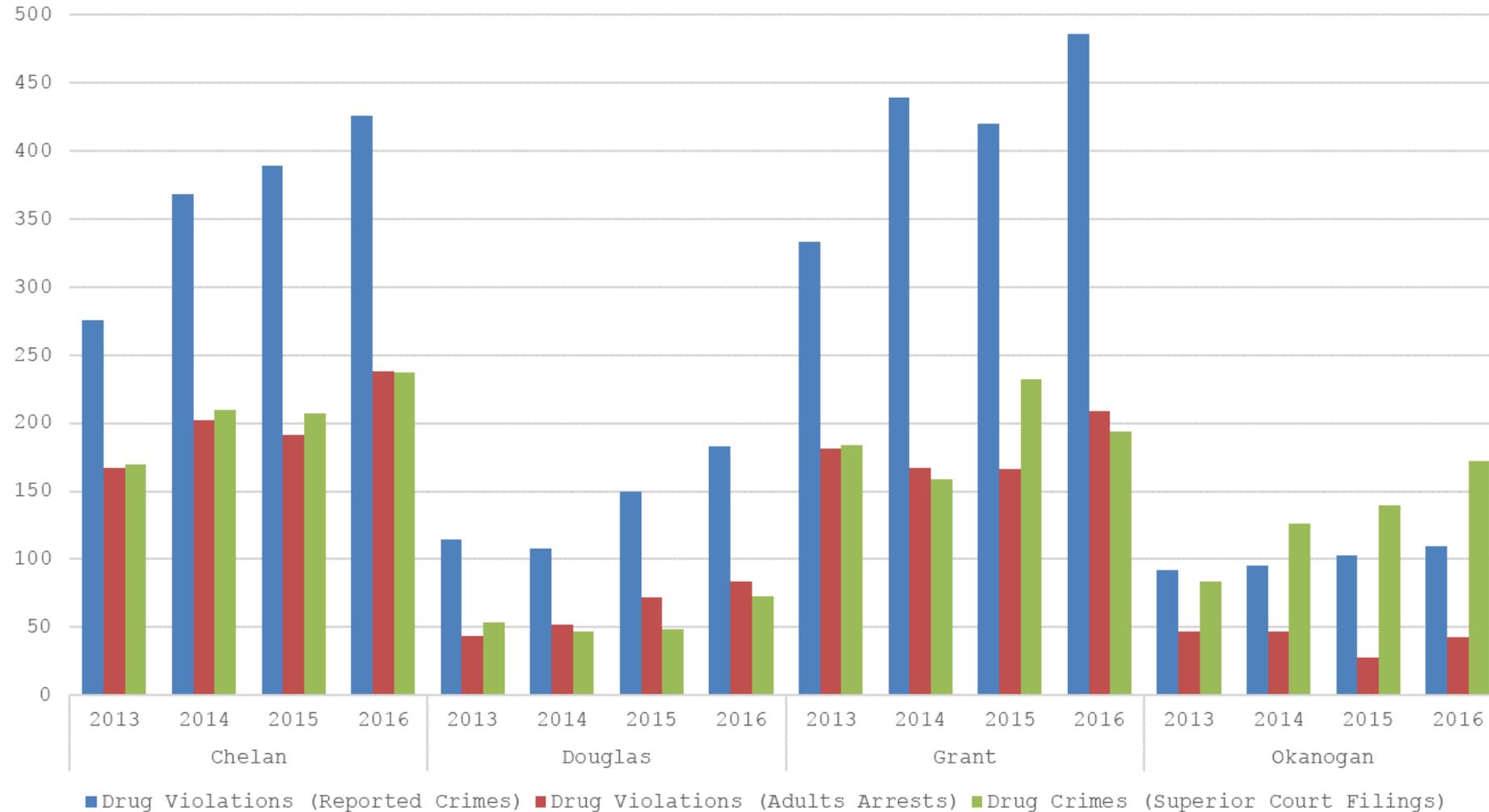


Source: Health Care Authority (ED utilization by Facility data set)

Note: Triage Levels based on CPT code groupings

Arrest/Incarceration Data

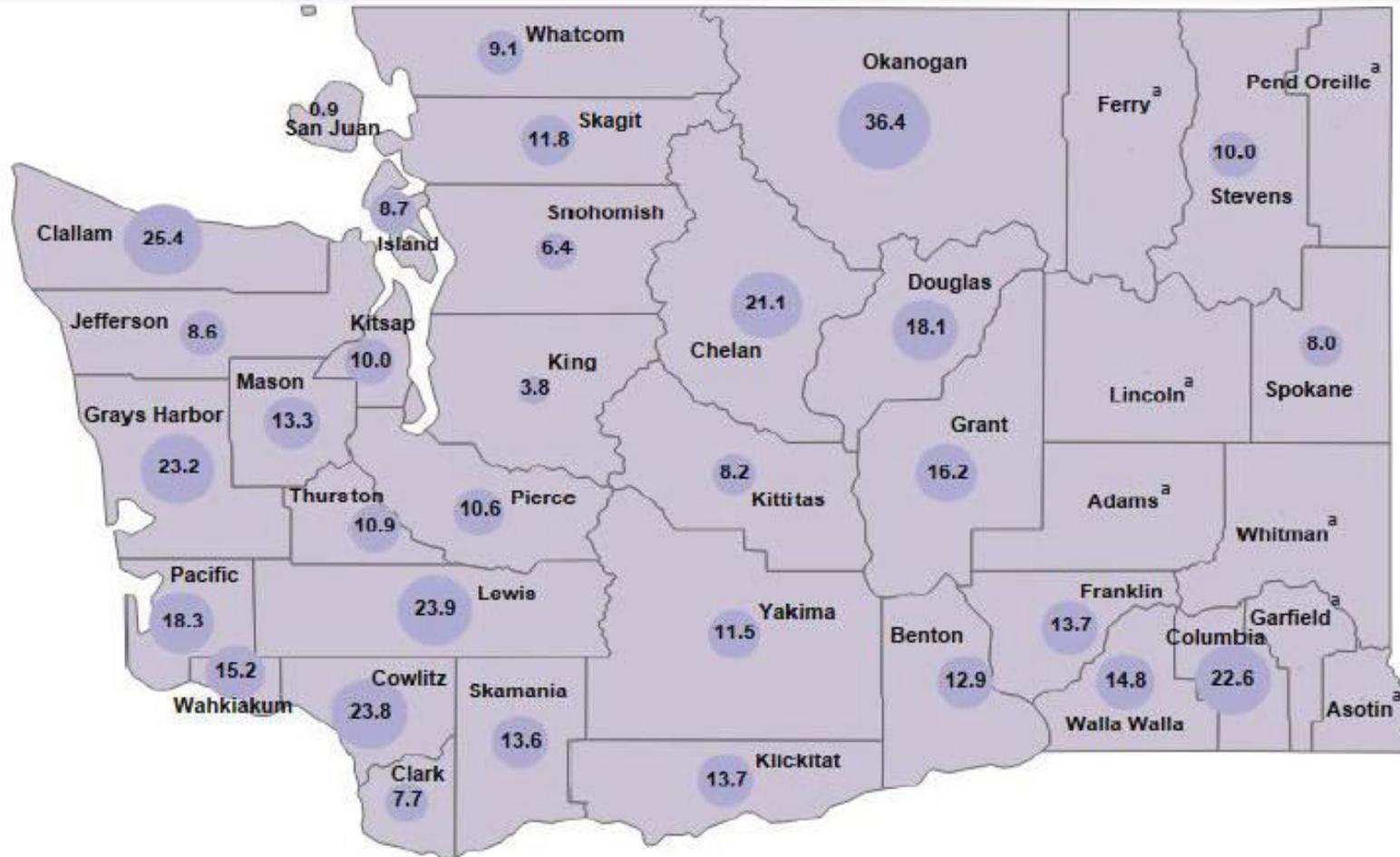
NCACH Criminal Justice Summary by County



Source: Washington State Statistical Analysis Center County Profiles

Youth Detention Rates

Figure 3. Youth-Level Detention Rates by County. This figure shows the number of youth (per 1,000 youth age 10-17 in the county) who had at least one detention stay in 2016.

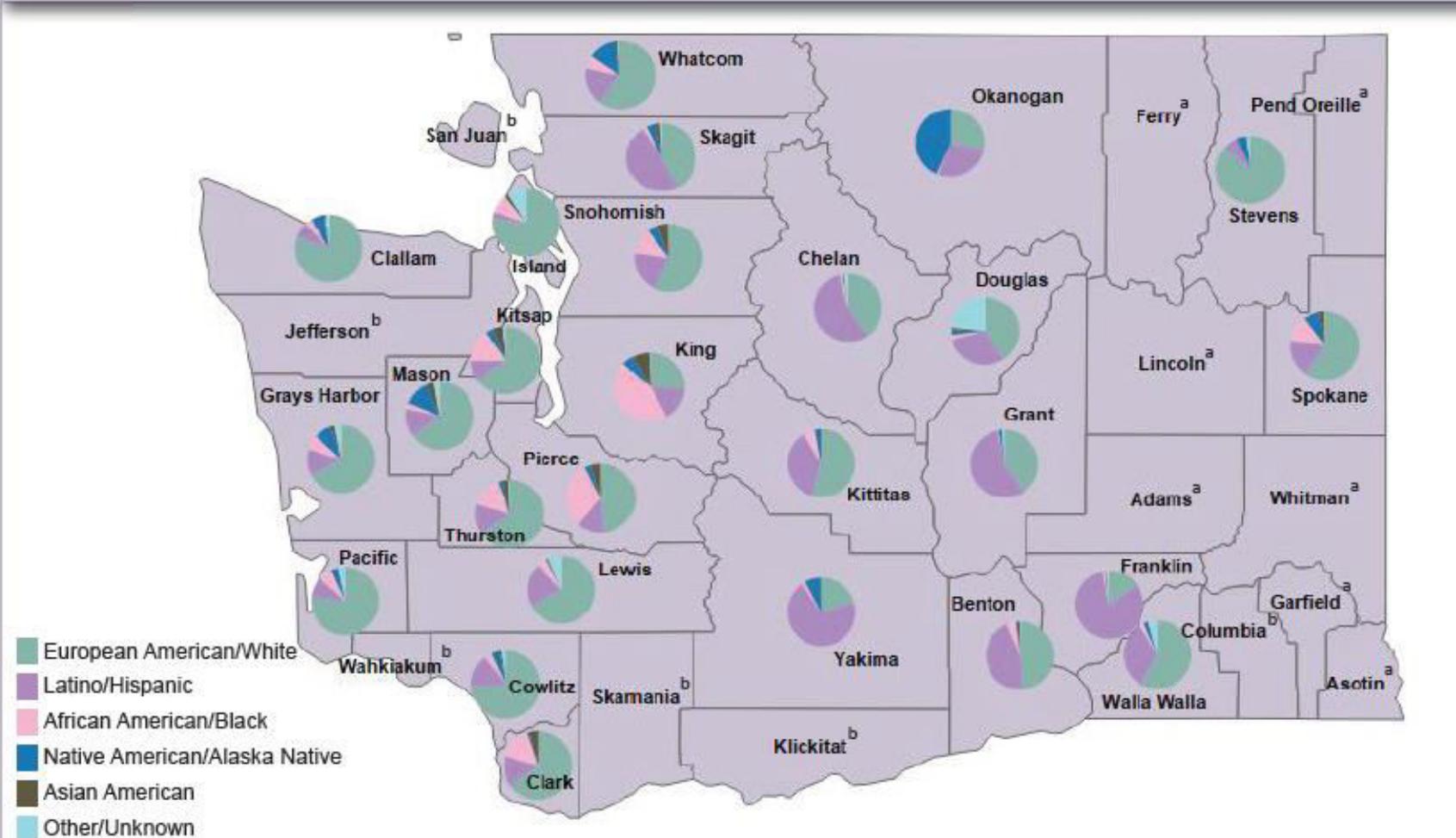


^aDetention data were not available for the full 2016 calendar year from these counties.

Source: Washington State Center for Court Research (Juvenile Detention 2016 Annual Report)

Youth Detention Rates

Figure 5. Youth in Detention in 2016 by Race/Ethnicity and County. This figure shows the racial/ethnic breakdown of youth who had at least one detention stay in 2016.



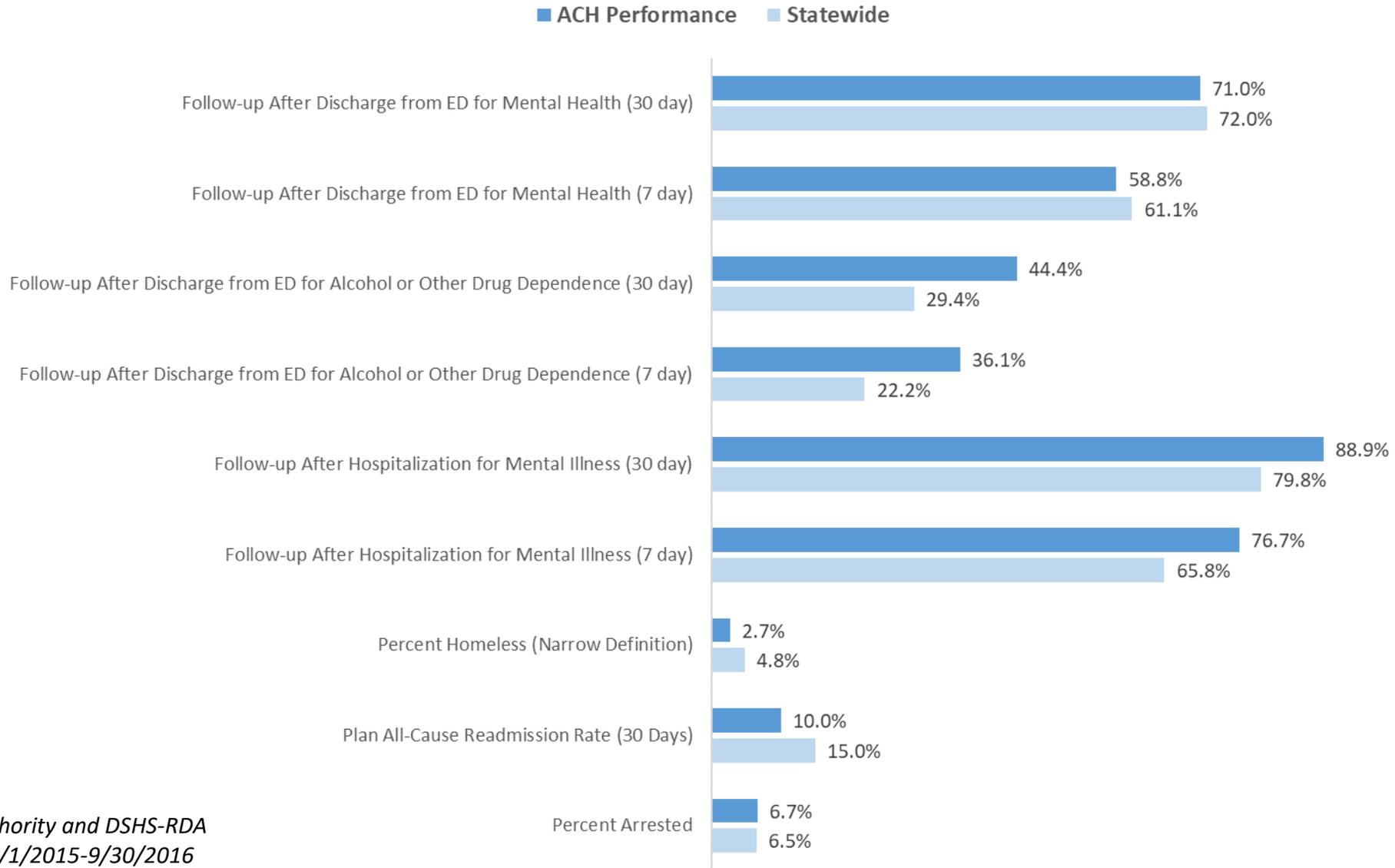
^aDetention data were not available for the full 2016 calendar year from these counties.

^bThese counties' rates are excluded because they had fewer than 30 youth in detention in 2016.

Source: Washington State Center for Court Research (Juvenile Detention 2016 Annual Report)

Accountability Measures

Transitional Care & Diversion Interventions



Source: Health Care Authority and DSHS-RDA
Measurement period 10/1/2015-9/30/2016

Risk Factors for ED Utilization

Risk Factor	X times more likely to exhibit risk factor, if have 3+ ED visits		
Hematological	8.85 (extra high)	4.3 (medium)	4.3 (low)
Type 1 diabetes (high)	7.2		
Pulmonary	6.8 (very high)		4.7 (medium)
Cardiovascular	6.6 (very high)		4.1 (medium)
Renal (extra high)	6.0		
Co-occurring mental illness/substance use disorder	5.2		
Substance abuse (low)	4.8		

Risk Factors for Arrests

Risk Factor	X times more likely to exhibit risk factor, if have 3+ ED visits
Substance abuse - low (drug abuse/dependence)	6.5
SUD treatment need	5.4
Co-occurring mental illness/substance use disorder	4.8
Substance abuse – very low (alcohol abuse/dependence)	3.4
HIV (asymptomatic infection)	3.0
Psychiatric – high (schizophrenia)	2.7
Psychiatric – medium (bipolar)	2.6

Feedback from CHIS

Implications for Transition Care	Implications for Diversion Interventions
Release to homelessness (lack of affordable housing, rigid transitional housing, lack of wet/low barrier shelters)	Ranked order of needs for client populations served by CHI members (both medical and social service providers) <ol style="list-style-type: none"> 1. Non-acute ER use (no same day appointments, nighttime access) 2. Mental health and substance abuse challenges a big issue 3. Inappropriate use of EMS
Need follow up post release (primary care, coaching, patient education, follow up phone calls)	Low health literacy
Referrals to other community resources (non-medical) – need to match to biggest issue	No access to care (in clients’ minds) – don’t know how to access services, lack system navigator, transportation
Legal barriers post incarceration	Lack of coordination of services
Lack of interagency planning	Contact with law enforcement often symptom of lack of engagement with social service network
Lack of system supports (overwhelming, systems not well explained)	
Discharge instructions should be written at 3 rd grade level	

Feedback from CHIs

Data Requests

- Where do ED utilizers (including high utilizers) live? (zip code frequencies and mapping)
- For *Outpatient ED visits* measure from HCA, could we get demographic breakouts?
- For top reasons for hospitalization, can we get data by county?
- Is there aggregate information we could request from WSHA (EDIE) that would help with project planning?
- Can we get measure rates for projects broken out by county?
- **What else would you like to add?**

Feedback from CHIs

Questions / Thoughts

- Is there a way to increase primary urgent care to avoid ER visits? Is there capacity with such few providers? (workforce implications)
- Need to recognize that rural areas with no urgent care clinics may have not other option than ER (e.g. Okanogan County)
- Provide more health literacy course for parents who are taking children to ER
- There is misuse of EMS for non-emergent transport to services
- **What other questions or thoughts do you have?**

Project Reporting Measures

- Report against QIP metrics
- Number of partners trained by selected model/approach: projected vs. actual and cumulative
- Number of partners participating and number implementing each selected model/approach
- % partnering provider organizations sharing information (via HIE) to better coordinate care
- % of partnering provider organizations with staffing ratios equal or better than recommended (Diversion only)
- VBP arrangement with payments/metrics to support adopted model (2021 only)

Project Performance Measures

Transitional Care

- Antidepressant Medication Management
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization
- Medication Management for People with Asthma (5 – 64 Years)
- Mental Health Treatment Penetration (Broad Version)
- **Outpatient ED Visits per 1000 Member Months**
- **Plan All-Cause Readmission Rate (30 Days)**
- Substance Use Disorder Treatment Penetration
- **Percent Homeless (Narrow definition)**
- Percent Arrested
- Medication Assisted Therapy (MAT): With Buprenorphine or Methadone
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Substance Use Disorder Treatment Penetration (opioid)
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

Project Performance Measures

Diversion Interventions

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Next Steps – Project Planning

Project Plan Application Due November 16th

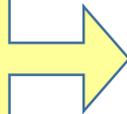
- Preliminary Evidence based Approaches and Target Populations
- Signed Membership Agreement (email to john.Schapman@cdhd.wa.gov)

Project Implementation Planning Timeline

- Read Evidence Based Approaches & review data for Target Populations
- Ensure Alignment with other Demonstration Projects

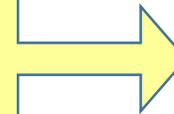
Nov 2017 – Feb 2018

- Assess current state capacity
- Select Target population
- Select Evidence-Based Approach



March 2018 – June 2018

- Identify implementation partners and binding letters of intent
- Financial Sustainability, Workforce, Population Health Management strategies



June 2018 – Sept 2018

Completed
Implementation Plan
***Prefer completion by
July 2018***



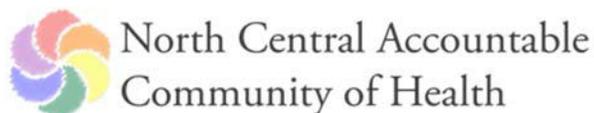
North Central Accountable
Community of Health

Contact

John Schapman

Transitional Care and Diversion Interventions Project Lead

email: john.Schapman@cdhd.wa.gov



Transitional Care and Diversion Interventions Workgroup Charter

Background

On January 9th, 2017 the Washington State Health Care Authority (HCA) signed an 1115 Waiver, now known as the Medicaid Transformation Demonstration Project. The goal of the Demonstration is to improve care, increase efficiency, reduce costs and integrate Medicaid contracting. To align clinical integration with payment integration within the Demonstration Project, HCA developed the [Medicaid Demonstration Project Toolkit](#). Two of the projects that were selected are Transitional Care and Diversion Intervention. The project objects, as described in the toolkit, are:

- Transitional Care – improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place
- Diversion Interventions – Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

Charge

The Transitional Care and Diversion Interventions Workgroup will ensure that the North Central region implements effective evidence based practices that align with the milestones and approaches described in the Toolkit. Specifically the Workgroup will complete the following:

- Provide recommendations to the NCACH Governing Board and staff on approaches to take for Transitional Care and Diversion Interventions projects.
- As much as possible, ensure Diversion Interventions and Transitional Care projects align with all six projects NCACH selected to implement.
- Collect, synthesize, and use stakeholder and community input on project planning and implementation.
- Work with NCACH partners to implement sustainable changes in the regional health care system (broadly conceived) that improve effective transitions for patients re-entering the community from intensive care settings or incarceration, and provide more effective alternatives to incarceration, inpatient treatment or emergency department care for patients whose needs can be better addressed in other ways.
- Determine how work completed through Transitional Care and Diversion Interventions are able to be financially sustainable past the Demonstration period.
- As much as possible, ensure projects effectively connect patients with resources to mitigate the negative consequences of the social determinants of health.
- Identify how IT, workforce, and value-based payment strategies can support this project.

Composition

The Transitional Care and Diversion Interventions Workgroup will include representatives from Grant, Chelan, Douglas, and Okanogan Counties. Workgroup membership is not a prerequisite to receiving funding through the Demonstration. The NCACH Executive Committee will recommend to the Governing Board workgroup members from a list of interested parties which may include representation from:

- Emergency Medical Services (EMS)
- Law Enforcement
- Legal Services
- Regional Justice Centers (Jails)

- Hospitals
- Skilled Nursing Facilities/Assisted living/Long-term Care Facility/Hospice
- Aging and Adult Care
- Managed Care Organizations (*Operating in all 4 NCACH counties after January 1st, 2018*)
- Behavioral Health Administrative Service Organization
- Behavioral Health Providers including Crisis providers
- Primary Care Providers
- Care Coordination agency/Case Managers
- Education
- Tribal

Additional representation will be added to the Workgroup by the Executive Director if it is deemed necessary. A Workgroup Chair will be appointed by the Executive Director. The Transitional Care and Diversion Interventions Workgroup is a sub-committee of the NCACH board and as such will be led by the Workgroup Chair and NCACH staff and must have a minimum of two board members serving on the Workgroup.

Meetings

Transitional Care and Diversion Interventions Workgroup meetings will be held once per month, with additional meetings scheduled as necessary. Meetings will be held in Chelan, Douglas, Grant, and Okanogan Counties; locations will vary and an effort will be made to hold meetings in each of the Local Health Jurisdictions throughout the year. Whenever possible, meetings will have an option to participate via teleconference or audioconference for those unable to attend in person, although in-person participation is encouraged. NCACH program staff and the Workgroup Chair shall be responsible for establishing the agendas. Notes for all meetings will be provided to the Workgroup by NCACH staff within two weeks of each meeting. Monthly meetings will be open meeting minutes and materials will be posted on the NCACH website (www.ncach.org).

Membership Roles and Responsibilities

1. Attend at least 75% of regular meetings of the Workgroup and actively participate in the work of the Workgroup.
2. Sign a Membership Agreement (attachment A)
3. Communicate with other members of your sector and/or community to ensure broader input into the design, planning, and implementation process.
4. Assess current state capacity to effectively deliver Transitional Care and Diversion Interventions.
5. Select initial target population and evidence-supported approaches informed by the regional health needs assessment and community data.
6. Review prepared data to recommend target population(s), to guide project planning and implementation, and to promote continuous quality improvement
7. Assist in identifying, recruiting, and securing formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.

8. Recommend to the Board a project implementation plan, including a financial sustainability model and how projects will be scaled to full region in advance of HCAs project implementation deadline.
9. Monitor project implementation plan, including scaling of implementation plan across region, and provide routine updates and recommended adjustments of the implementation plan to the NCACH Governing Board.
10. Develop and recommend a funding process to the NCACH Governing Board for non-primary care and outpatient behavioral health members involved in Transitional Care and Diversion Interventions projects
11. Collaborate with NCACH staff on data and reporting needs related to Demonstration metrics, and on the application of continuous quality improvement methods in this project.
12. Use strategies that are supported by regional data, to advance equity and reduce disparities in the development and implementation of the Transitional Care and Diversion Intervention Projects.

Authority

The Transitional Care and Diversion Interventions Workgroup is an advisory body that will inform decision-making by the NCACH Governing Board and ensure regional priorities and local considerations are incorporated in program design decisions. Recommendations and input developed by the Workgroup will be shared in regular monthly progress reports to the NCACH Governing Board.

**North Central Accountable Community of Health
Transitional Care and Diversion Interventions Workgroup
(Attachment A)**

Membership Agreement

I acknowledge by my signature of this membership agreement that I have read, understood, and agreed to follow the guidelines and policies outlined in the North Central Accountable Community of Health Transitional Care and Diversion Interventions Workgroup Charter.

I understand that continued membership in the Workgroup is contingent on following the requirements of membership that are outlined in the Charter. Not meeting the requirements for membership could result in the loss of my membership status in the Workgroup.

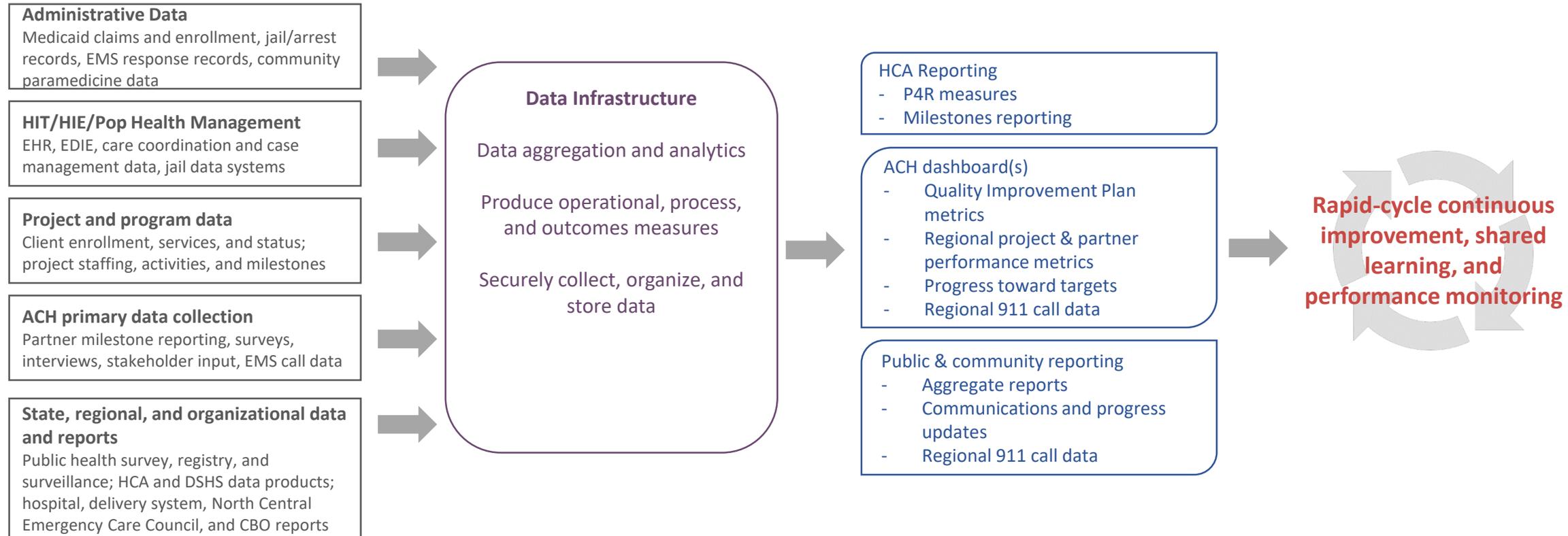
Dated: _____

Signed: _____

Print Name: _____

Title: _____

Diversion Intervention Planned Approach for Monitoring and Continuous Improvement



SECTION II: PROJECT-LEVEL

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

Transformation Project Description

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

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

Project Selection & Expected Outcomes

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

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

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

population, regardless of chosen target population(s) or selected approaches/strategies

ACH Response

The opioid crisis in the U.S. has reached unprecedented levels, with more than 64,000 drug overdose deaths in 2016¹. Perhaps the most compelling statistic is that more people died from drug overdoses nationally in 2016 than died during the peak years for car accident deaths (54,589 in 1972), HIV deaths (50,628 in 1995), and homicide deaths (24,703 in 1991)^{2,3}. Because each of these crises threatened public health, there were massive, national efforts to respond to and curb these problems. The opioid epidemic is no different. It is beyond time for a substantial response from national, state, and local levels. The process began in October 2016 when Washington Governor Jay Inslee signed Executive Order 16-09⁴ directing state agencies to implement the state opioid response plan, with an immediate focus on the prevention, treatment, overdose prevention, and data-driven evaluation of opioid interventions. More recently, in October 2017, President Trump declared the opioid crisis a public health emergency⁵, which could release additional resources and waive some regulations to help fight the opioid crisis. North Central Accountable Community of Health (NCACH) is working at the regional and local levels to harness the urgency and make dramatic reductions in opioid morbidity and mortality in our four counties (Chelan, Douglas, Grant, and Okanogan). Though the Opioid Use Public Health Crisis Project (Opioid Project) is a

Drug overdose deaths 1980 to 2016

59,000 to 65,000 people died from drug overdoses in the U.S. in 2016

- Peak car crash deaths (1972)
- Peak H.I.V. deaths (1995)
- Peak gun deaths (1991)

*Estimate based on preliminary data

Source: Adapted from the New York Times, Drug overdose deaths, 1980-2016.

¹ Overdose Death Rates. (Revised September 2017.) Retrieved from National Institute on Drug Abuse website: <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

² Katz, J. (June 5, 2017). Drug Deaths in America Are Rising Faster Than Ever. *New York Times*.

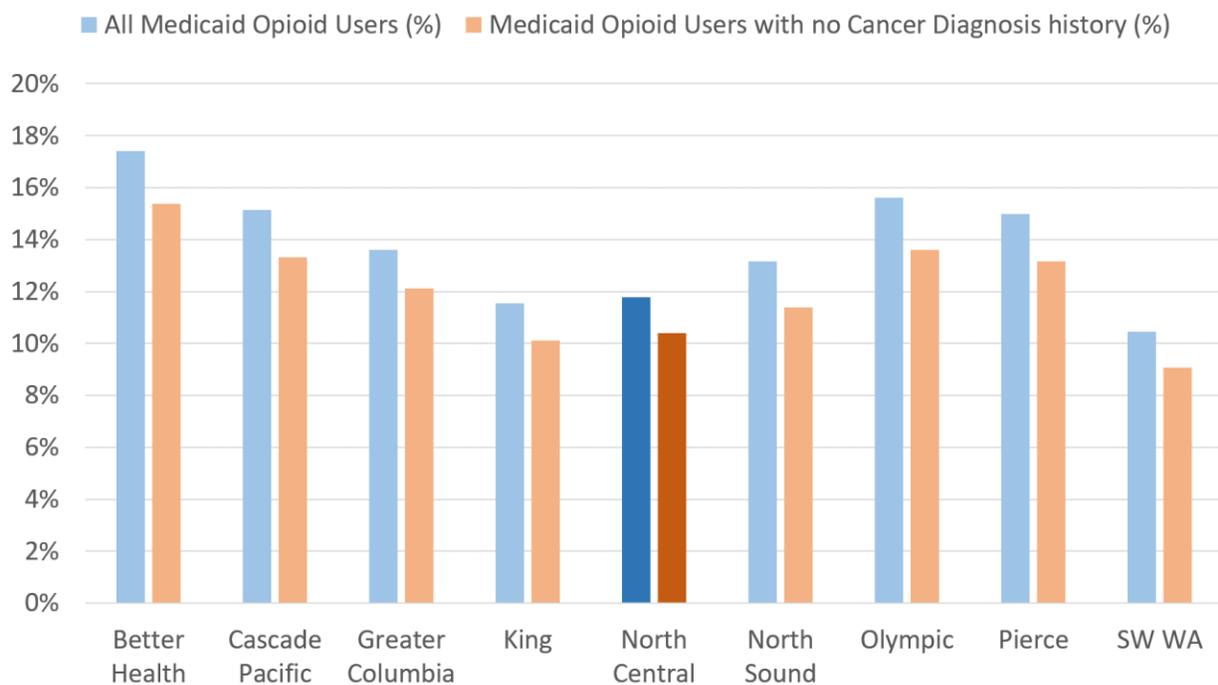
³ Police Executive Research Forum. (September 2017). *The Unprecedented Opioid Epidemic: As overdoses become a leading cause of death, police, sheriffs, and health agencies must step up their response*. Retrieved from Police Executive Research Forum website: <http://www.policeforum.org/assets/opioids2017.pdf>

⁴ Executive Order 16-09: Addressing the Opioid Use Public Health Crisis. (October 7, 2016). Retrieved from Washington Governor’s website: <http://www.governor.wa.gov/sites/default/files/16-09OpioidPreventionE.pdf>

⁵ Merica, D. (October 26, 2017). Trump declares opioid epidemic a national public health emergency. *CNN*. Retrieved from: <http://www.cnn.com/2017/10/26/politics/donald-trump-opioid-epidemic/index.html>

required project in the Medicaid Transformation Demonstration Toolkit, qualitative and quantitative data indicate that this project is necessary for our region.

Opioid use and abuse in the NCACH region has mirrored national trends showing increases in the number of individuals using prescription opioids. The NCACH region has 492 providers who prescribe opioids⁶. Of the 11,068 Medicaid members with opioid prescriptions, 88% (9,764) have no history of cancer diagnosis. Of those members, 19% (1,742) are considered heavy users and 19% (1,815) are chronic users with prescriptions for 30 days or more. Although the total volume of opioid users is smallest in our region compared to the rest of the state, NCACH rates of prescription opioid use are similar to statewide rates⁷. Opioid use based on Health Care Authority (HCA) indicators, however, is likely underreported since indicators are based on claims data that does not account for users who are obtaining prescription opioids illegally or are using non-prescriptions opiates.



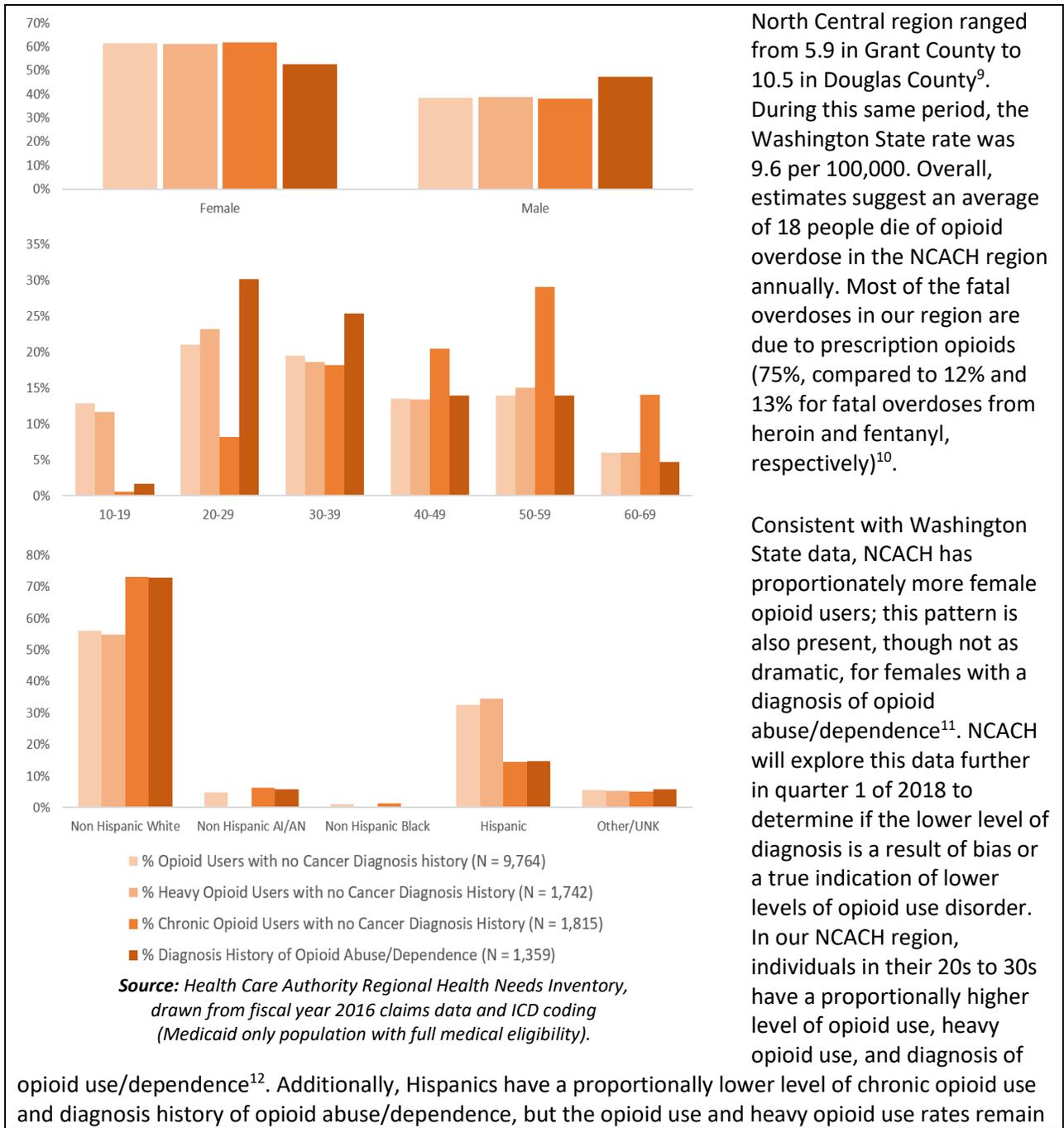
Source: Health Care Authority Regional Health Needs Inventory Starter Kit, 2016

From 2002 to 2013, treatment admissions for opiates increased for all four counties in the region. Okanogan County had 21.6 publicly funded opiate treatment admissions per 100,000 population in 2002-2004. This rate more than quadrupled, with 99.4 admissions in 2011-2013. The rate for Douglas County increased fivefold, from nine treatment admissions per 100,000 population in 2002-2004 to 50 in 2011-2013⁸. From 2012-2016, the opioid-related overdose death rates (age-adjusted rate per 100,000) in the

⁶ Health Care Authority Regional Health Needs Inventory Starter Kit. (April 25, 2017) "Project-Opioid-Medicaid" tab.

⁷ Health Care Authority Regional Health Needs Inventory Starter Kit. (April 25, 2017) "Project-Opioid-Medicaid" tab.

⁸ University of Washington Alcohol and Drug Abuse Institute. (April 2015). *Opioid Trends Across Washington State*. Retrieved from UWADAI website: <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>



North Central region ranged from 5.9 in Grant County to 10.5 in Douglas County⁹. During this same period, the Washington State rate was 9.6 per 100,000. Overall, estimates suggest an average of 18 people die of opioid overdose in the NCACH region annually. Most of the fatal overdoses in our region are due to prescription opioids (75%, compared to 12% and 13% for fatal overdoses from heroin and fentanyl, respectively)¹⁰.

Consistent with Washington State data, NCACH has proportionately more female opioid users; this pattern is also present, though not as dramatic, for females with a diagnosis of opioid abuse/dependence¹¹. NCACH will explore this data further in quarter 1 of 2018 to determine if the lower level of diagnosis is a result of bias or a true indication of lower levels of opioid use disorder. In our NCACH region, individuals in their 20s to 30s have a proportionally higher level of opioid use, heavy opioid use, and diagnosis of

opioid use/dependence¹². Additionally, Hispanics have a proportionally lower level of chronic opioid use and diagnosis history of opioid abuse/dependence, but the opioid use and heavy opioid use rates remain

⁹ Washington State Department of Health. (May 2017). *Opioid-related Deaths in Washington State, 2006-2016*. Retrieved from Department of Health website: <https://www.doh.wa.gov/Portals/1/Documents/Pubs/346-083-SummaryOpioidOverdoseData.pdf>

¹⁰ Washington Department of Health. *Washington Tracking Network*. Data based on 2011-2015 time period (not specific to Medicaid recipients.)

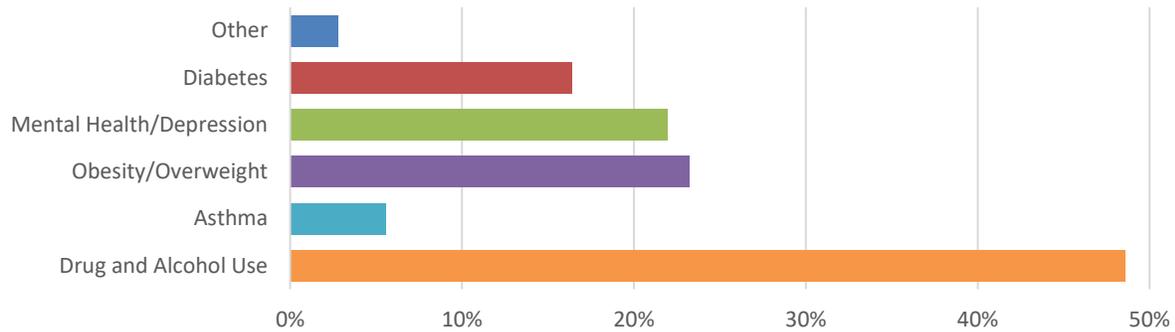
¹¹ Health Care Authority Regional Health Needs Inventory Starter Kit. (April 25, 2017) "Project-Opioid-Medicaid" tab.

¹² Health Care Authority Regional Health Needs Inventory Starter Kit. (April 25, 2017) "Project-Opioid-Medicaid" tab.

fairly proportional for the Hispanic population¹³. This data indicates that the Hispanic population uses opioids at a rate consistent with the Non-Hispanic White population, however the Hispanic population does not appear to transition to chronic opioid use or be diagnosed with opioid abuse at the same frequency. These quantitative data are supported by community feedback. Our NCACH region’s Community Health Needs Assessment, which was released in December 2016, identified drug and alcohol use as a high priority health need (ranked sixth overall)¹⁴. As a follow up to this assessment, NCACH staff administered a community survey at three outreach events in Wenatchee, Moses Lake, and Grand Coulee. Of 323 survey respondents, 157 (49%) identified drug and alcohol use as the biggest health problem in their community¹⁵.

What is the biggest health problem in your community?

(n= 323)



Together, these data show the true need for a comprehensive response to the opioid epidemic that involves prevention, treatment, overdose prevention, and recovery supports. Through efforts of the Opioid Project, we expect to reduce the number of opioid-related deaths, the number of opioid overdoses, the number of people abusing opioids, and inappropriate use of opioids (people with higher than recommended prescriptions). In order to accomplish these expected outcomes, NCACH will align with the 2016 Washington State Interagency Opioid Working Plan (Interagency Plan) which uses a multi-pronged approach that includes strategies targeting prevention, treatment, and overdose. It is also NCACH's goal to embed whole person care in all six of our projects; therefore, it is imperative to promote recovery supports and whole person care for those in recovery or seeking treatment.

The Interagency Plan is a comprehensive plan collaboratively developed by five Washington State agencies. Within the Interagency Plan, there are a number of strategies to accomplish each goal (prevention, treatment, overdose prevention). NCACH will use the Interagency Plan as a guideline for selecting approaches to implement based on proposed strategies in the Interagency Plan. NCACH, through the Regional Opioid Stakeholders Workgroup (described below), will select approaches that are most critical to success of reduction of opioid morbidity and mortality in the NCACH region based on need, impact, health equity, sustainability, and feasibility (monetary, data, political, and practical). Though specific selections of strategies have not been decided upon yet, there have been preliminary discussions regarding potential approaches to implement.

¹³ Health Care Authority Regional Health Needs Inventory Starter Kit. (April 25, 2017) "Project-Opioid-Medicaid" tab.

¹⁴ Chelan-Douglas Health District. (December 31, 2016). *2016 Community Health Needs Assessment*.

¹⁵ North Central Accountable Community of Health. (2017.) *Community Survey*.

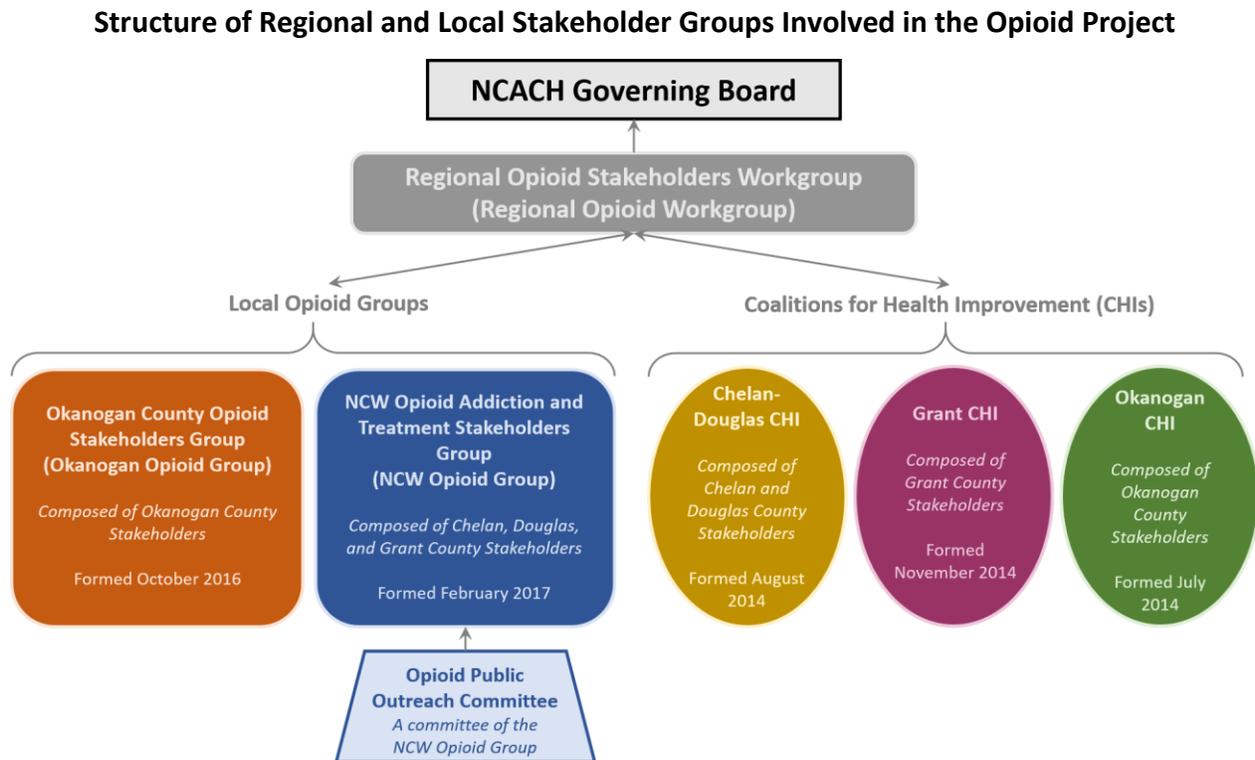
Approaches that have been discussed include naloxone distribution with emergency department discharge after overdose, expansion of medication take-back box program, development of syringe exchange program in Grant County, and conducting a regional opioid use prevention and health education media campaign targeting youth and parents.

A significant aspect of the Opioid Project will be implemented through our Whole Person Care Collaborative (WPCC). Established May 4th, 2016, the WPCC membership includes all major primary care and behavioral health care providers serving Medicaid beneficiaries in the region. In 2018, WPCC members will be tasked with developing organizational change plans to address bi-directional integration of primary care and behavioral health. The change plans will also incorporate key clinical aspects of the other five projects (i.e., Care Coordination Project, Transitional Care Project, etc.). Specific to the Opioid Project, the change plans will have a required section dedicated to increasing use of the Washington State Prescription Monitoring Program, increasing number of buprenorphine prescribers and caseload, and increasing the number of physicians trained on the 2015 Agency Medical Director's Group Interagency Guideline for Prescribing Opioid for Pain (AMDG Prescribing Guidelines) and/or the CDC Guideline for Prescribing Opioids for Chronic Pain (CDC Prescribing Guidelines). Of note, a pay-for-reporting metric NCACH will be required to report is the number of health care providers trained on the AMDG's Prescribing Guidelines. However, NCACH will likely include both AMDG's Prescribing Guidelines and CDC Prescribing Guidelines in the change plan since the Affiliated Tribes of Northwest Indians (ATNI), on September 18-21, 2017, adopted a resolution stating "in the absence of any tribal-specify policy to reduce opioid addiction, overdose and death of AI/AN people, the ATNI supports adoption of the CDC Guideline for Prescribing Opioids for Chronic Pain."¹⁶ Each of these change plan requirements is in alignment with the Interagency Plan. These components may evolve as the change plan template and scoring criteria are still in draft form, but will address the key aspects of promoting use of best practices among health care providers and accessing opioid use disorder treatment services.

NCACH is aware that there are already many efforts under way in our region to address the opioid epidemic. NCACH can provide a regional perspective and approach as well as leverage the WPCC to engage clinical and behavioral health providers in a multi-sector collaborative approach. There are currently two opioid stakeholder groups in our region: Okanogan County Opioid Stakeholders Group (Okanogan Opioid Group) and North Central Washington Opioid Addiction and Treatment Stakeholders Group (NCW Opioid Group). In late 2016, the Okanogan Opioid Group originated in response to a community concern to opioid overdose deaths. This group is organized and led by the Okanogan County Health District. The NCW Opioid Group was formed in February 2017, and is organized and led by the Douglas County Prosecutor. Membership consists of Chelan, Douglas, and Grant County stakeholders; Okanogan County stakeholders are invited and welcome to participate, though they generally do not (presumably due to travel time/distance). Grant County stakeholders are currently participating in the NCW Opioid Group, though it is unclear if a separate Grant County Opioid Group will form or they will continue to be combined. An Opioid Public Outreach Committee formed as a subgroup of the NCW Opioid Group, with the mission to develop a regional (Chelan, Douglas, Grant, and Okanogan Counties) communications plan for opioid outreach and public education. The two local opioid groups and the Opioid Public Outreach Committee meet at least quarterly. NCACH staff has regularly participated in these meetings and will continue to participate. For a visual representation of these groups and how

¹⁶ Affiliated Tribes of Northwest Indians. (September 18-21, 2017). Resolution #17-59. *Support for Adoption of "Center for Disease Control Guideline for Prescribing Opioids for Chronic Pain by Indian Health Service Facilities and Tribal Health Organizations."* Retrieved from ATNI website: <http://www.atntribes.org/sites/default/files/Res-17-59.pdf>.

they relate, see the *Structure of Regional and Local Stakeholder Groups Involved in the Opioid Project* diagram on the following page.



Since no regional group existed, NCACH established a Regional Opioid Stakeholders Workgroup (Regional Opioid Workgroup). Over the next six to nine months, the Regional Opioid Workgroup will select approaches to implement and develop a detailed implementation plan while ensuring our work is coordinated with and does not duplicate existing efforts in the NCACH region. The Regional Opioid Workgroup members were carefully selected by the NCACH Governing Board Executive Committee to have broad regional and sector representation. Membership of this group includes three representatives from each local health jurisdiction (Chelan-Douglas, Grant, and Okanogan) that are also members of the Okanogan Opioid Group or the NCW Opioid Group. Additionally, the charter specifically ensures representation of the following sectors: emergency medical services, law enforcement, regional justice centers and juvenile court, education, public health, emergency departments, primary care, behavioral health, Managed Care Organizations (MCOs), behavioral health-administrative service organization, dental, pharmacy, and tribal partners. Since each of these sectors interconnects with the opioid epidemic in varied ways, the Board felt each were critical to engage in developing our detailed project plans to ensure we do not overlook essential aspects of addressing the opioid epidemic. Each of the representatives brings expertise in their field and a unique and necessary perspective to the Regional Opioid Workgroup. Though they are often prescribers of opioids, the dental sector had not yet been engaged in local opioid efforts, making NCACH especially fortunate to be able to recruit a dental provider to the Regional Opioid Workgroup. Each of the specified sectors, with the exception of tribal, is currently represented on the Regional Opioid Workgroup. The individual recommended as the tribal representative on the Regional Opioid Workgroup recently declined participation due to lack of time (not lack of interest). NCACH is working with the NCACH Governing Board tribal representative to identify an alternative representative.

Another avenue for the Regional Opioid Workgroup to ensure NCACH is addressing regional and local priorities is through the Coalitions for Health Improvement (CHIs). The CHIs are local coalitions in each of the three local health jurisdictions (Chelan-Douglas, Grant, and Okanogan). These broad-based coalitions are open to all members in the community and community-based organizations, health care providers, and community members are all encouraged to participate. The CHIs serve two main functions with respect to the Opioid Project:

1. Provide input to the Regional Opioid Workgroup on strategies chosen from the Interagency Plan including identifying areas within their community where existing efforts exist.
2. Work with the Regional Opioid Workgroup to better engage local partners and utilize the Demonstration to enhance current opioid efforts in the community.

Bi-directional communication between the Regional Opioid Workgroup and each of the CHIs will be instrumental in ensuring that our work is coordinated with and not duplicative of existing opioid efforts.

Lastly, NCACH staff will continue to attend bi-monthly regional meetings of law enforcement (police chiefs and sheriffs) within the current North Central Washington Behavioral Health Organization's service areas. This group meets to address law enforcement issues related to behavioral health. NCACH staff will coordinate with and share opioid efforts occurring in the region (specifically as they address law enforcement) to ensure we work to enhance the current work occurring in this sector.

Working through the Regional Opioid Workgroup with the local opioid groups, the CHIs, and the Behavioral Health Law Enforcement Group, NCACH will develop an initiative matrix identifying current and planned opioid initiatives. The initiative matrix will also identify where there is interest in developing certain initiatives. The Regional Opioid Workgroup will determine where the NCACH can supplement and enhance the work currently taking place in the region. Additionally, by quarter 3 of 2018, NCACH will provide a matrix of how all six projects within the Demonstration connect to each other to ensure each project supports one another.

The target population is preliminarily defined as Medicaid individuals who use or abuse opioids (prevention, treatment, overdose prevention, recovery) and those at risk for using or abusing opioids (prevention). Though our target population selection is preliminary and will need further refinement during the development of the implementation plan, we do anticipate there to be an educational component of this project specifically targeting youth opioid use prevention. For this component, we hope to be able to provide direct presentations or a toolkit/train-the-trainer approach to reach 25-50% of the 29 school districts in our region¹⁷ over the course of the Demonstration, in particular targeting school districts in more rural areas that may not have necessary resources to develop opioid prevention and education materials. This approach will also give us the opportunity to expand the scope and size of the intervention with relatively low marginal costs (i.e., the marginal cost of adding additional school districts will be quite small).

Additionally, we aim to reach all Medicaid beneficiaries currently receiving prescription opioids through expanded medication-assisted treatment access, expansion of medication take-back boxes, and education efforts aimed at opioid users, opioid prescribers, and pharmacists. NCACH has an estimated

¹⁷ North Central Education Service District 171. www.ncesd.org

9,764 Medicaid individuals who use opioids, so our optimistic estimated reach is just under 10,000 individuals who use or abuse opioids¹⁸. While our selected strategies will target Medicaid populations, many strategies will “spill-over” to the non-Medicaid population (e.g., provider training on prescribing practices, education and prevention campaigns).

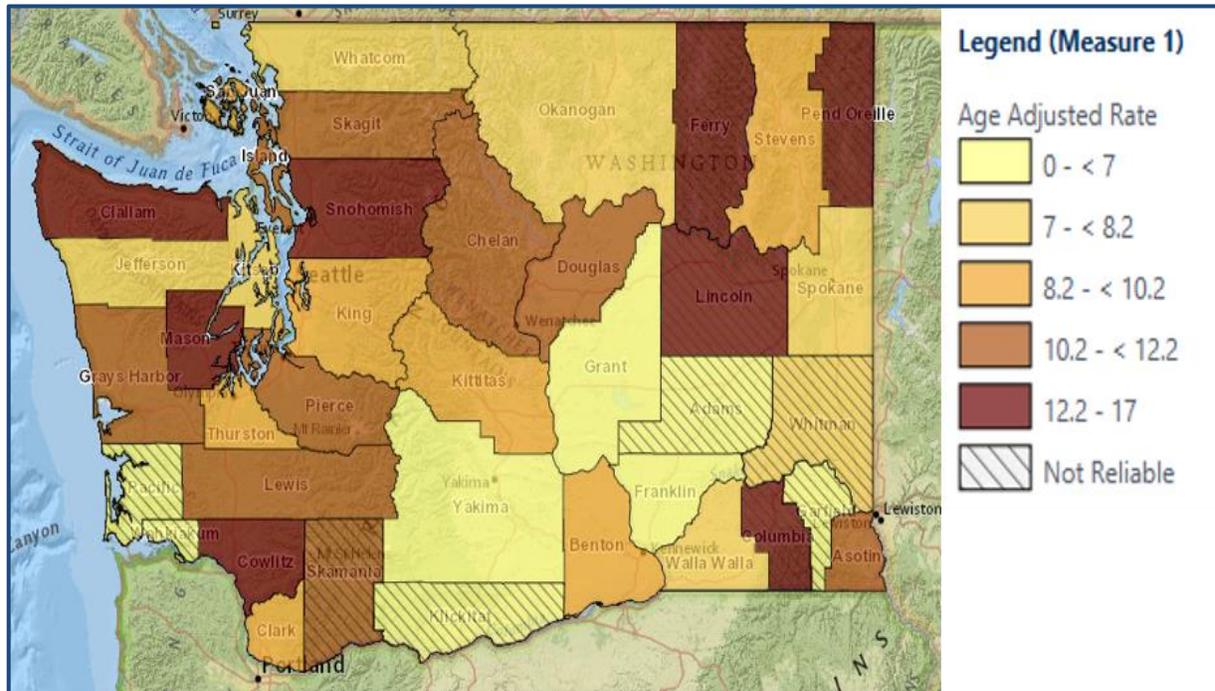
Furthermore, NCACH anticipates developing a comprehensive approach to overdose prevention which includes expanded distribution of naloxone to first responders and law enforcement, distribution to opioid patients at pharmacies, and distribution to patients discharged from EDs who had an opioid overdose. The ideal goal is to be able to utilize naloxone on 100% of people who experience an overdose. In 2016, there were 47 opioid overdose hospitalizations in the North Central region¹⁹ and in 2015 there were 20 fatal opioid overdoses (calculated based on a five-year average)²⁰ in our four counties (2016 data is not yet available at the regional level). An important aspect of this work is to note that naloxone distribution, while being a lifesaving necessity, also allows touch points to capture individuals into treatment at a point in time when they may be ready to accept it. NCACH understands that this is a lofty goal. However, shortly after Grant County Sheriff’s department started carrying naloxone, they saved two lives from opioid overdose. Increased distribution, awareness, and training of naloxone can amplify these results throughout our region and help us move towards our target.

¹⁸ Health Care Authority Drawn from fiscal year 2016 claims data and ICD coding (Medicaid only population with full medical eligibility).

¹⁹ Washington Department of Health – Quarterly Opioid Dashboard. 2016. (not specific to Medicaid only)

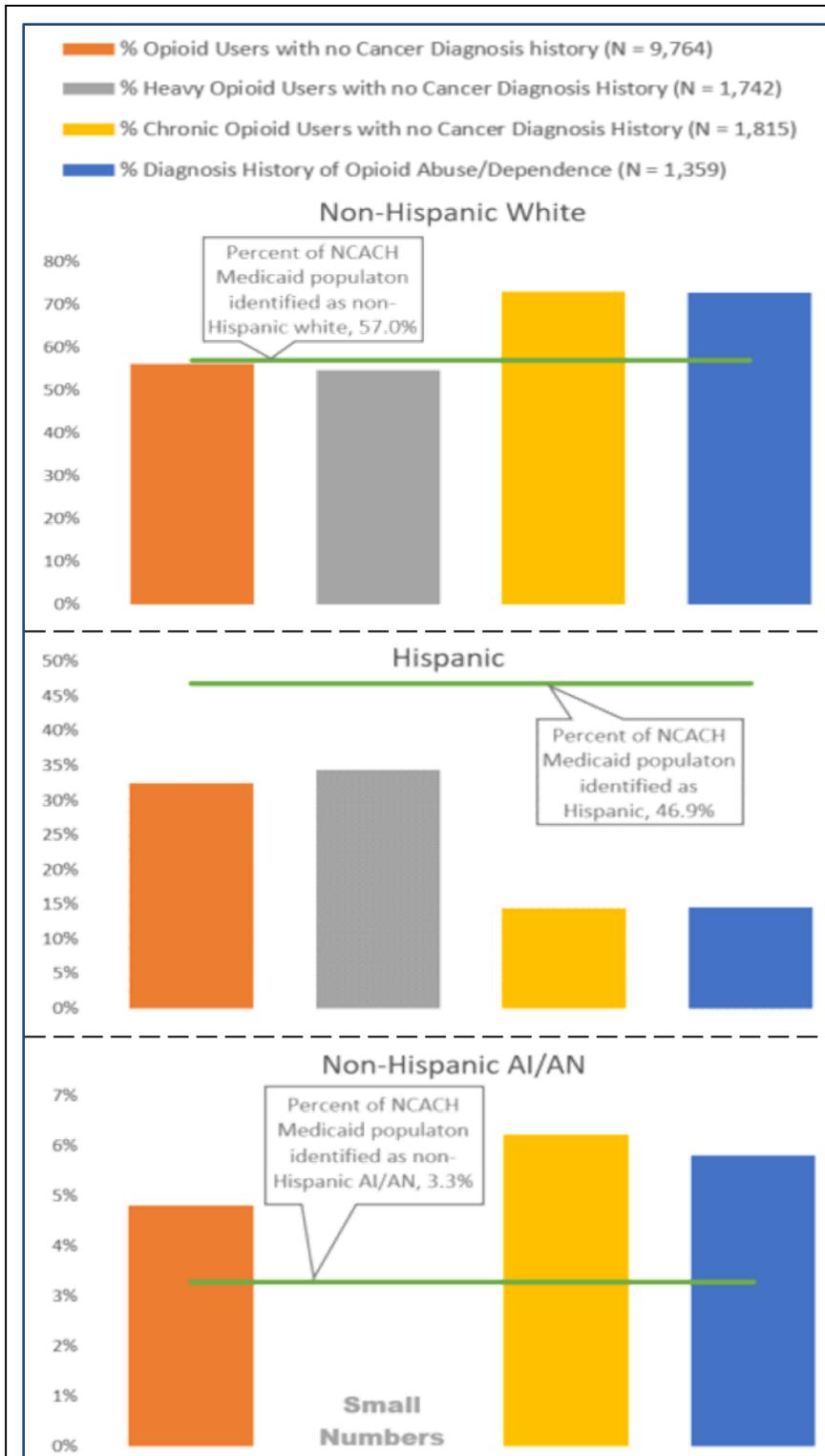
²⁰ Washington Department of Health. *Washington Tracking Network*. Data based on 2011-2015 time period (not specific to Medicaid recipients.)

As NCACH looks at the final project design, the Regional Opioid Workgroup will ensure health equity is considered in the project plan and during implementation. More Medicaid enrollees in the region identify as Hispanic compared to the state average (47% and 21%, respectively). In Okanogan County, 14% of the Medicaid population identifies as Native American²¹. As we review data to select strategies, we will consider how we can implement and support projects that will help close gaps in health disparities, and how we include cultural considerations into the direct planning and implementation.



Source: Washington Tracking Network, Washington State Department of Health, Fatal Overdoses (all opioids), 2011-2015.

²¹ Healthier Washington Dashboard. October 1, 2015-September 30, 2016. HCA Medicaid enrollment and claims data.



Preliminarily, there appears to be some differences in opioid use, abuse, overdose, and mortality patterns based on geography (see figure on previous page), gender, and race/ethnicity (see figure to

Source: Health Care Authority Regional Health Needs Inventory Starter Kit, 2016

left)^{22,23}. NCACH will work to further analyze opioid data stratified by these demographic variables to uncover patterns and health disparities. In addition to those mentioned above, NCACH will analyze data, if available, for discrepancies in socioeconomic status and incarceration rates as it relates to opioid use to look for underlying causes of health inequity that can be addressed through the Opioid Project.

A key factor in selecting opioid strategies to implement is sustainability. NCACH maintains Demonstration funds should not be used to support direct services, except in limited cases where there is a clear and relatively quick path to sustainability. In addition, it is important for this work to create a lasting impact on the region.

Specific to the Opioid Project, NCACH views Demonstration funds as a way to provide monetary support where there are short term financial barriers to initiative implementation rather than providing sustained programmatic support. This can be especially difficult for outreach and public education interventions. One specific avenue that the workgroup will explore to establish sustainability is leveraging the work and staff of the NCACH to secure outside grant funding, local support, and in-kind donations of time and materials for Opioid Project work.

Several aspects of our anticipated work include education targeting providers, youth, and the general public, along with increasing buprenorphine prescribers. A portion of this education will be to reduce the stigma the community and providers have around patients with opioid use disorder. If done well, the combination of education and increased access to treatment can reduce stigma of opioid use disorder, increased the number of providers who provide medication-assisted treatment, and improve health literacy of the community.

On the clinical side, NCACH will primarily focus on systems change that will be incorporated into regular ongoing work. An example of this would include changing work processes to incorporate checking the Prescription Monitoring Program for the day's patient panel each morning. Other examples of sustainable systems changes that the Opioid Project will address include consistent opioid prescribing patterns by providers following state and national prescribing guidelines, increased access to medication assisted treatment, and increased availability of naloxone.

The primary charge of the Regional Opioid Workgroup is to support and work through the local opioid groups already in existence in Chelan, Douglas, Grant, and Okanogan Counties (described above). The local opioid groups formed organically as grassroots efforts by motivated community partners in response to the opioid epidemic. NCACH will promote connections to existing opioid efforts in the region and leverage current capacity. This approach will allow the Demonstration to bolster and build on work already taking place in our communities. Since we will be working through existing local opioid groups, we anticipate the efforts of the local opioid groups to continue beyond the duration of the Demonstration.

Furthermore, it will be important for the Regional Opioid Workgroup and NCACH to take into consideration the potentially emerging heroin epidemic. As opioid prescribing patterns improve and the supply of prescription opioids is systematically reduced, individuals with opioid use disorder—

²² Washington Department of Health. *Washington Tracking Network*. Data based on 2011-2015 time period (not specific to Medicaid recipients.)

²³ Health Care Authority Regional Health Needs Inventory Starter Kit. (April 25, 2017) "Project-Opioid-Medicaid" tab.

particularly those who have been misusing prescriptions or illegally obtaining prescription opioids—may seek illegal drugs, such as heroin, as an alternative. NCACH is being thoughtful and working to proactively address these potential unintended consequences.

Implementation Approach and Timing

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

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

Partnering Providers

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

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

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

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

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

- Demonstrate how the ACH has included partnering providers that collectively serve a significant portion of the Medicaid population.
 - Describe process for ensuring partnering providers commit to serving the Medicaid population.
 - Describe the process for engaging partnering providers that are critical to the project’s success, and ensuring that a broad spectrum of care and related social services is represented.
- Describe how the ACH is leveraging MCOs’ expertise in project implementation, and ensuring

there is no duplication.

ACH Response

NCACH established a Regional Opioid Workgroup, in part, to develop a comprehensive implementation plan for the Opioid Project. Members from our Regional Opioid Workgroup were vetted and recruited by our Board Executive Committee with a specific focus on sector representatives who serve a significant portion of the Medicaid population. For example, we have workgroup members representing Federally Qualified Health Centers, MCOs, public health, medication-assisted treatment providers, the criminal justice system, law enforcement, and community-based service organizations. These representatives work with many Medicaid beneficiaries in light of the strong overlap between these sectors and people impacted by poverty. The Opioid Project Workgroup knows that they are charged with focusing on the Medicaid population for the Demonstration, however, given the overarching goals of the Opioid Project, promoting improvements to opioid prevention, treatment, and recovery supports will impact the broader population. This broad outreach to all residents in the NCACH region is the goal of our regional efforts.

As a result of our work to become a mid-adopter for Fully-Integrated Managed Care (FIMC) and the partnerships developed from the Whole Person Care Collaborative, NCACH has close relationships with physical and behavioral health providers who serve a large proportion of our Medicaid beneficiaries. We are able to leverage these relationships to engage partnering providers in the Opioid Project efforts as well. On our Regional Opioid Workgroup, for example, we have a representative from Samaritan Hospital (approximately 5,300 Medicaid clients in 2016), Okanogan Behavioral Healthcare (approximately 1,500 Medicaid clients in 2016), and Confluence, which handles the largest volume of the Medicaid population (over 46,000 Medicaid clients in 2016)²⁴. As the list of partnering providers involved in the Opioid Project implementation becomes clearer, we plan to ask them to assert their commitment to serving the Medicaid population in our memorandums of understanding.

The NCACH Governing Board has identified a minimum sector representation critical to the project's success from the social service and medical sectors, as well as other systems involved in opioid work. These sectors were specifically identified in the Regional Opioid Workgroup charter that was approved by the Board on October 2, 2017 (See Opioid Project - Attachment A). The sectors identified are: emergency medical services, law enforcement, regional justice centers and juvenile court, education, public health, emergency departments, primary care, behavioral health, MCOs, behavioral health-administrative service organization, dental, pharmacy, and tribal partners. In order to ensure broad regional and sector representation, the Board Executive Committee carefully selected members for the Workgroup. Each of the sectors are currently represented on the Workgroup, with the exception of tribal. The individual nominated for the tribal seat on the Opioid Project Workgroup recently declined participation due to lack of time (not lack of interest). We are working our Governing Board tribal representative to identify an alternative representative.

Due to size constraints, we are not able to have all interested stakeholders of the Opioid Project as part of the Regional Opioid Workgroup. However, NCACH is actively participating in and communicating with both local opioid groups and all three CHIs (described above). Through

²⁴ Beneficiary Counts for Selected Medicaid Providers in North Central ACH, claim and beneficiary counts for 2016. Revised September 9, 2017. Washington Health Care Authority, AIM Team.

involvement with these groups and coalitions, NCACH has regular contact with a substantial number of partnering providers. NCACH will work during planning and implementation to ensure partnering providers are consistently engaged in each of the counties through local implementation efforts.

To jumpstart the Opioid Project work, NCACH staff met with staff from key partnering providers to ensure NCACH and the Regional Opioid Workgroup started with a good basic understanding of the landscape in the NCACH region with regards to opioid use and current initiatives (See Opioid Project - Attachment B). A key outcome of these meetings was strong engagement by key partners and the beginning of an initiative matrix to identify current, planned, and interest in local or regional opioid initiatives.

NCACH views MCOs as full partners in all aspects of the Demonstration. This is demonstrated by an MCO sector seat on the Governing Board and seat for each of the MCOs on the Regional Opioid Workgroup. Given the work that NCACH has undertaken this year to become a mid-adopter on January 1, 2018 for FIMC, we have established great working relationships with each of the MCOs in our region. Since NCACH chose to be a middle-adopter, we are fortunate to know which MCOs will continue to be active in our region for the duration of the Demonstration, allowing NCACH to focus on fostering and leveraging those relationships. NCACH has established a monthly joint meeting with all three MCOs for planning purposes to ensure alignment and prevent duplication of work in our six projects and any initiatives the MCOs may be undertaking individually. NCACH recognizes the value and expertise that the MCO sector adds to our projects and is looking to maximize collaboration and alignment wherever possible.

Regional Assets, Anticipated Challenges and Proposed Solutions

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

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

ACH Response

NCACH is extremely fortunate to have highly motivated and engaged clinical and community-based partners in the Opioid Project work. Arguably, our biggest regional asset is our local opioid groups, formed organically by local stakeholders as a grassroots effort to address the opioid epidemic. The members of these groups have allocated personal and professional time and resources to bring these groups together because they saw a need. NCACH is fortunate to be able to support these local efforts through the Demonstration. These efforts have brought additional resources and programs to the community. An example of the success of these groups is the implementation of a multi-sector collaboration between the Chelan County Regional Jail, The Center for Drug and Alcohol Treatment, and Columbia Valley Community Health implementing a Jail Inmate MAT and Re-Entry Program to engage inmates re-entering society in medication-assisted treatment at release. Each of the organizations involved has provided time and resources to bring this program to fruition. Grant County is currently exploring the possibility of expanding this program to their community.

Through the Whole Person Care Collaborative (WPCC), NCACH has engaged all primary care and behavioral health providers serving the majority of our Medicaid population. As part of the work of

the WPCC, providers will be expected to complete a comprehensive organizational change plan that primarily describes how they intend to address bi-directional integration of primary care and behavioral health. A small, but required section of the change plan will include how providers will address the opioid epidemic, including training providers on state and national opioid prescribing guidelines, increasing buprenorphine prescribers, and utilization of the Washington State Prescription Monitoring Program.

NCACH has support and strong engagement with the largest health care system in our region, which accounted for nearly half of North Central Medicaid encounters in 2016²⁵. This provider system is independently implementing initiatives to address the opioid epidemic through several programs including incentivizing providers to become buprenorphine prescribers, creating an opioid oversight committee, establishing three opioid workgroups (acute opioid workgroup, chronic opioid workgroup, and drug diversion workgroup), and instituting new chronic opioid agreements with a lowered morphine equivalent doses. These initiatives are slated to be rolled out region-wide in early 2018.

Earlier this year, NCACH recognized a gap in data and analytic capacity. Over the past several months, we have addressed this gap in a variety of ways: (1) hired a full-time data analyst to do in-house data analysis; (2) contracted with Center for Outcomes Research and Education (CORE) to provide technical assistance and consultation to assist NCACH with data-related needs for the project planning process; (3) formed an Health Information Technology/Health Information Exchange (HIT/HIE) Workgroup to address regional population health management systems and information exchanges that can be expanded, enhanced, or initiated; and (4) contracted with the Centre for Coordination, Motivation, and Innovation (CCMI) and CSI Solutions, Inc. for technical support in developing a learning collaborative as well as performance monitoring software, tools, dashboards, and processes. The steps we have taken to address a previously identified weakness have not only turned data and analytic capacity into an area of strength for NCACH, but demonstrate that we can rapidly and systematically address future identified challenges.

NCACH anticipates several challenges that we may encounter including sustainability of funding and interventions and the rural nature of our region. NCACH is committed to funding sustainable interventions. Each proposed strategy must first be able to show how it would provide a sustainable intervention before it can be considered for implementation. Certain interventions included in the Opioid Project have a clear path to sustainability (e.g., incorporating prescription monitoring programs into standard workflows, training providers on AMDG Prescribing Guidelines, increasing the number of buprenorphine prescribers). Others need a more creative approach to sustainability (e.g., opioid health education). A key task of both NCACH staff and the Regional Opioid Workgroup over the next nine months will be to develop a comprehensive implementation plan that addresses prevention, treatment, overdose prevention, and recovery in a sustainable manner. One potential solution to intervention and funding sustainability involves using a braided funding strategy approach by seeking additional funding from grants (e.g., DSHS community grants to address opioid use), community foundations (e.g., healthcare foundations, United Way), and in-kind support from local partners (e.g., public health).

²⁵ Professional Service Volume and Beneficiaries for Selected North Central Medicaid Providers. 2016. Health Care Authority, AIM Team.

The NCACH region is an extremely rural region with only 19.4 persons per square mile²⁶. Okanogan County, our largest county by geography (5315 square miles), is even more rural with only 7.8 people per square mile²⁷. The rural geography of our region is one of the factors that led mental health care access and access to health care to be identified as the top two needs in our 2016 Regional Community Health Needs Assessment²⁸. To highlight Okanogan County again, with 17,035 Medicaid beneficiaries (41% of the county's population)²⁹, there are only four Medicaid chemical dependency providers available for the entire county and they are all located in Omak. We will work in our region to improve access to care through bi-directional integration of primary care and behavioral health, increasing workforce capacity, and advocating tele-health payment policy change for substance use disorder and rural providers.

Monitoring and Continuous Improvement

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

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

ACH Response

The goal of NCACH's monitoring plan is to use real-time or close to real-time data to support project implementation and continuous improvement. Largely pulling from existing data sources, NCACH will track operational, process, and outcomes measures for each project and for the ACH overall. These existing data sources include the Healthier Washington dashboard, the Department of Health Quarterly Drug Overdose Dashboard, the Department of Health Prescription Monitoring Program (PMP) Dashboard, the HCA DSRIP Dashboard, and other reports and products currently available from or under development by the state. We will work with workgroups to supplement this data with regional and partner data. Monitoring data will be used to drive shared learning, form the foundation of rapid-cycle continuous improvement processes, and support program evaluation efforts. This will allow the ACH and key partners to identify issues, barriers, and successes quickly. Key elements of this system include: (1) convening key stakeholders; (2) identifying monitoring metrics, benchmarks, and improvements; (3) building data infrastructure to collect, aggregate, analyze, and report data for monitoring; and (4) implementing continuous improvement processes.

Convening key stakeholders. NCACH has convened the Regional Opioid Stakeholders Workgroup to guide decisions for the Opioid Project. This group will include clinical and program subject matter

²⁶ US Census Bureau, 2010-14.

²⁷ US Census Bureau, 2010-14.

²⁸ Chelan-Douglas Health District. (December 31, 2016). *2016 Community Health Needs Assessment*.

²⁹ Healthier Washington Dashboard. October 1, 2015-September 30, 2016. HCA Medicaid enrollment and claims data.

experts, and will make recommendations regarding project implementation. NCACH will work with stakeholder groups to monitor progress on a regular basis and triage issues that arise in implementation, such as access to data or recruitment and enrollment delays.

Key stakeholders for this project include:

- Emergency medical services
- Law enforcement
- Regional justice centers and juvenile court
- Education
- Public health
- Emergency departments
- Primary care
- Behavioral health
- Narcotics Anonymous
- Managed Care Organizations
- Behavioral Health-Administrative Service Organization
- Dental
- Pharmacy
- Tribal

The exact approach and tools to support partner reporting and rapid cycle monitoring and improvement will be developed in 2018 with guidance from our specific project workgroups (including the WPCC, Opioid Workgroup, Transitional Care and Diversion Interventions Workgroup, and Pathways Community HUB Workgroup). The development of continuous monitoring and improvement systems will be led by NCACH staff with technical assistance from our consultants (e.g. CORE and CCMI/CSI).

Identifying monitoring metrics, data sources, benchmarks, and targets. Monitoring metrics will vary by project, and will include ACH toolkit pay-for-reporting and pay-for-performance metrics, as well as regional accountability and quality improvement plan metrics. In order to improve our project performance measures, it will be critical to identify proxy measures that we can track at a local level and that are likely to impact the measures. This may involve process, output, and/or outcome measures (e.g., number of people reached, broken out by year). NCACH data staff will begin working with key contractors (e.g., CORE) beginning quarter 3 of 2018 to develop and recommend to the workgroup a detailed quality improvement plan that NCACH will support to monitor the health impact of our Opioid Project. NCACH staff will facilitate linkages where input from our regional HIT/HIE workgroup or the statewide HIT/HIE efforts led by the HCA may be needed. NCACH also will ask MCOs to review quality metrics and agree on quality reporting for Value-Based Payment (VBP) models. For the implementation phase, many metrics will be process or operational in focus. NCACH will work with the data team (NCACH staff and contracted data support) and Regional Opioid Workgroup to identify benchmarks and, where possible, improvement targets. Potential metrics for the Opioid Project are listed in the table below; final metrics will be identified in the implementation plan.

Potential Monitoring Metrics – Opioid Project

Implementation/Operational Measures – Regional monitoring metrics to track implementation progress

<i>Measures TBD; examples may include:</i>	
- Number of partners who have signed memorandums of understanding	- Number of providers trained on AMDG’s Interagency Guideline on Prescribing Opioids for Pain or CDC Guideline for Prescribing Opioids for Chronic Pain
- Number of waived providers to prescribe	

buprenorphine	- Number of providers registered with Prescription Monitoring Program
Toolkit P4R Measures – Required metrics for ACH reporting	
- Number and locations of MDs, ARNPs, and PAs who are approved to prescribe buprenorphine	- Number of local health jurisdictions and community-based service organizations that received technical assistance to organize or expand syringe exchange programs
- Number of mental health and Substance Use Disorder providers delivering acute care and recovery services to people with opioid use disorder	- Number of emergency departments with protocols in place for providing overdose education and take-home naloxone to individuals seen for opioid overdose
- Number of community partnerships	- Number and types of access points in which persons can receive medication assisted therapy
- Number of health care providers trained on AMDG’s Interagency Guideline on Prescribing Opioids for Pain	
- Number of health care organizations with Electronic Health Records (EHR) or other systems newly put in place that provide clinical decision support for the opioid prescribing guideline, such as defaulting to recommended dosages or linking to PDMP	
Toolkit P4P Measures – Incentive measures, which will be reported by HCA and tracked by the ACH	
- Outpatient emergency department visits per 1,000 member months	
- Patients on high-dose chronic opioid therapy by varying thresholds	
- Patients with concurrent sedatives prescriptions	
- Inpatient hospital utilization (2020, 2021)	
- Substance use disorder treatment penetration (2020, 2021)	
Quality Improvement Plan Metrics – Regional performance metrics	
<i>Quality Improvement Plan metrics will be identified by quarter 2 of 2019</i>	
<p>Building data infrastructure to collect, aggregate, analyze, and report data for monitoring. NCACH plans to develop a data infrastructure to collect and aggregate project information, in order to support continuous analysis, monitoring and improvement. The potential data infrastructure to support monitoring and continuous improvement (see figure below, <i>Planned approach for monitoring and continuous improvement</i>) should be designed to complement existing data assets (such as the Healthier Washington Dashboard, other dashboards under development, and reporting from regional associations). An ideal system will be able to securely collect, combine, store, and report data. Through our Whole Person Care Collaborative, we are planning on using a customized web portal (Healthcare Communities) developed by one of our current contractors, CSI Solutions, Inc. Originally developed in 2005, this platform has grown to support nearly 70 communities, including CMS’s Transforming Clinical Practices Initiative. This portal would serve multiple functions, providing centralized access to resource sharing, document sharing, tracking of process measures through consistent form-fillable reporting templates and surveys, and tracking of measures through dashboards. Based on conversations with CSI Solutions, it seems very likely that we can leverage this web portal for monitoring progress and reporting associated with the rest of our projects. Ideally, partners would submit monthly reports through this online portal.</p> <p>Reports from implementation partners will focus on project milestones and process details that can be used to support overall monitoring, identify potential challenges or barriers that individual or multiple partners are experiencing, and identify potential champions and best practices. Reporting will be contractually required of project partners, though every effort will be made to keep these reports simple</p>	

and streamlined in order to minimize the reporting burden for partners (one of our key design principles). Data from partner reporting will complement existing data resources, including the Healthier Washington Data Dashboard and the Department of Health Drug Overdose Dashboard, (both currently operational), as well as the Department of Health Prescription Monitoring Program (PMP) Dashboard and the HCA DSRIP Dashboard. Some of these data assets are currently under development by the State using a Tableau interface, with the hopes of being released in early 2018 and updated on a quarterly basis.

Other ACHs are also investigating options, and NCACH has participated in several webinars from vendors offering these types of solutions. For example, a webinar presented by one New York DSRIP provider with SpectraMedix, their data infrastructure partners; a webinar organized by the Washington Health Alliance regarding a healthcare quality improvement tool from 10xHealth; a webex on a Salesforce platform built by Persistent Systems which was designed for another New York DSRIP provider to see a 360 degree view of project management and progress; and a webinar with the Washington State Hospital Association on a specific quality benchmarking system they are interested in making available to ACHs. NCACH staff will continue exploring options, consult with other ACHs who may have investigated their own solutions, and solicit input from our regional HIT/HIE Workgroup. We plan on identifying a strategy for collecting all of this data by the end of 2018. Ideally, we would find a way to use the same platform for most or all of our projects in order to minimize administrative costs.

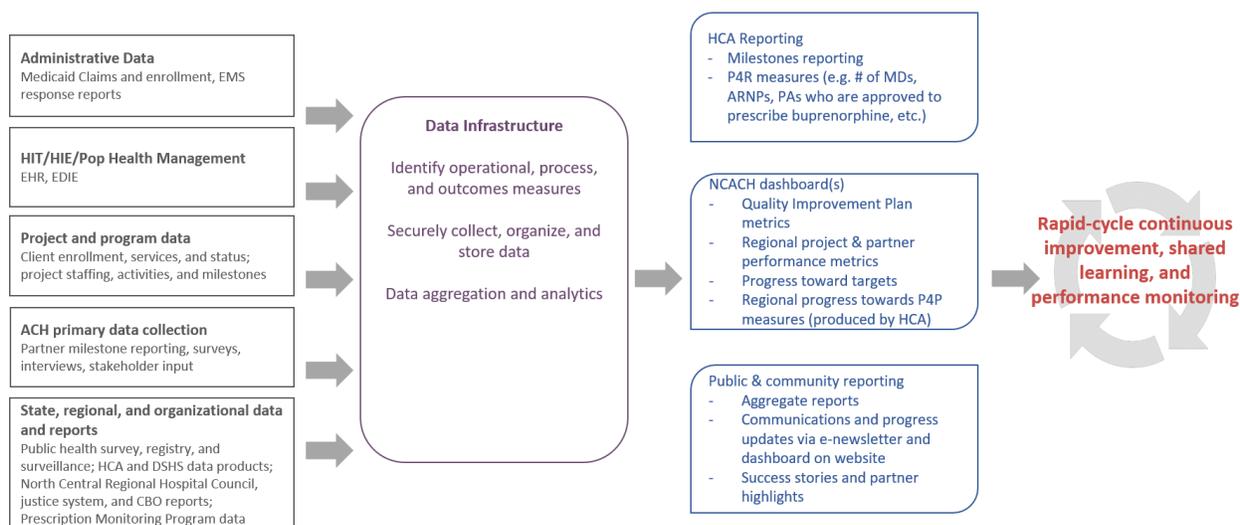
As part of the data infrastructure work, NCACH will identify data sources and a plan for data collection; establish data use agreements with partnering providers (potentially including MCOs); establish data governance models; comply with relevant privacy and security regulations; implement processes for transferring data; and identify tools to collect, manage, store, analyze, visualize, and report data. Efforts will be made to minimize the reporting burden on partnering providers, leveraging existing data reporting where possible.

Implementing continuous improvement (CI) processes. Drawing on this data infrastructure, NCACH will develop continuous improvement (CI) processes based on best practices for clinical and health systems improvement, bringing in expertise from contractors (e.g., CORE or CCMI/CSI) where needed. Drawing on monthly reports, and ad-hoc check-ins with partnering providers, staff will regularly monitor performance and understand, in real-time, whether we are on the path to reaching expected outcomes. Project workgroups also will be involved in project monitoring and course correction, through quarterly improvement cycles accompanied by collaborative peer learning sessions. With each cycle, NCACH and partners will adapt, test, and refine strategies, document learnings and results, and spread learnings across partners. These processes should allow for identification of barriers, challenges, and risks. If timelines still cannot be met, NCACH will communicate back to HCA regarding reasons why timelines weren't met and a plan for adapting the timeline, and preventing/risk mitigation strategies will be shared to other programs where appropriate.

Quality improvement efforts will be coordinated with existing local and statewide technical assistance providers, including Qualis, the Practice Transformation Support Hub, MCO initiatives, and HCA resources. For example, the HCA AIM team is planning on creating monitoring reports containing specific project level detail (they anticipate that production of these reports would start in 2018). Information, reports, and assessments from other quality improvement efforts may also be helpful data sources to monitor ACH and partner progress (e.g. MCO assessments and measures). NCACH envisions supporting quality improvement in a variety of ways, ranging from connecting partnering providers to relevant

resources to creating new opportunities for partnering providers. NCACH may provide training or technical assistance to partners around specific issues or barriers, such as HIT/HIE adoption or workforce development. NCACH’s goal is for partners to be as successful as possible in project implementation and will design quality improvement efforts that offer a flexible approach. If partners are identified as struggling in a particular area, or lagging behind, NCACH intends to determine what will be needed to ensure that partner’s success and determine whether existing or additional resources can be provided. This may involve extensions, and/or more comprehensive or intensive technical assistance.

Planned approach for monitoring and continuous improvement



(See Opioid Project - Attachment C for a larger version)

Project Metrics and Reporting Requirements

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

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

YES	NO
X	

Relationships with Other Initiatives

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

- *Securing descriptions from partnering providers in DY 2 of any initiatives that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives currently in place.*

- *Securing attestations from partnering providers in DY 2 that submitted DSRIP projects are not duplicative of other funded initiatives, and do not duplicate the deliverables required by the other initiatives.*
- *If the DSRIP project is built on one of these other initiatives, or represents an enhancement of such an initiative, explaining how the DSRIP project is not duplicative of activities already supported with other federal funds.*

YES	NO
X	

Project Sustainability

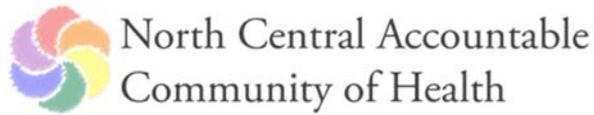
Describe the ACH’s strategy for long-term project sustainability, and its impact on Washington’s health system transformation beyond the Demonstration period.

ACH Response

As previously mentioned, sustainability has been and continues to be a key factor in all NCACH project decisions. NCACH firmly believes that Demonstration funds should not be used to fund direct services, except on a limited basis where there is a clear and relatively quick path to sustainability. In addition, it is important for this work to create a lasting impact on the region. Overall, the Opioid Project will aim to reduce opioid-related morbidity and mortality.

The primary charge of the Regional Opioid Workgroup is to support and work through the local opioid groups already in existence in Chelan, Douglas, Grant, and Okanogan Counties. These groups formed organically as a grassroots effort by motivated community partners in response to the opioid epidemic. NCACH will promote connections to existing opioid efforts in the region and leverage current capacity. This approach will allow the Demonstration to bolster and build work already taking place in our communities. Since we are working through existing coalitions, we anticipate the efforts of the coalitions to continue beyond the duration of the Demonstration.

Specific to the Opioid Project, NCACH views Demonstration funds to provide monetary support where there are short-term financial barriers to initiative implementation rather than providing sustained programmatic support. This can be especially difficult for outreach and public education interventions. One specific avenue that the workgroup will explore to establish sustainability is leveraging the work and staff of the NCACH to secure outside grant funding, local support, and in-kind donations of time and materials to support current and future opioid initiatives.



Regional Opioid Stakeholder Workgroup Charter

Background

On January 9th, 2017 the Washington State Health Care Authority (HCA) signed an 1115 Waiver, now known as the Medicaid Transformation Demonstration Project. The goal of the Demonstration is to improve care, increase efficiency, reduce costs and integrate Medicaid contracting. To align clinical integration with payment integration within the Demonstration Project, HCA developed the [Medicaid Demonstration Project Toolkit](#). One of the projects that all ACHs are required to select is to address the opioid use public health crisis. The project objective, as described in the toolkit, is to support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

Charge

The Regional Opioid Stakeholder Workgroup will ensure that the North Central region implements effective evidence based practices that align with the milestones and approaches described in the Toolkit that will result in reducing opioid-related morbidity and mortality in North Central Washington. Specifically the Workgroup will complete the following:

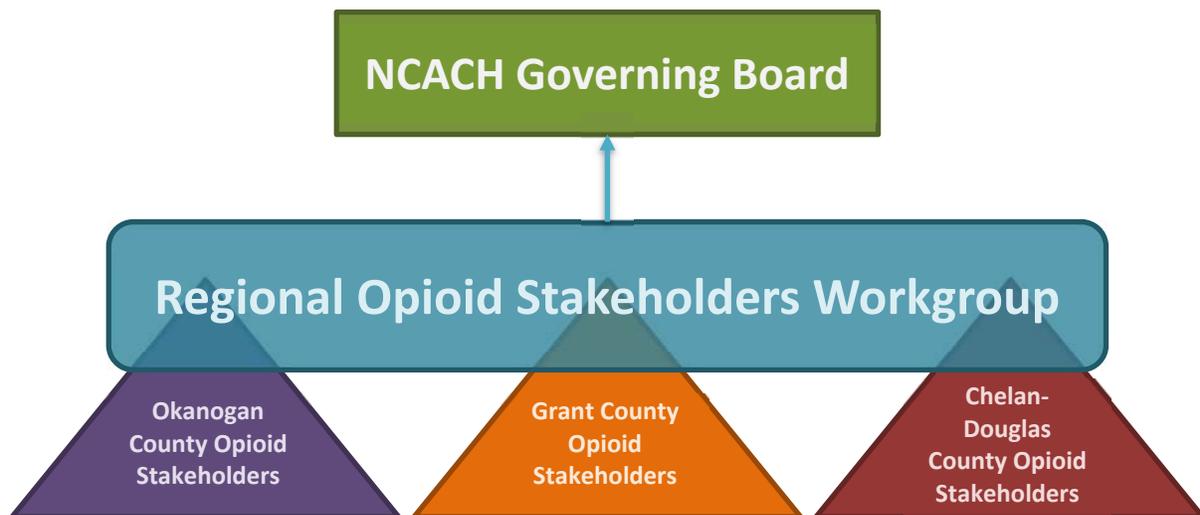
- A primary aspect of this Workgroup's approach will be to support and work through the Local Opioid Stakeholder Groups already working in Chelan-Douglas, Grant, and Okanogan Counties to promote connections to existing opioid efforts in the region, leverage current capacity, and address identified gaps.
- Provide specific recommendations to the NCACH Governing Board and staff on approaches to take for opioid prevention, treatment, overdose prevention, and recovery projects.
- As much as possible, ensure opioid projects and approaches align with all six projects NCACH selected to implement.
- Collect, synthesize, and use stakeholder and community input on opioid project planning and implementation.
- Determine how opioid prevention and treatment work is able to be financially sustainable after the Demonstration period.
- As much as possible, ensure projects effectively connect patients with resources to mitigate the negative consequences of the social determinants of health.
- Identify how IT, workforce, and value-based payment strategies can support this project.

Composition

The Regional Opioid Stakeholder Workgroup will include representatives from Grant, Chelan, Douglas, and Okanogan Counties. Workgroup membership is not a prerequisite to receiving funding through the Demonstration. Each of the Local Opioid Stakeholders Group will be asked to identify three members to participate in the Regional Opioid Stakeholder Workgroup. The Executive Committee will recommend to the Governing Board additional members as needed to assure representation from:

- Emergency Medical Services (EMS) and First Responders
- Law Enforcement
- Regional Justice Centers (Jails) and Juvenile Court
- Education
- Public Health

- Emergency Departments (Hospitals)
- Primary Care
- Behavioral Health
- Managed Care Organizations (*Operating in all 4 NCACH counties after Jan. 1, 2018*)
- Behavioral Health Administrative Service Organization
- Dental
- Pharmacy
- Tribal



Additional representation will be added to the Workgroup by the Executive Director if it is deemed necessary. A Workgroup Chair will be appointed by the Executive Director. The Regional Opioid Stakeholder Workgroup is a sub-committee of the ACH board, and as such will be led by the Workgroup Chair and NCACH staff and must have a minimum of two board members serving on the Workgroup.

Meetings

Regional Opioid Stakeholders Workgroup meetings will be held once per month, with additional meetings scheduled as necessary. Meetings will be held in Chelan, Douglas, Grant, and Okanogan Counties; locations will vary and an effort will be made to hold meetings in each of the Local Health Jurisdictions throughout the year. Whenever possible, meetings will have an option to participate via teleconference or audioconference for those unable to attend in person, although in-person participation is encouraged. NCACH program staff and the Workgroup Chair shall be responsible for establishing the agendas. Notes for all meetings will be provided to the Workgroup by NCACH staff within two weeks of each meeting. Monthly meetings will be open and meeting minutes and materials will be posted on the NCACH website (www.ncach.org).

Member Responsibilities

1. Attend at least 75% of regular meetings of the Workgroup and actively participate in the work of the Workgroup.
2. Sign a Membership Agreement (attachment A).

3. Local Opioid Stakeholder Groups representatives members are expected to report Workgroup progress at County Stakeholder meeting to ensure bi-directional communication and provide direction to Regional Opioid Workgroup.
4. Work with Local Opioid Stakeholders Groups on the Opioid Project planning and implementation for the Medicaid Demonstration Project.
5. Assess current state capacity to deliver effective opioid use prevention and treatment interventions.
6. Select initial promising practices and/or evidence-supported approaches informed by the regional health needs assessment.
7. Review prepared data to recommend target population(s), guide project planning and implementation, and promote continuous quality improvement.
8. Assist in identifying, recruiting, and securing formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.
9. Recommend to the Board a project implementation plan, including a financial sustainability model and how projects will be scaled to full region in advance of HCAs project implementation deadline.
10. Monitor project implementation plan, including scaling of implementation plan across region, and provide routine updates and recommended adjustments of the implementation plan to the NCACH Governing Board.
11. Develop and recommend a process for primary care and outpatient behavioral health partners involved in the implementation of the Opioid Project to receive Demonstration funds.
12. Collaborate with NCACH staff on data and reporting needs related to Demonstration metrics, and on the application of continuous quality improvement methods in this project.
13. Use strategies, that are supported by regional data, to advance equity and reduce disparities in the development and implementation of the Opioid Projects.

Authority

The Regional Opioid Stakeholders Workgroup is an advisory body that will inform decision-making by the NCACH Governing Board and ensure regional priorities and local considerations are incorporated in program design decisions. Recommendations and input developed by the Workgroup will be shared in regular monthly progress reports to the NCACH Governing Board.

**North Central Accountable Community of Health
Regional Opioid Stakeholder Workgroup
(Attachment A)**

Membership Agreement

I acknowledge by my signature of this membership agreement that I have read, understood, and agreed to follow the guidelines and policies outlined in the North Central Accountable Community of Health Regional Opioid Stakeholder Workgroup Charter.

I understand that continued membership in the Workgroup is contingent on following the requirements of membership that are outlined in the Charter. Not meeting the requirements for membership could result in the loss of my membership status in the Workgroup.

Dated: _____

Signed: _____

Print Name: _____

Title: _____



North Central Accountable
Community of Health

NCACH Opioid Project Plan – Attachment B

Regional Opioid Workgroup

October 27th, 2017

Healthier Washington

Healthier WA is a statewide initiative that is focused on achieving system wide change to link clinical and community factors that support health and spread integrated value based payment and care delivery models.

To achieve these goals, Healthier WA focuses on three goals:

1. Building healthier communities through a collaborative regional approach.
2. Integrating how we meet physical and behavioral health needs so that health care focuses on the whole person.
3. Improving how we pay for services by rewarding quality over quantity.

Locally, this work is accomplished through Regional Collaboratives such as the Accountable Communities of Health.

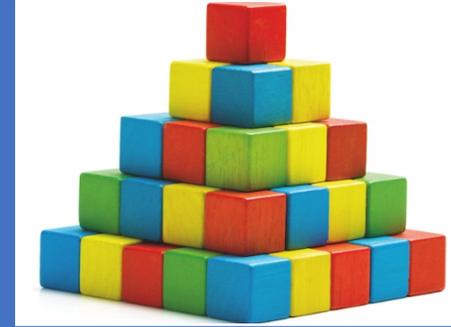


5 Years from now



Current system

- Fragmented care delivery
- Disjointed care transitions
- Disengaged clients
- Capacity limits
- Impoverishment
- Inconsistent measurement
- Volume-based payment



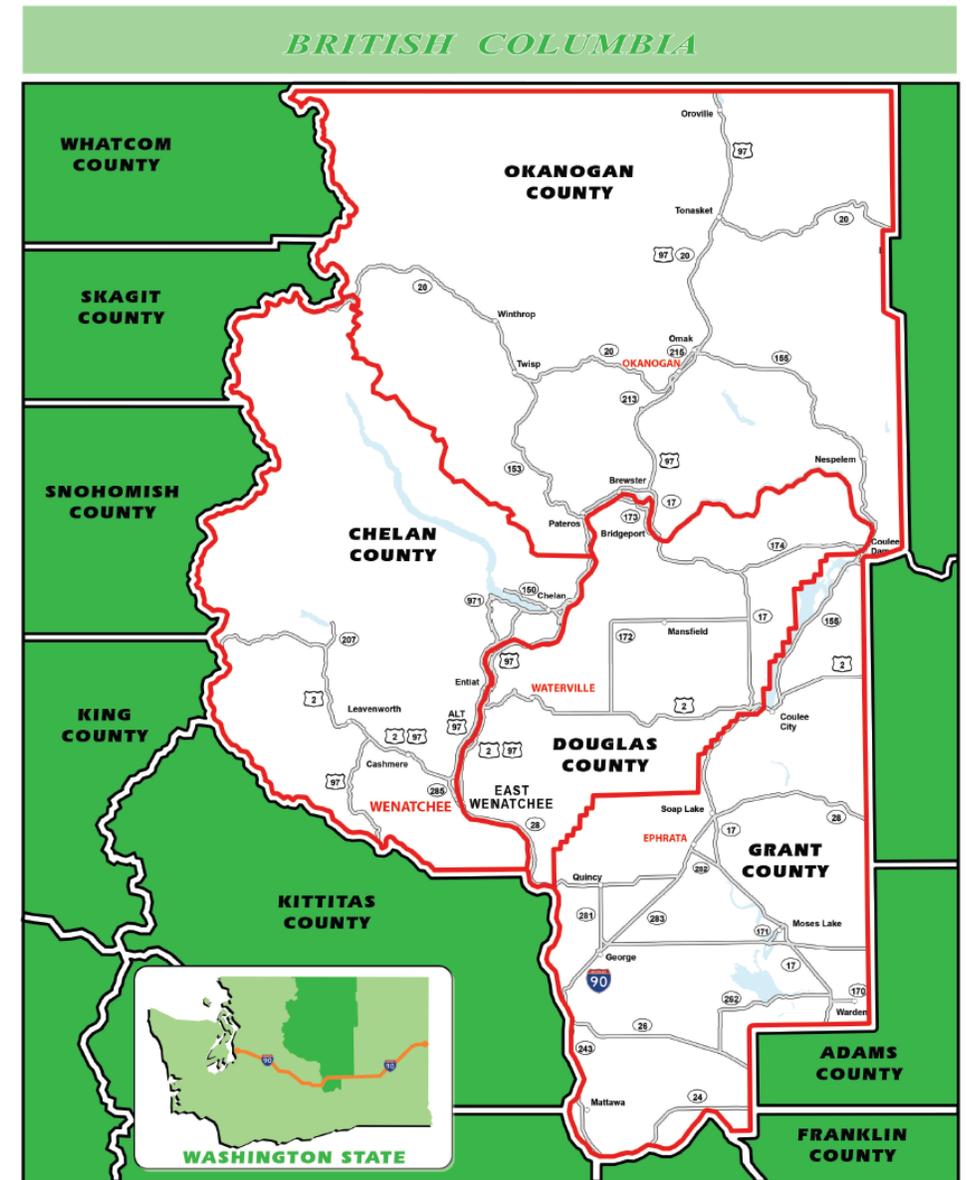
Transformed System

- Integrated, whole-person care
- Coordinated care
- Activated clients
- Access to appropriate services
- Timely supports
- Standardized measurement
- Value-based payment

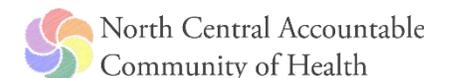


A Regional Approach

- ACHs play a critical role:
 - **Coordinate** and **oversee** regional projects aimed at improving care for Medicaid beneficiaries.
 - **Apply** for transformation projects, and incentive payments, on behalf of partnering providers within the region.
 - **Solicit** community feedback in development of Project Plan applications.
 - **Decide** on distribution of incentive funds to providers for achievement of defined milestones.



North Central Accountable Community of Health



Medicaid Transformation Demonstration

Through a five-year demonstration, Healthier WA will use up to \$1.5 Billion to address three initiatives aimed at transforming Medicaid to improve quality and control costs

Of the \$1.5 Billion available through the Demonstration, **\$1.125 Billion will be available to address Initiative 1.**

Initiative 1

Transformation through Accountable Communities of Health

Delivery System Reform

- Each region, through its Accountable Community of Health, will be able to pursue projects that will transform the Medicaid delivery system to serve the whole person and use resources more wisely.

Transformation Projects

Initiative 2

Enable Older Adults to Stay at Home; Delay or Avoid the Need for More Intensive Care

Benefit: Medicaid Alternative Care (MAC)

- Community based option for Medicaid clients and their families
- Services to support unpaid family caregivers

Benefit: Tailored Supports for Older Adults (TSOA)

- For individuals “at risk” of future Medicaid LTSS not currently meeting Medicaid financial eligibility criteria
- Primarily services to support unpaid family caregivers

Medicaid Benefits/Services

Initiative 3

Targeted Foundational Community Supports

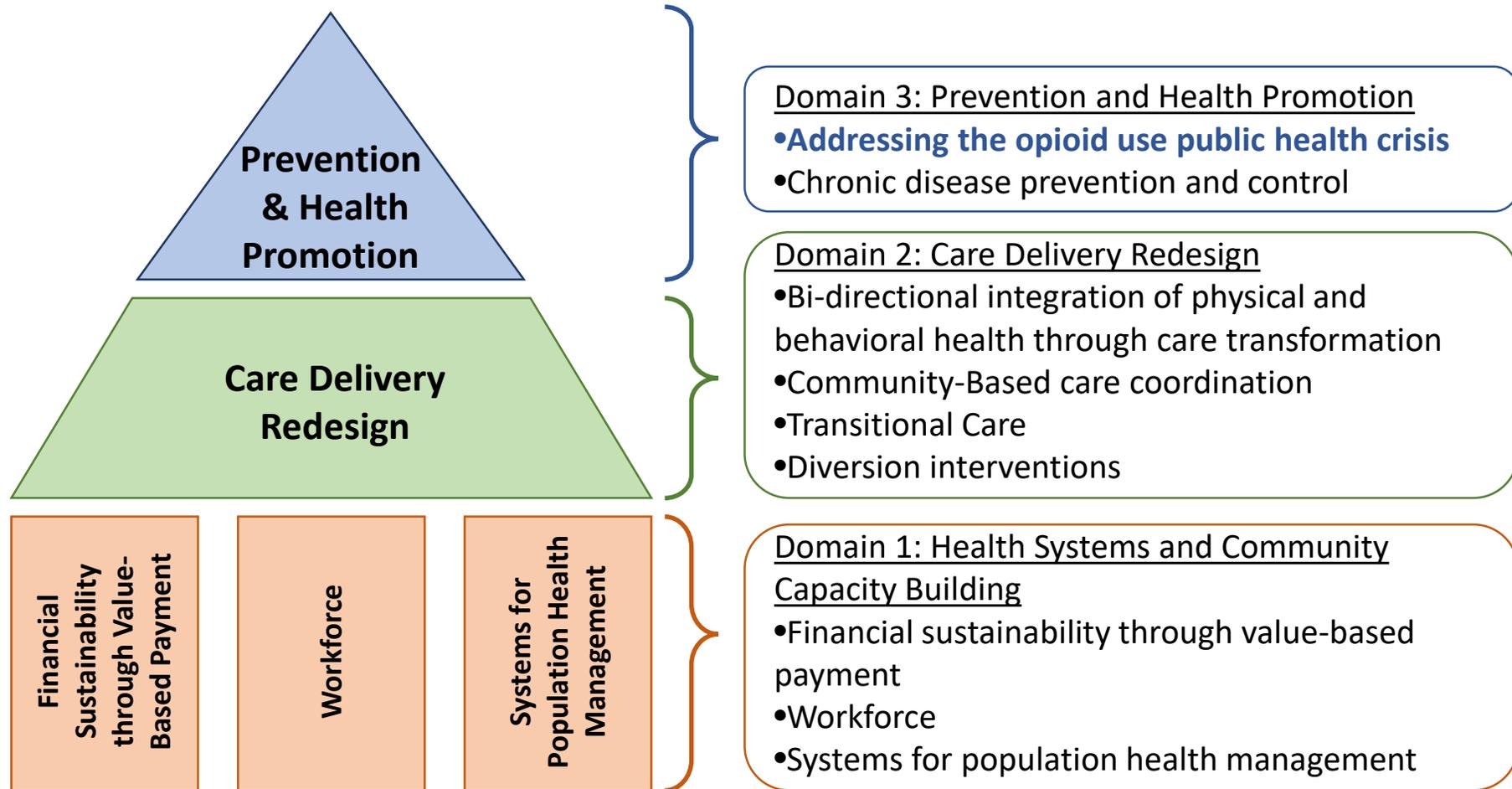
Benefit: Supportive Housing

- Individualized, critical services and supports that will assist Medicaid clients to obtain and maintain housing. The housing-related services do **not** include Medicaid payment for room and board.

Benefit: Supported Employment

- Services such as individualized job coaching and training, employer relations, and assistance with job placement.

Initiative 1: Care Transformation



Projects and general target populations

Bi-Directional Integration

Community-Based Care Coordination (aka HUB)

Transitional Care

Diversion Interventions

Addressing the Opioid Use Public Health Crisis

Chronic Disease Prevention and Control

Objective

Integrate health system and community approaches to improve chronic disease management and control.

General target population (as defined by HCA)

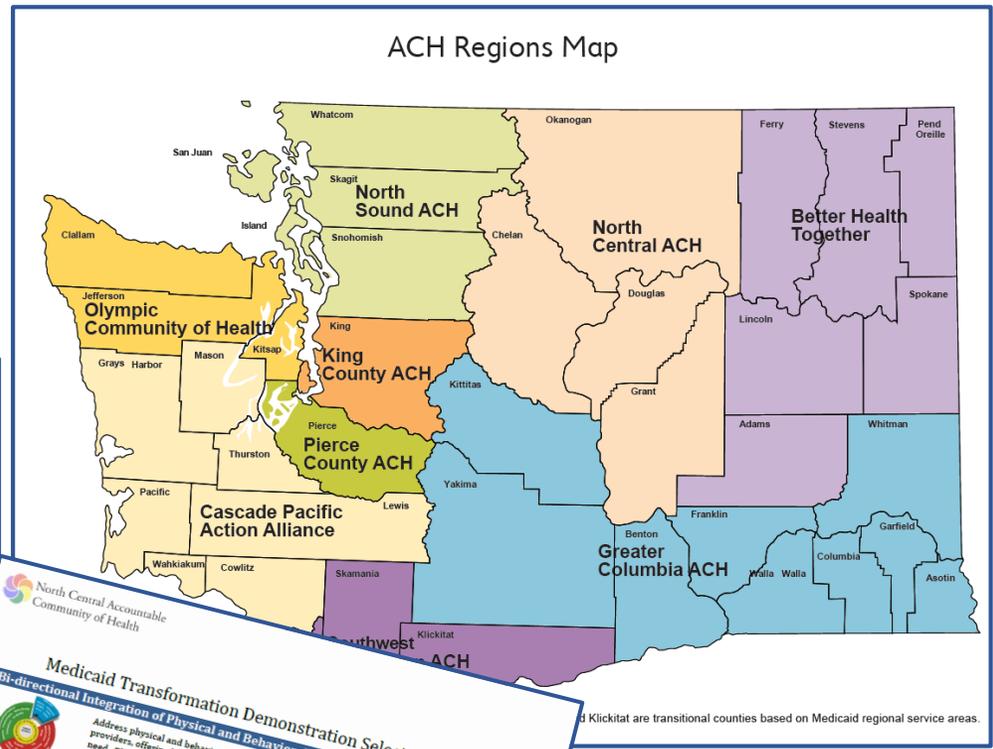
Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a **focus on those populations experiencing the greatest burden of chronic disease(s) in the region.**

Please See Handout Selected Medicaid Demonstration Projects for details

More Information



MEDICAID TRANSFORMATION APPROVED PROJECT TOOLKIT
June 2017



North Central Accountable Community of Health

Medicaid Transformation Demonstration Selected Projects
Chelan, Douglas, Grant, and Okanogan Counties

Bi-directional Integration of Physical and Behavioral Health through Care Transformation
Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through Managed Care Organizations, for people enrolled in Medicaid to address the whole person.

Community Based Care Coordination
Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. This will rely on the development of the Pathways HUB infrastructure which will coordinate care coordinators and allow current care coordinators to provide more effective and efficient care coordination.

Transitional Care
Improve transitional care services of Medicaid beneficiaries moving from intensive medical care or institutional settings. This includes those discharged from acute care to home or to supportive housing, those with serious mental illness discharged from inpatient care, or clients returning to the community from prison or jail. Improvement in these services will lead to a reduction in avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

Diversion Interventions
Implement diversion strategies to promote more appropriate use of emergency services and person centered care through increased access to primary care and social services, especially for medically underserved populations. Strategies targeted at Medicaid beneficiaries presenting at the Emergency Department for non-emergency conditions, Medicaid beneficiaries who access the EMS system for emergency conditions, and Medicaid beneficiaries with mental health and substance use conditions coming into contact with law enforcement.

Reduce the Opioid Use Public Health Crisis
Address opioid-related morbidity and mortality through strategies to prevent opioid misuse and abuse, treatment of opioid use disorder, and diversion of patients into long term recovery, and whole person care.

Chronic Disease Prevention and Control
Improve chronic disease management and control by using the Chronic Care Model. The Chronic Care Model is an organizational approach to caring for chronic disease in a primary care setting. The CCM identifies a health care system that encourage high-quality chronic disease management, the health system self-management support, decision support, and clinical information systems.

North Central Accountable Community of Health

Selected Medicaid Demonstration Projects

Bi-Directional Integration	Objective: Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers. General target population (as defined by HCA): All Medicaid beneficiaries (children and adults) particularly those with or at risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).
Community-Based Care Coordination (aka HUB)	Objective: Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. General target population (as defined by HCA): Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke), mental illness/depressive disorders, moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high FQHS utilization).
Transitional Care	Objective: Improve transitional care services to reduce avoidable hospital utilization and ensure Medicaid beneficiaries are getting the right care in the right place. General target population (as defined by HCA): Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including: • beneficiaries discharged from acute care and inpatient care to home or to supportive housing (including beneficiaries with serious mental illness (SMI)) • client returning to the community from prison or jail.
Diversion Interventions	Objective: Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. General target population (as defined by HCA): Medicaid beneficiaries with mental health and/or substance use conditions • Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement
Addressing the Opioid Use Public Health Crisis	Objective: Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports. General target population (as defined by HCA): Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.
Chronic Disease Prevention and Control	Objective: Integrate health system and community approaches to improve chronic disease management and control. General target population (as defined by HCA): Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.

North Central Accountable Community of Health

Medicaid Transformation Demonstration Selected Projects

Bi-directional Integration of Physical and Behavioral Health through Care Transformation
Address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through Managed Care Organizations, for people enrolled in Medicaid to address the whole person.

Community-Based Care Coordination
Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health. This will rely on the development of the Pathways HUB infrastructure which will coordinate care coordinators and allow current care coordinators to provide more effective and efficient care coordination.

Diversion Interventions
Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations. Strategies will be targeted at Medicaid beneficiaries presenting at the ED for non-emergency conditions, Medicaid beneficiaries who access the EMS system for a non-emergency mental health and/or substance use conditions coming into contact with law enforcement.

Resources and Relationships

- Domains and Projects *should not* be implemented in isolation from one another.
 - Projects will be highly interrelated and interdependent
- Transformation projects must:
 - Be based on community-specific needs for the Medicaid population
 - Avoid redundancy and duplication
- Regional projects will be assessed based on achievement of defined milestones and metrics.

Funding the Demonstration Projects

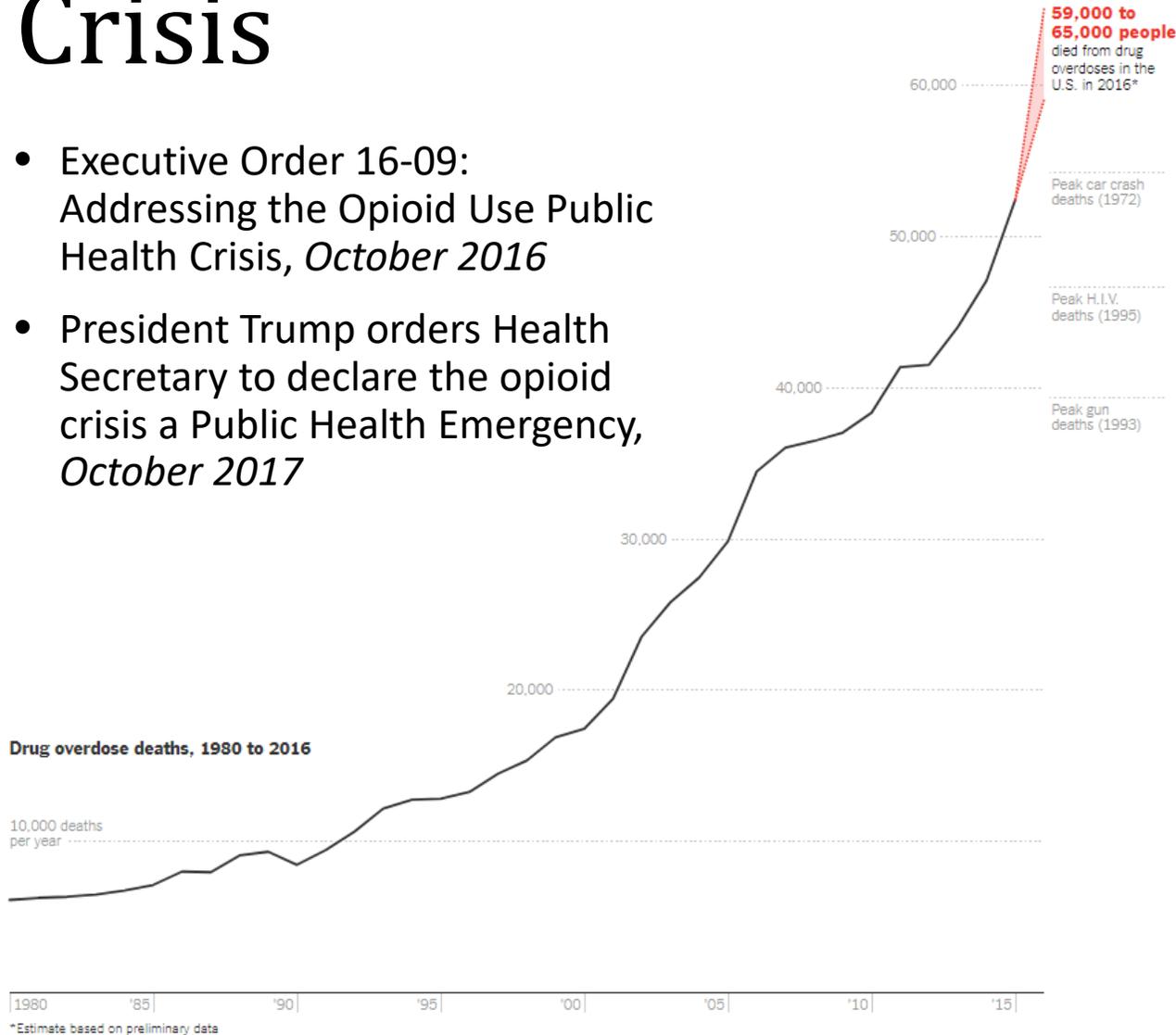
Each project involves metrics

Funding will depend, in part, on our performance

- This is not a grant program. There will be up-front money for start-up, but much of the project funding must be earned by reaching performance targets.
- In the early years of the projects, we will be judged mainly on the progress we make in implementing project plans.
- In the later years of the projects, we will be judged mainly in terms of health care improvements such as reductions in unnecessary ER visits and hospitalization, and on clinical quality metrics such as the percent of Medicaid diabetes patients receiving HbA1c testing, percent receiving depression screening, and many others.
- It will be a heavy lift to measurably improve Medicaid clinical quality by the end of 2021.

Addressing the Opioid Use Public Health Crisis

- Executive Order 16-09: Addressing the Opioid Use Public Health Crisis, *October 2016*
- President Trump orders Health Secretary to declare the opioid crisis a Public Health Emergency, *October 2017*



DEATHS IN THE UNITED STATES, PEAK YEAR

64,070	Drug Overdoses, 2016
54,589	Car Accidents, 1972
50,628	HIV/AIDS, 1995
44,193	Suicides, 2015
24,703	Homicides, 1991
16,899	Vietnam War, 1968

Addressing the Opioid Use Public Health Crisis

Project Objective: Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

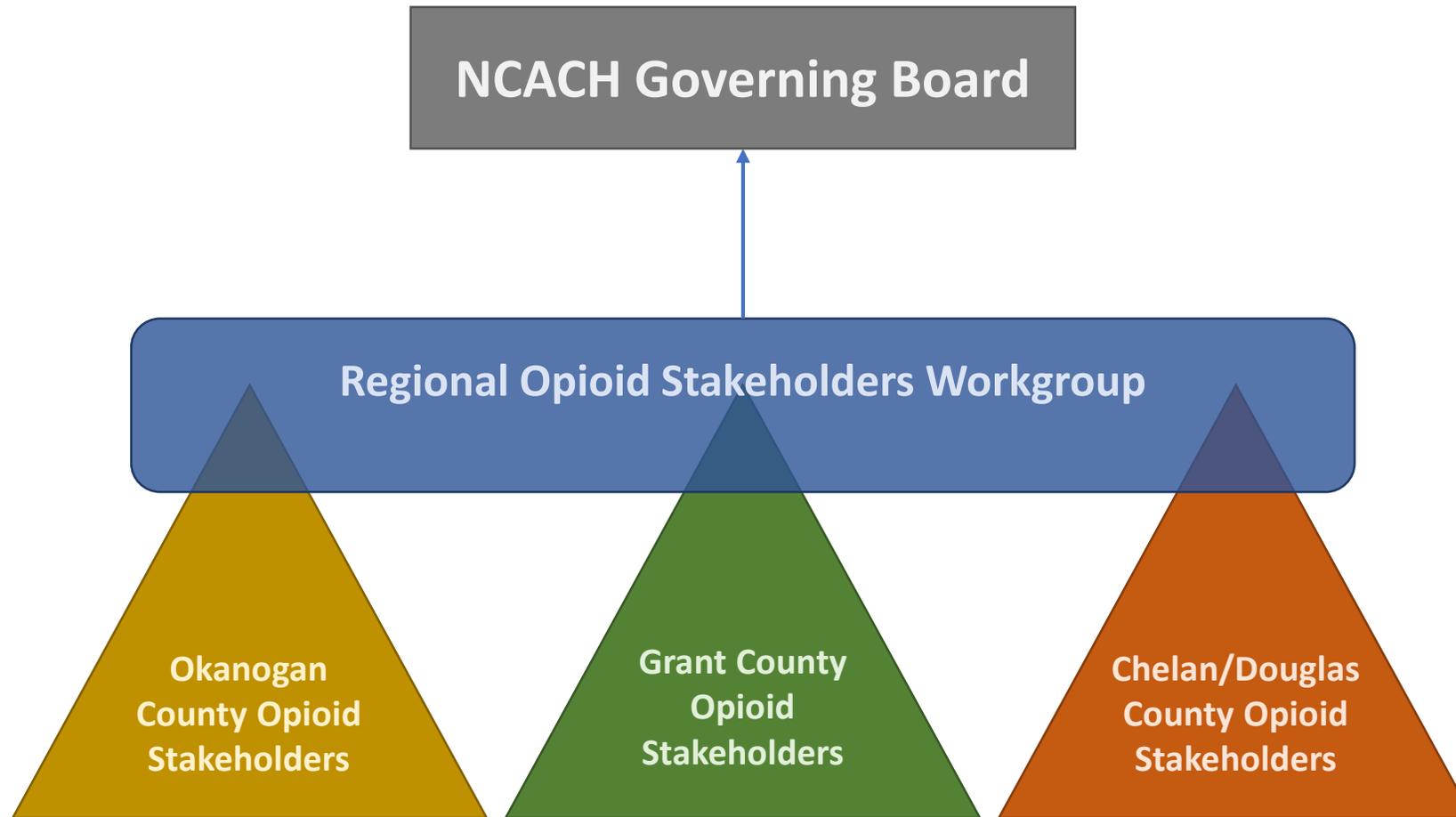
Statewide Plans

- [2016 Washington State Interagency Opioid Working Plan](http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf)
(http://www.stopoverdose.org/FINAL%20State%20Response%20Plan_March2016.pdf)
- [Substance Abuse Prevention and Mental Health Promotion Five-Year Strategic Plan](http://www.theathenaforum.org/sites/default/files/SPE%20Strategic%20Plan%202015%20Update%20FINAL%20for%20Athena.pdf)
(<http://www.theathenaforum.org/sites/default/files/SPE%20Strategic%20Plan%202015%20Update%20FINAL%20for%20Athena.pdf>)

Must demonstrate a multi-pronged approach that includes strategies targeting:

- Prevention
- Treatment
- Overdose Prevention
- Recovery

Relationships Among Groups

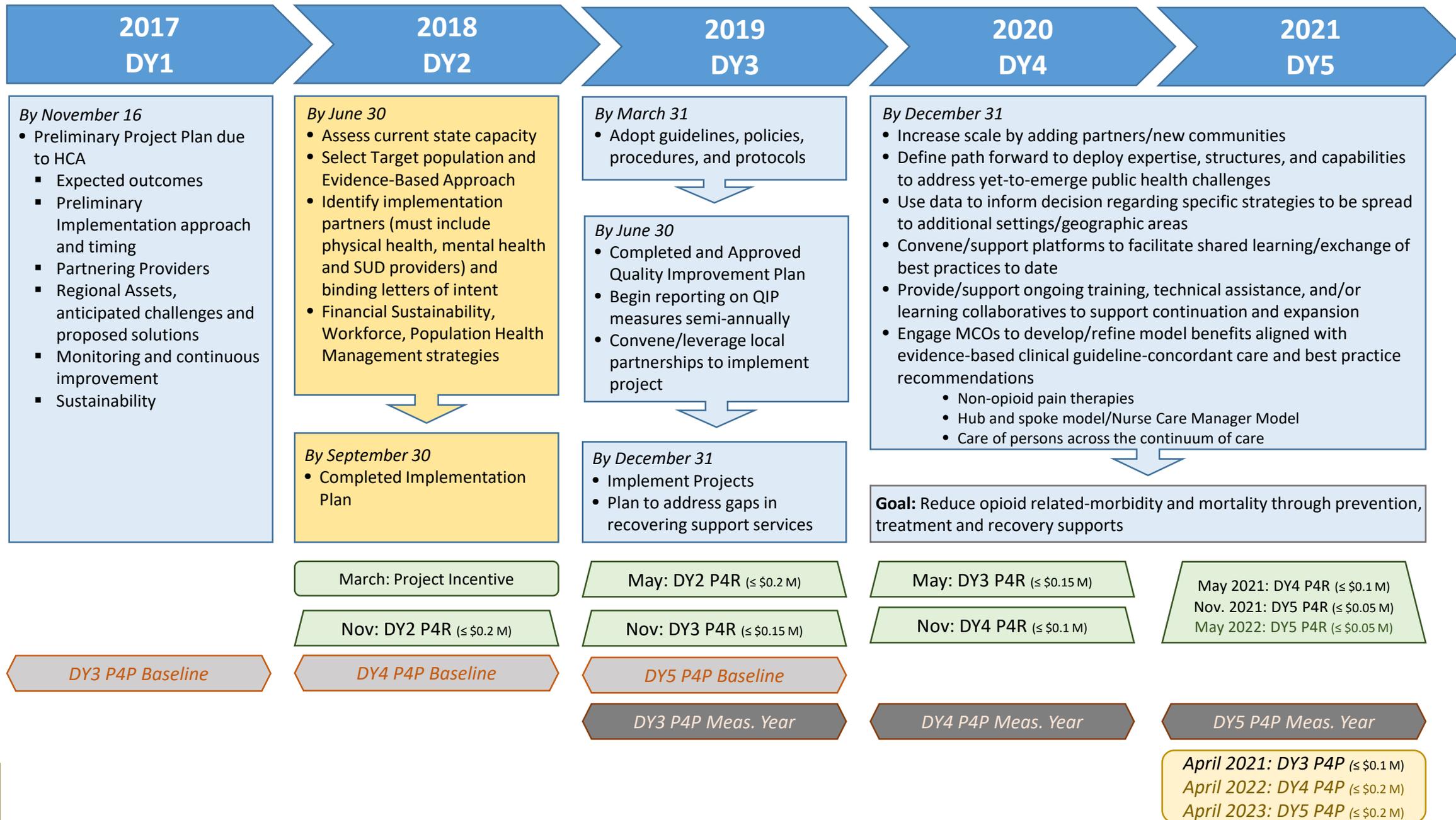


Regional Opioid Stakeholder Workgroup

Workgroup will ensure that the region implements effective evidence-supported practices that align with the Toolkit. Specifically the following:

- Support and work through the Local Opioid Stakeholder Groups already working in Chelan-Douglas, Grant, and Okanogan Counties to promote connections to existing opioid efforts in the region, leverage current capacity, and address identified gaps.
- Provide recommendations to the NCACH Governing Board and staff on approaches to take for opioid prevention, treatment, overdose prevention, and recovery projects.
- Ensure projects align with all six projects NCACH selected to implement.
- Use stakeholder and community input on project planning and implementation.
- Work with NCACH partners to implement sustainable changes
- Ensure projects effectively connect patients with resources to mitigate the negative consequences of the social determinants of health.
- Identify how IT, workforce, and value-based payment strategies can support this project.

Opioid Project Implementation Timeline

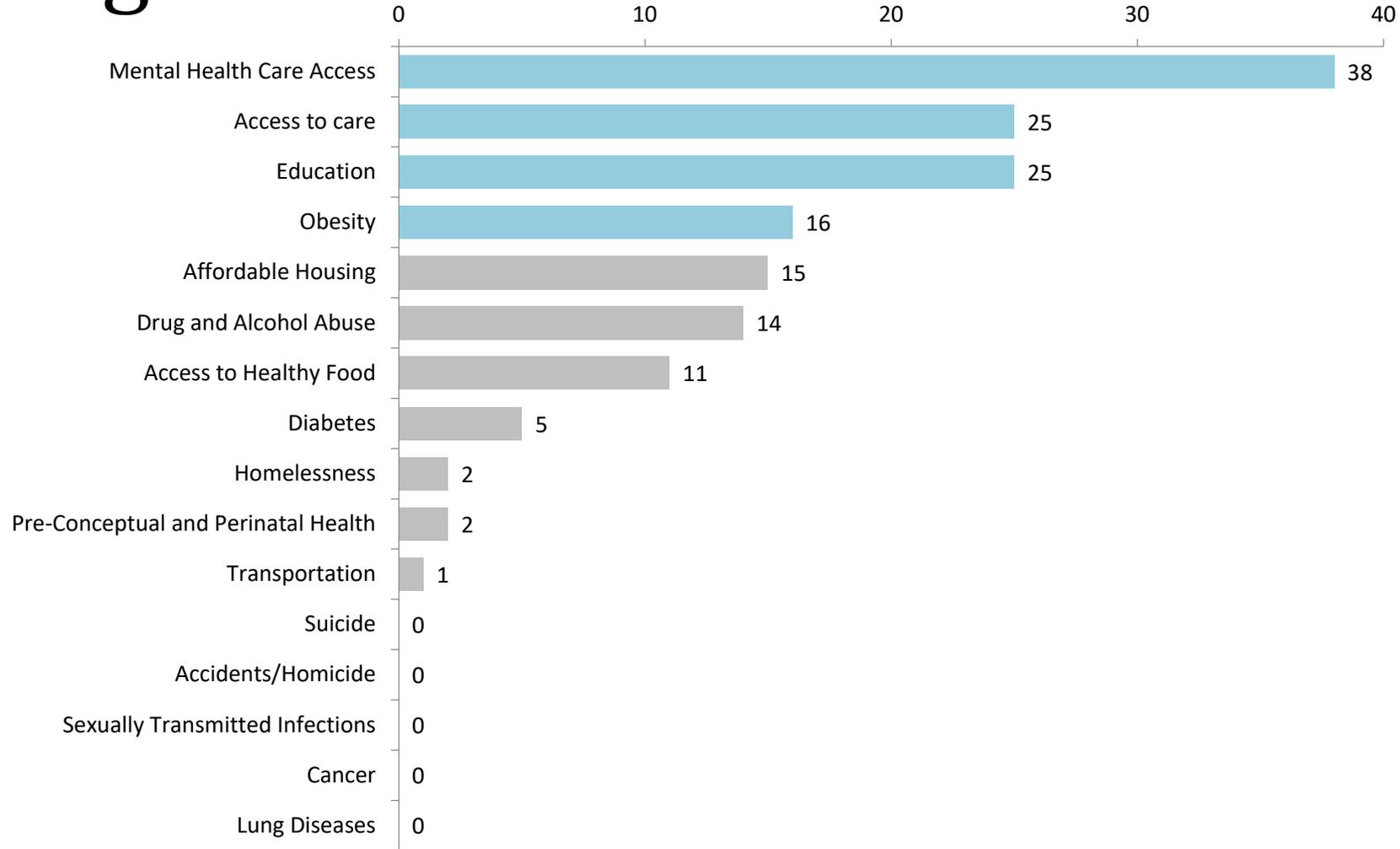


Implementation Plan

Minimum Requirements

- Implementation timelines for each strategy.
- A detailed description of how the ACH will implement selected strategies and activities that together create a comprehensive strategy addressing prevention, treatment, overdose prevention, and recovery supports aimed at supporting whole-person health.
- Identify the system supports that need to be activated to support an increase in the number of 1) providers prescribing buprenorphine; 2) patients receiving medications approved for treatment of OUD; 3) the different settings in which buprenorphine is or should be prescribed and 4) the development of shared care plans/communications between the treatment team of physical/mental health and SUD providers.
- Roles and responsibilities of key organizational and physical, mental health and SUD provider participants, including community-based service organizations, along with justification on how the partners are culturally relevant and responsive to the specific population in the region.
- Description of how project aligns with related initiatives and avoids duplication of efforts, including established local partnerships that are addressing the opioid crisis in their communities.
- Specific strategies and actions to be implemented in alignment with the 2016 Washington State Interagency Opioid Working Plan.
- Describe strategies for ensuring long-term project sustainability.

Regional Health Needs



Source: Community Health Needs Assessment

Medicaid Population Demographics

NCACH Region (N=94,009)

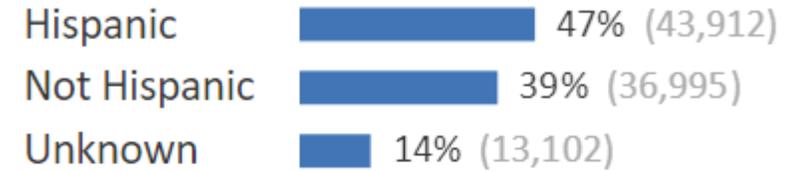
Age Group



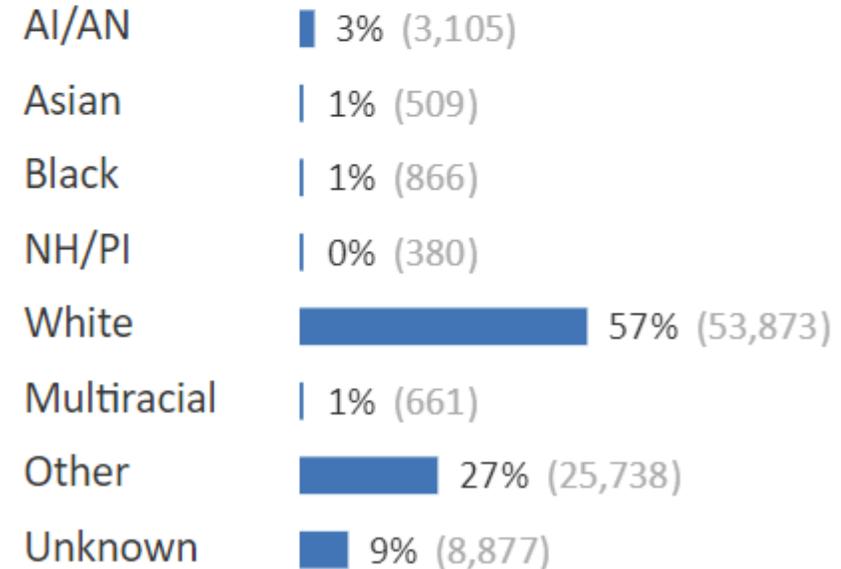
Gender



Ethnicity

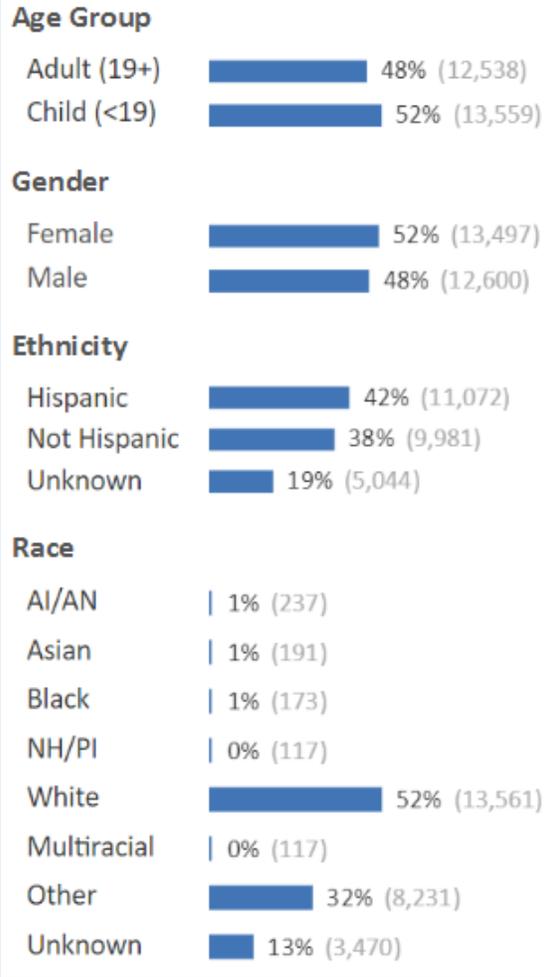


Race



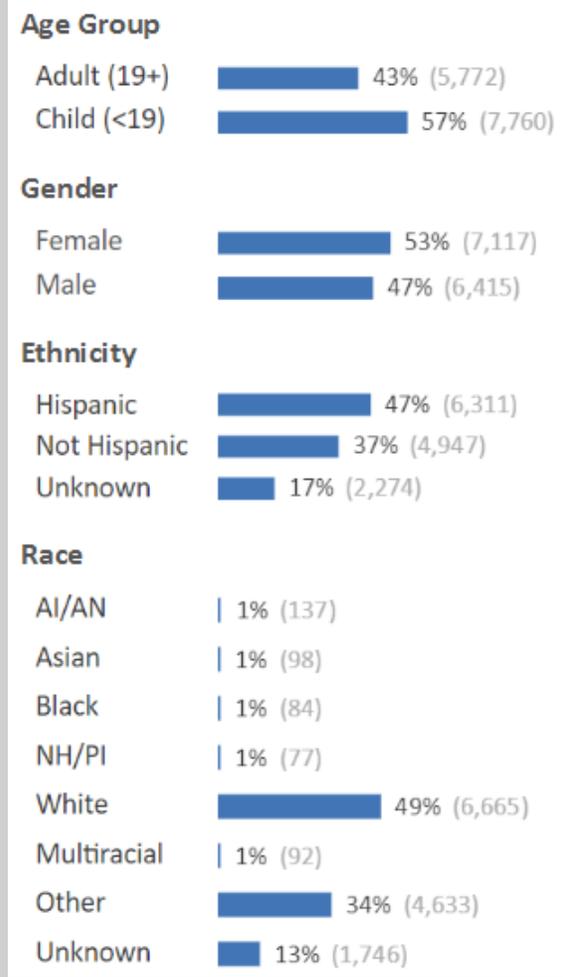
CHELAN

34% of population on Medicaid



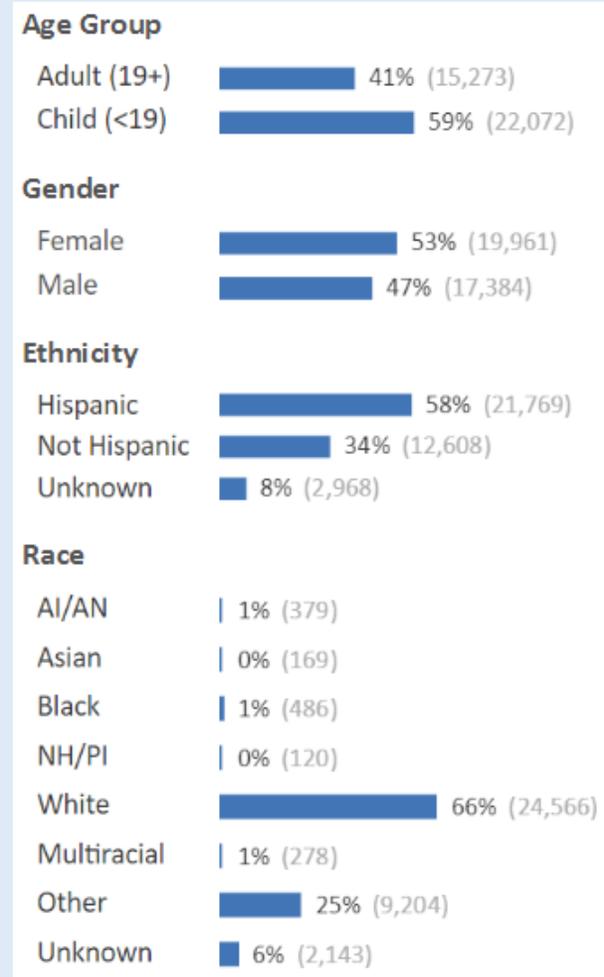
DOUGLAS

33% of population on Medicaid



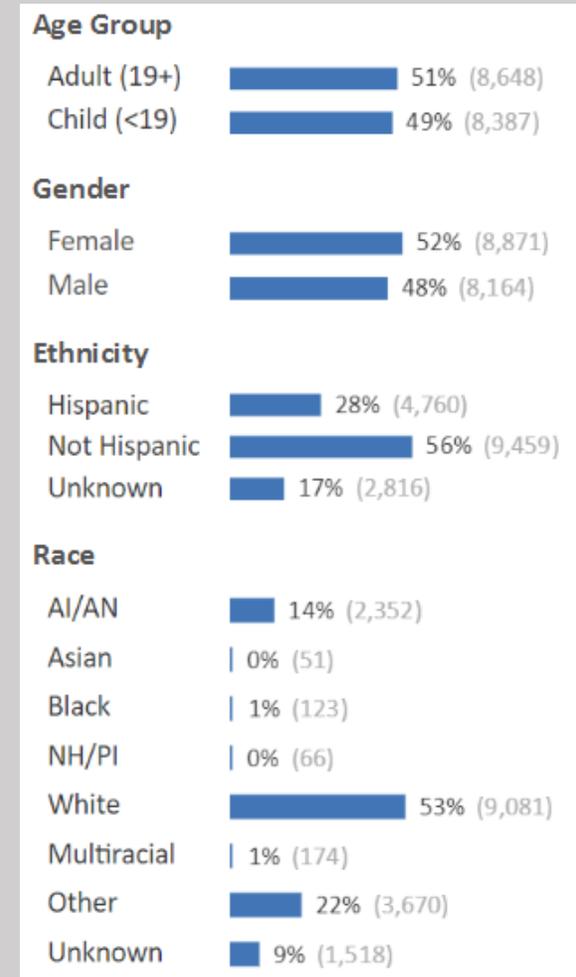
GRANT

39% of population on Medicaid

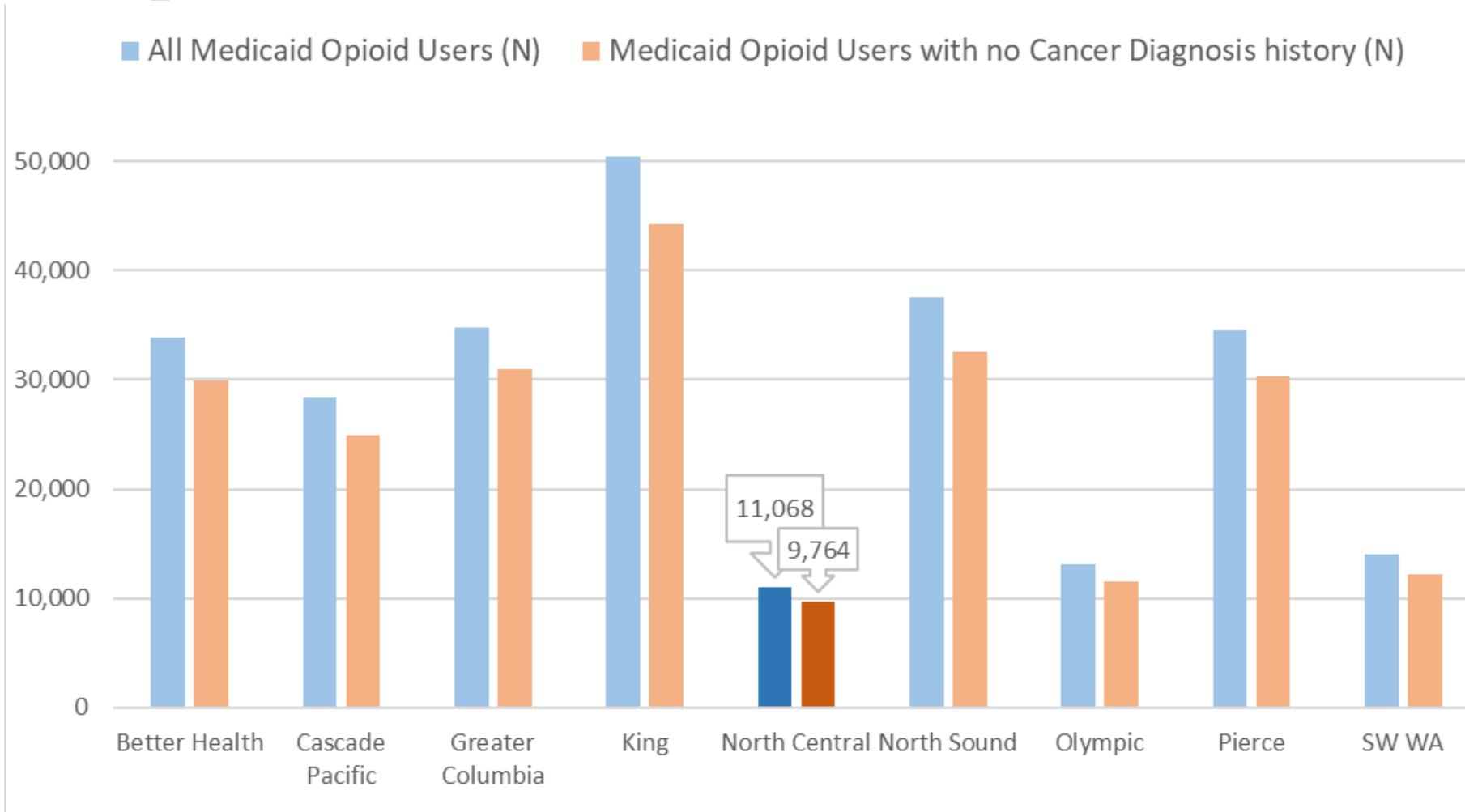


OKANOGAN

41% of population on Medicaid

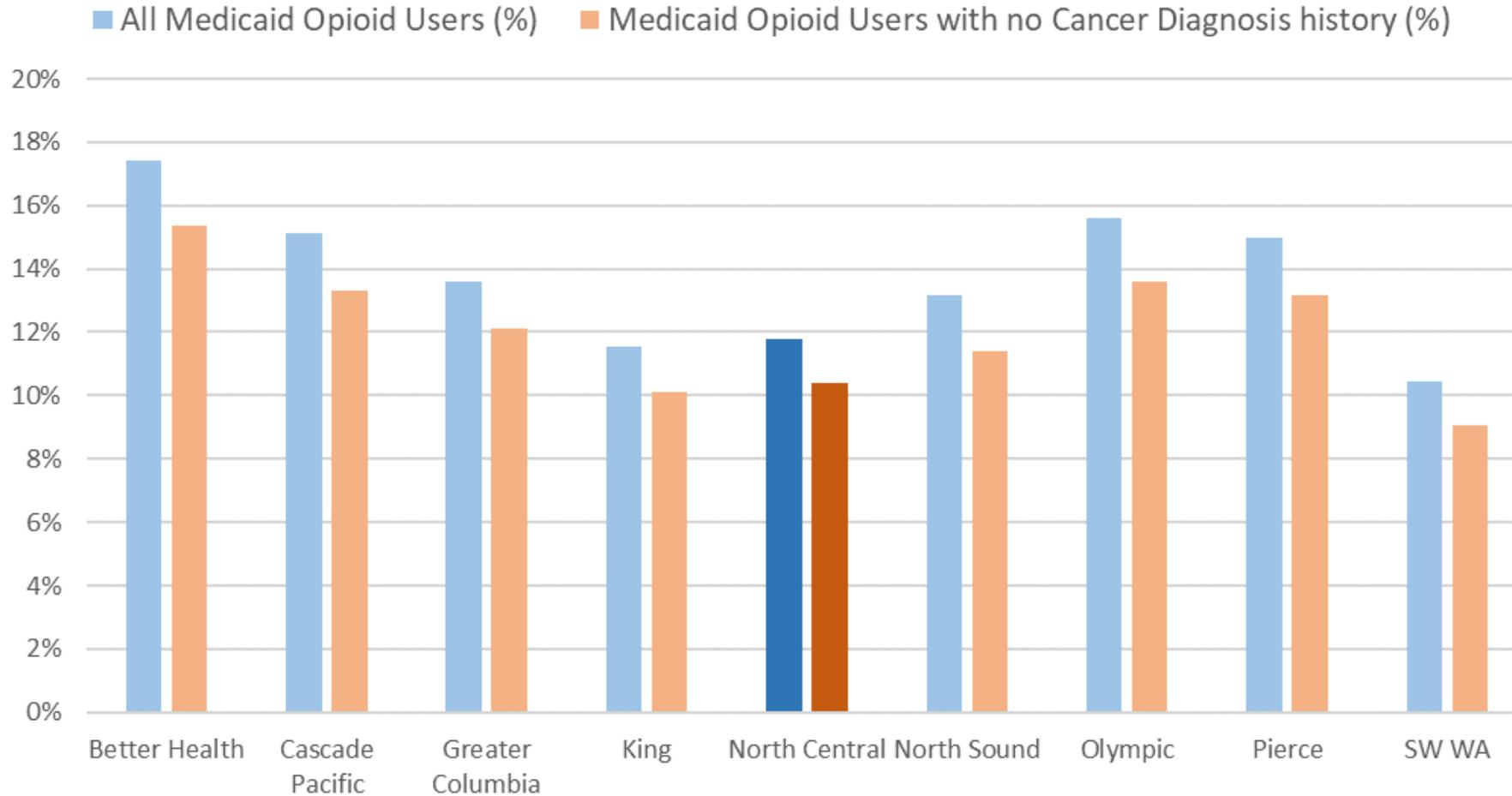


Opioid Use Across ACHs



Source: Health Care Authority
*Drawn from fiscal year 2016
claims data and ICD coding
(Medicaid only population with
full medical eligibility)*

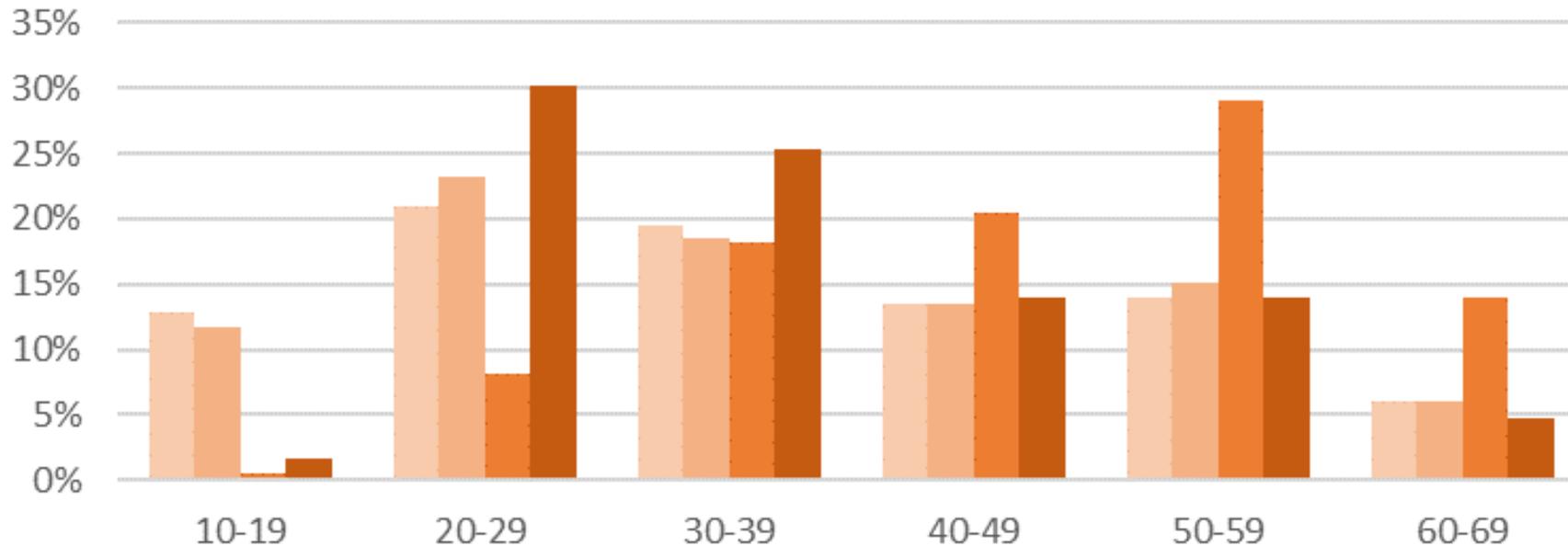
Opioid Use Across ACHs



Source: Health Care Authority
*Drawn from fiscal year 2016
claims data and ICD coding
(Medicaid only population with
full medical eligibility)*

Opioid Use by Age (NCACH Region)

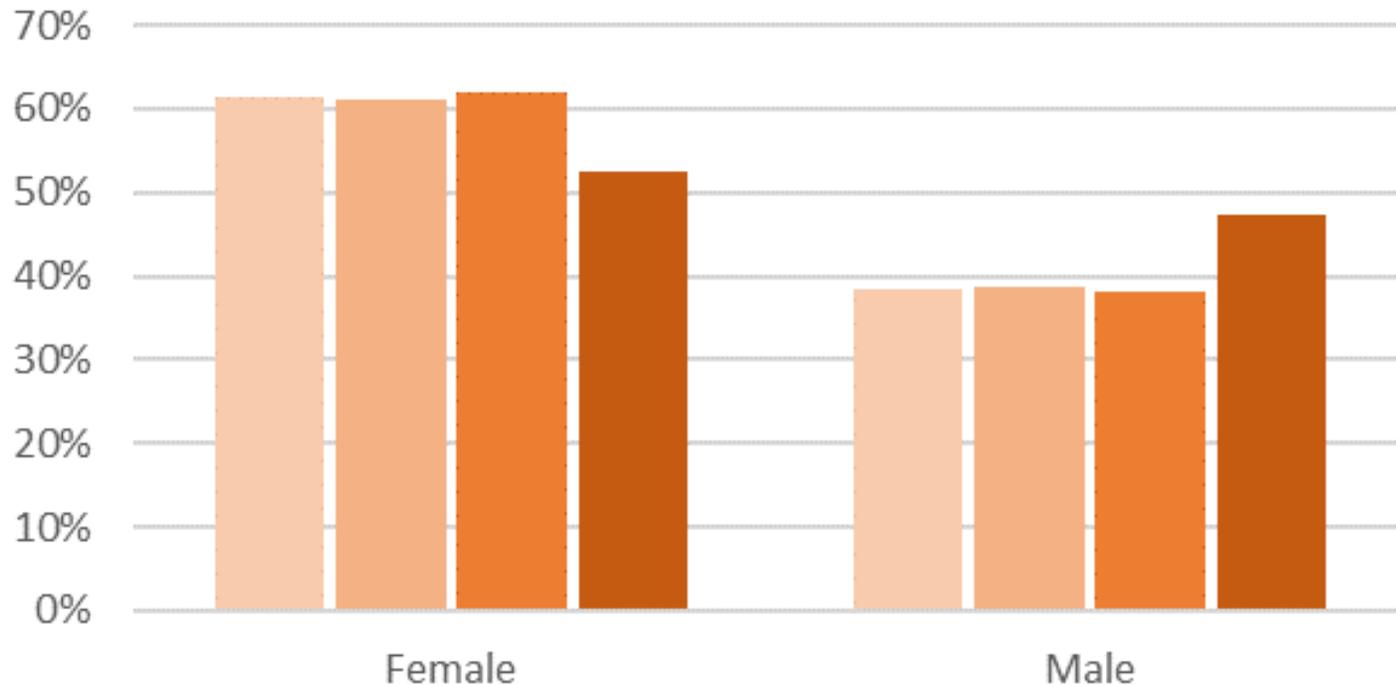
- % Opioid Users with no Cancer Diagnosis history (N = 9,764)
- % Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
- % Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
- % Diagnosis History of Opioid Abuse/Dependence (N = 1,359)



Source: Health Care Authority
*Drawn from fiscal year 2016
claims data and ICD coding
(Medicaid only population with
full medical eligibility)*

Opioid Use by Gender (NCACH Region)

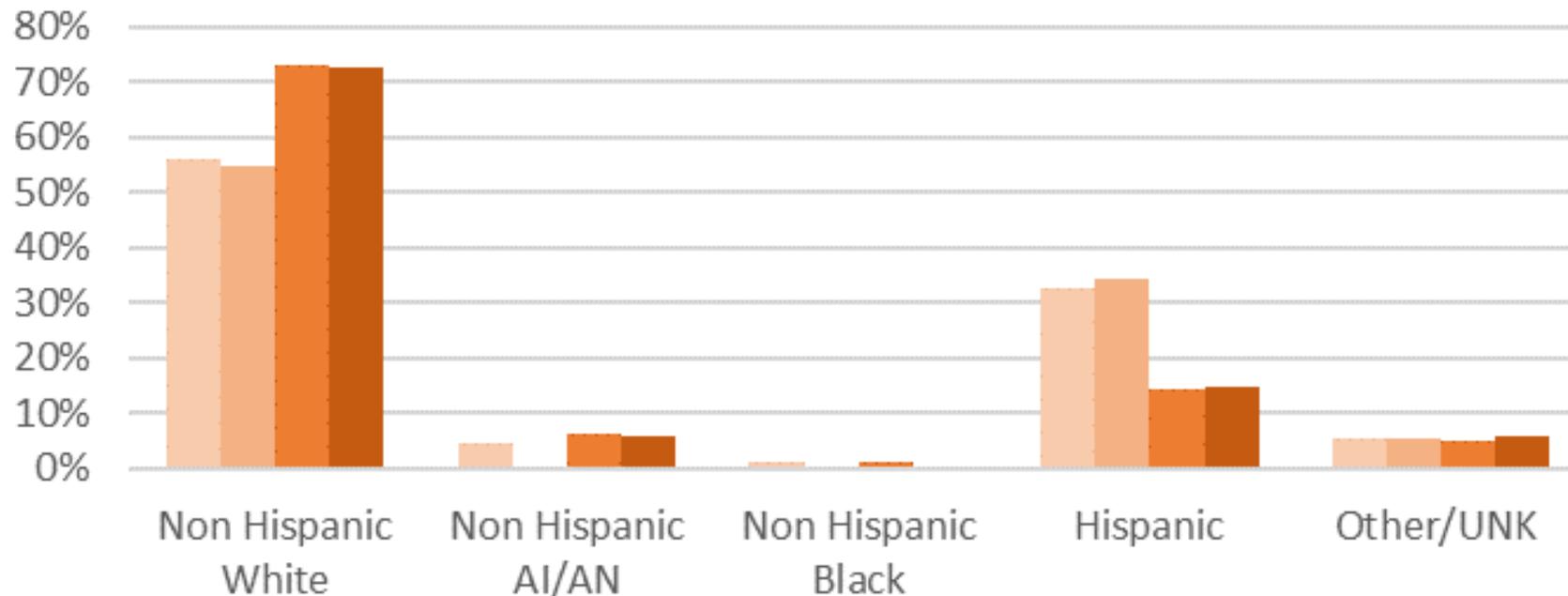
- % Opioid Users with no Cancer Diagnosis history (N = 9,764)
- % Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
- % Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
- % Diagnosis History of Opioid Abuse/Dependence (N = 1,359)



Source: Health Care Authority
*Drawn from fiscal year 2016
claims data and ICD coding
(Medicaid only population with
full medical eligibility)*

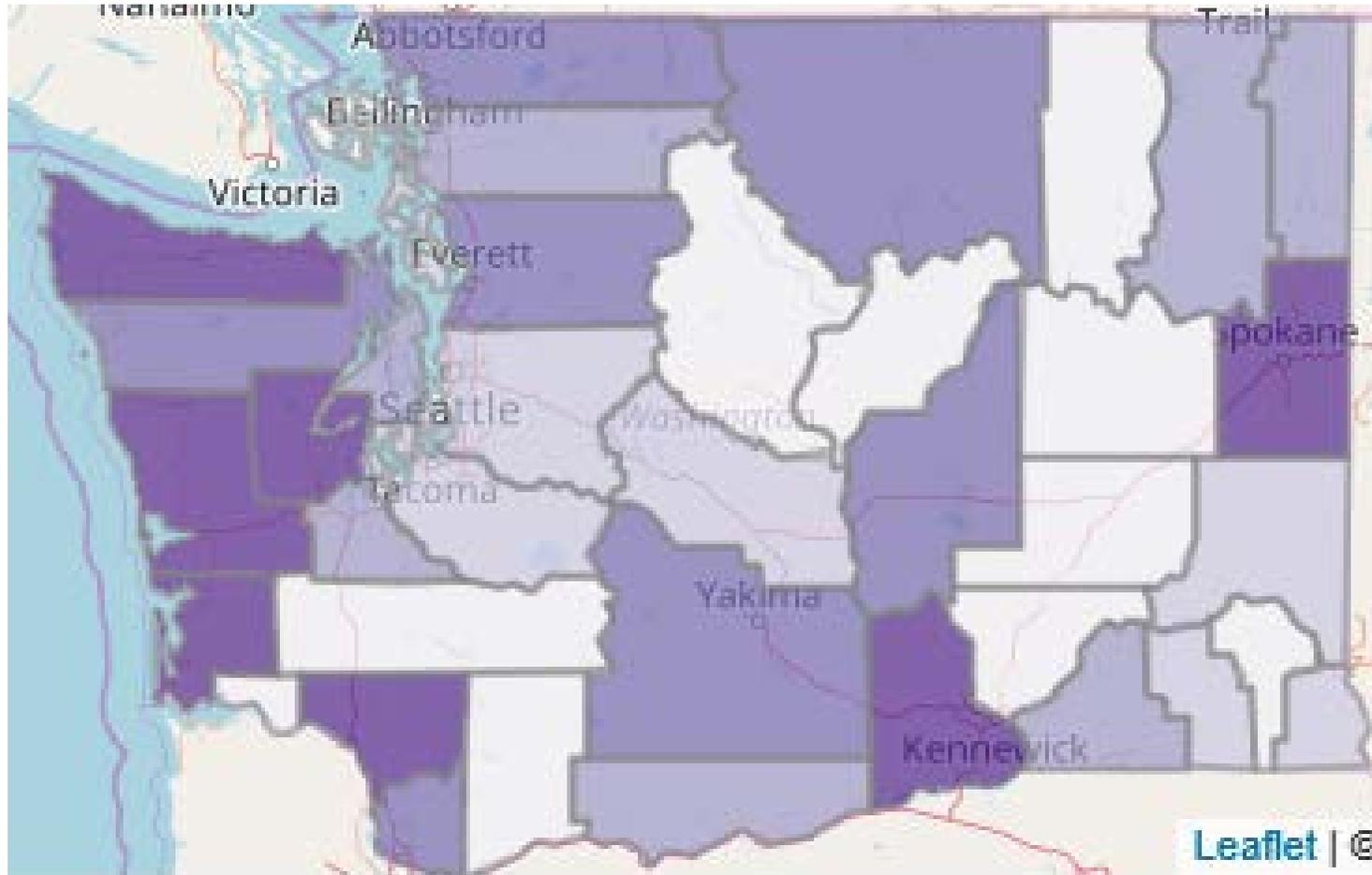
Opioid Use by Race/Ethnicity (NCACH Region)

- % Opioid Users with no Cancer Diagnosis history (N = 9,764)
- % Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
- % Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
- % Diagnosis History of Opioid Abuse/Dependence (N = 1,359)



Source: Health Care Authority
*Drawn from fiscal year 2016
claims data and ICD coding
(Medicaid only population with
full medical eligibility)*

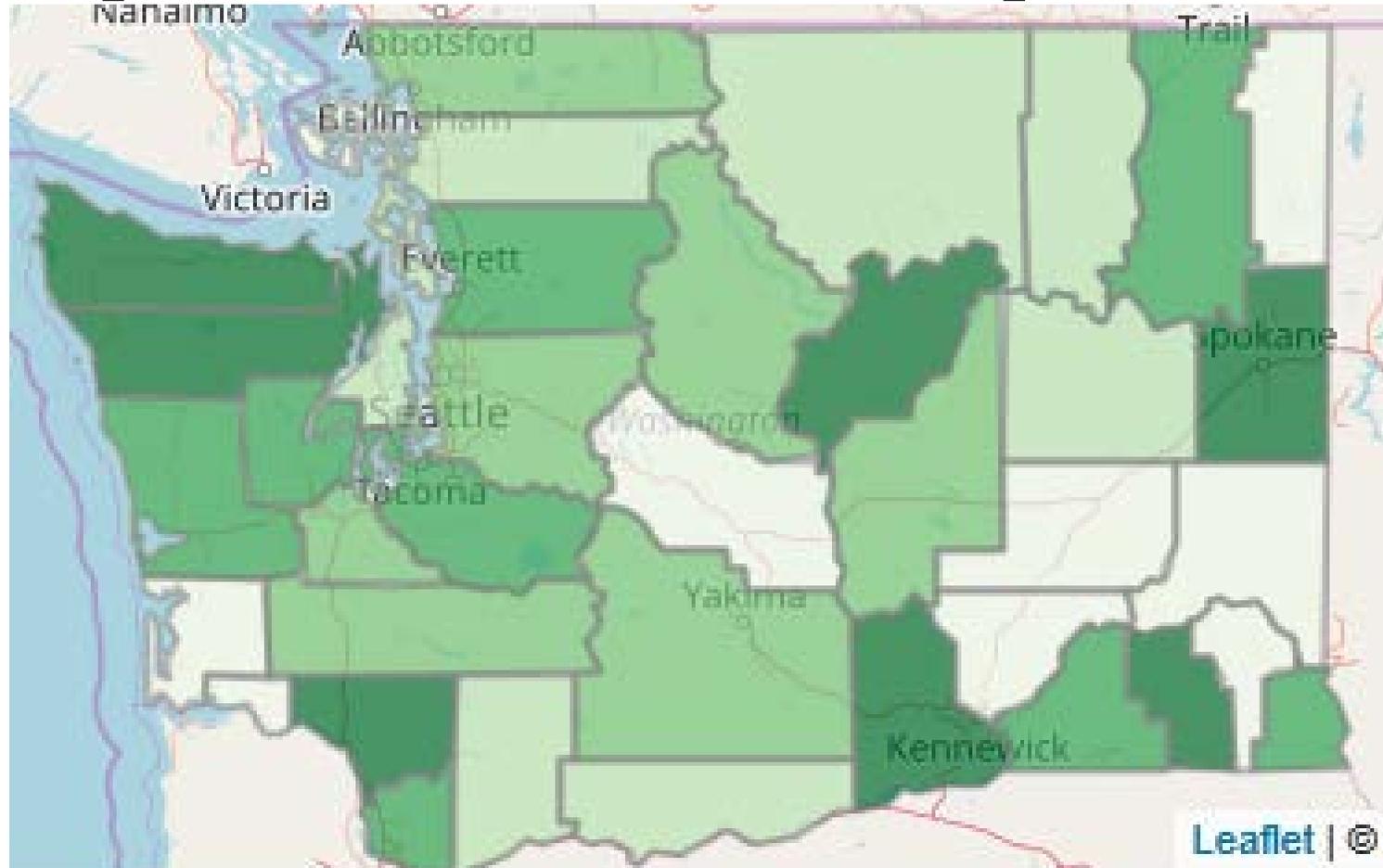
Opioid Emergency Department Visits



NCACH (2016)	Opioid ED Rate
Chelan	14.5
Douglas	0
Grant	53.9
Okanogan	64.7

Source: Washington Department of Health – Quarterly Opioid Dashboard
Measurement Period: 2016 (not specific to Medicaid only)

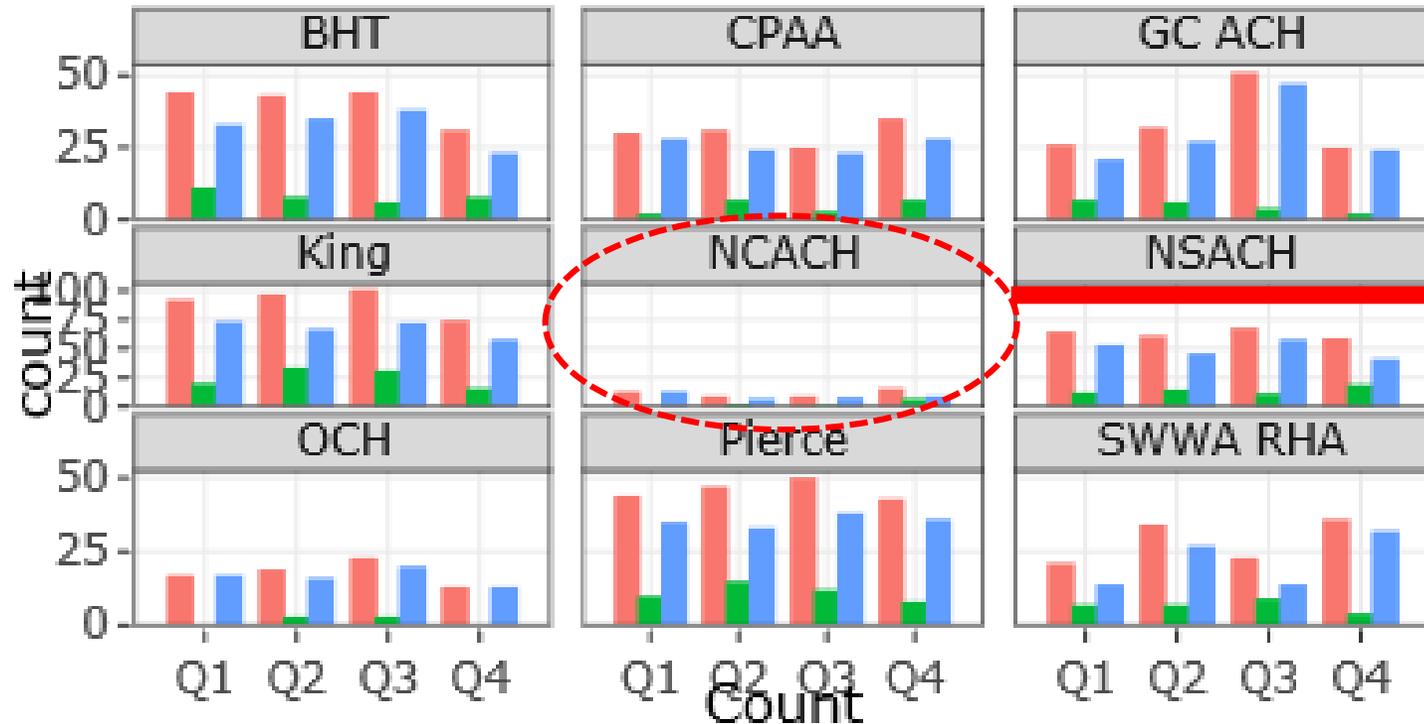
Opioid Overdose Hospitalizations



NCACH (2016)	Opioid Hospitalization Rate
Chelan	19.8
Douglas	29.5
Grant	16.9
Okanogan	9.6

Source: Washington Department of Health – Quarterly Opioid Dashboard
Measurement Period: 2016 (not specific to Medicaid only)

Opioid Overdose Hospitalizations

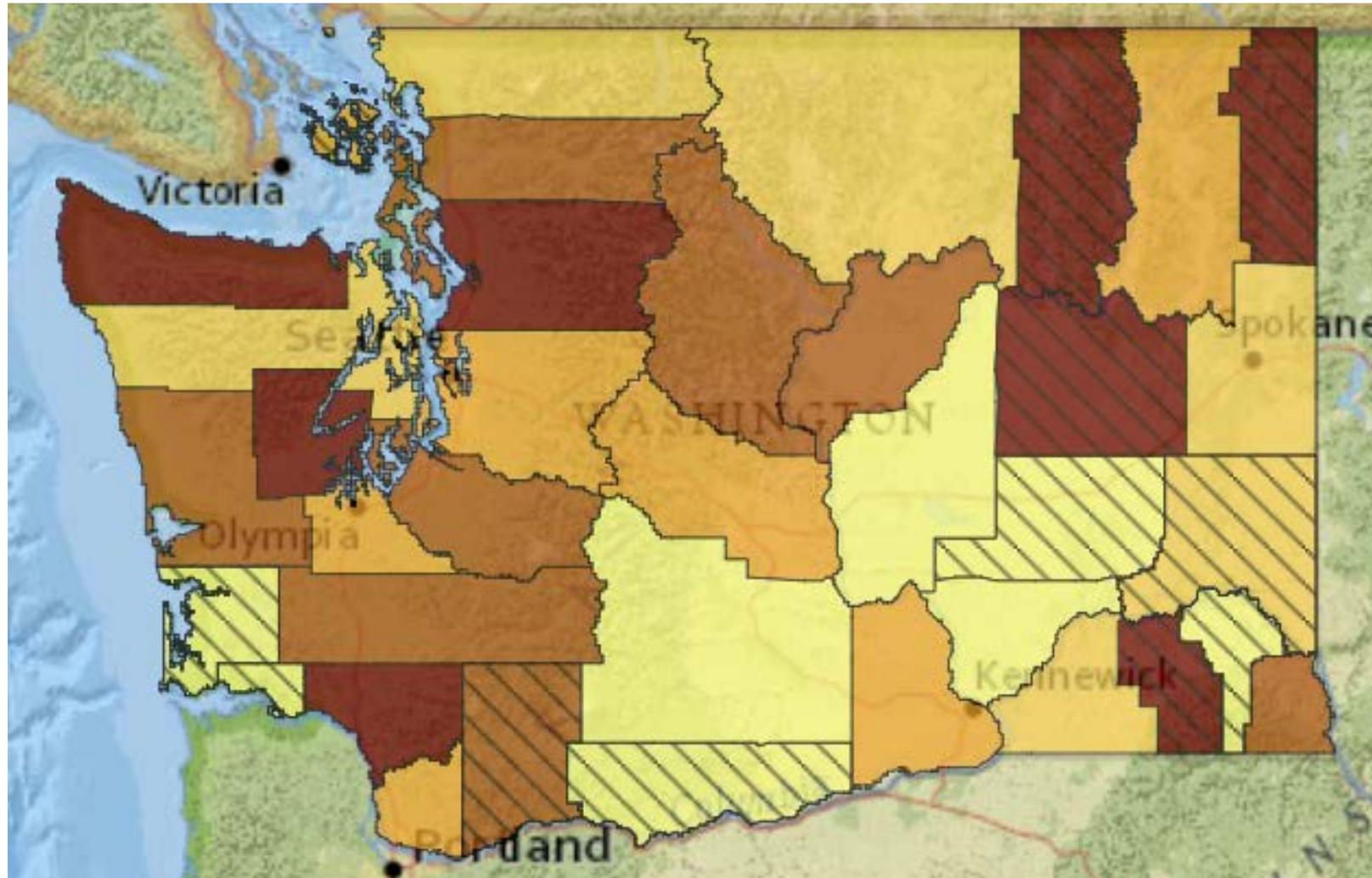


NCACH (2016)	Q1	Q2	Q3	Q4
All opioid	13	9	9	16
Heroin	0	2	1	7
Non heroin	13	7	8	9

- all_opioid
- heroin
- non_heroin

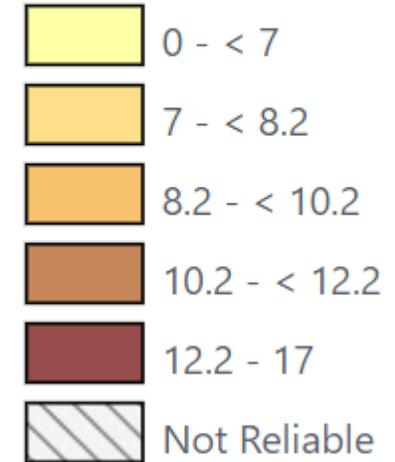
Source: Washington Department of Health – Quarterly Opioid Dashboard
 Measurement Period: 2016 (not specific to Medicaid only)

Fatal Overdoses - All Opioids



Legend (Measure 1)

Age Adjusted Rate



Source: Washington Tracking Network, Washington Department of Health
Time Period: 2011-2015 (not specific to Medicaid only)

Fatal Overdoses - All Opioids

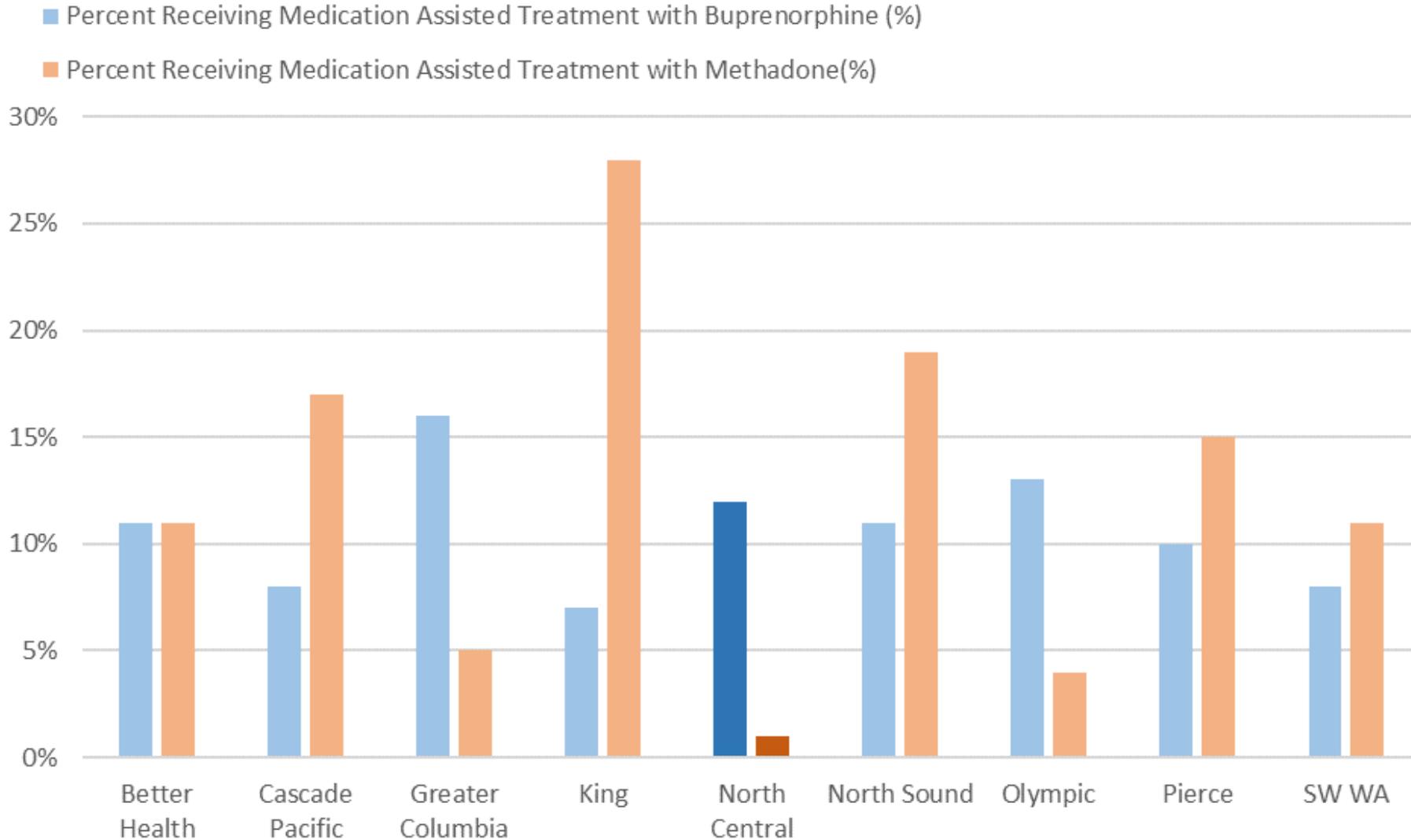
	Chelan	Douglas	Grant	Okanogan	TOTAL
Prescription opioids	31	14	17	12	74
Fentanyl and other synthetic opioids	6	4	1	2	13
Heroin	2	1	5	4	12
All Fatal Overdoses	40	19	24	16	99

Source: Washington Tracking Network, Washington Department of Health

Time Period: 2011-2015 (not specific to Medicaid only)

Note that these are the reported counts on the Washington Department of Health website, and the All Fatal Overdoses counts are close though do not always add up.

Medication Assisted Treatment Across ACHs



Source: Health Care Authority
*Drawn from fiscal year 2016
claims data and ICD coding
(Medicaid only population with
full medical eligibility)*

Feedback from CHIs

Data Requests

- Does opioid data from HCA include tribal health clinics?
- Is there data that can help us better understand who is at risk of using opioids? (to target prevention efforts)
- How do hospitals fit into opioid prescriber data (can we get data from EDIE?)
- What else would you like to add?

Feedback from CHIs

Questions / Thoughts

- Need better understanding of opioid addiction – what are drivers, what came first? (this is important for prevention efforts)
- Sub-populations affected by opioid use: people struggling with homelessness, incarceration, and/or dual diagnoses.
- Need to target underlying health reasons related to opioid abuse, e.g. chronic pain
- Education and awareness is needed (for providers and patients)
- **What other questions or thoughts do you have?**

Project Reporting Measures

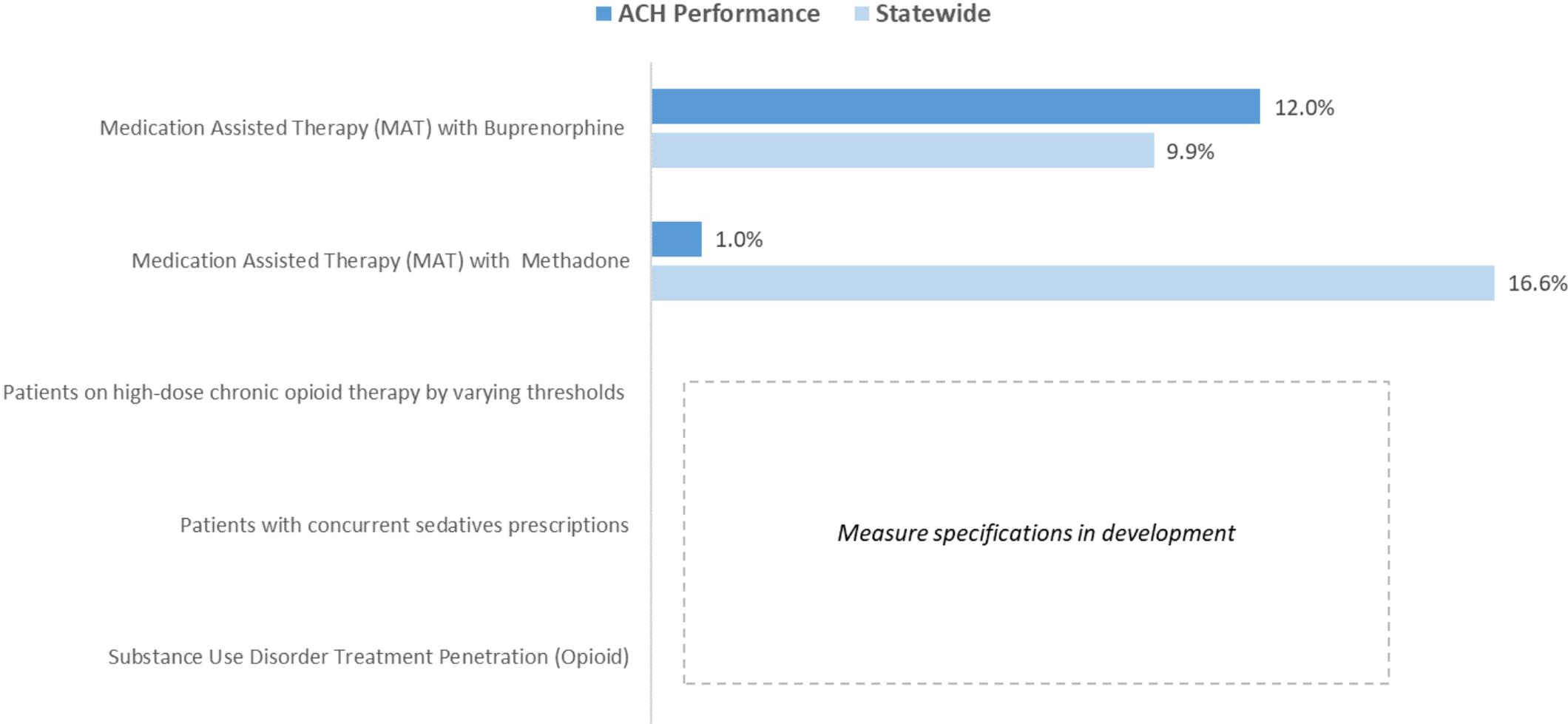
- Report against QIP metrics.
- Number and locations of MDs, ARNPs, and PAs who are approved to prescribe buprenorphine.
- Number and locations of mental health and SUD providers delivering acute care and recovery services to people with OUDs.
- Number and list of community partnerships. For each include list of members and roles, including the identification of partners through which MAT is accessible.
- Number of health care organizations with EHRs or other systems newly put in place that provide clinical decision support for the opioid prescribing guideline, such as defaulting to recommended dosages or linking to the PDMP.
- Number of health care providers, by type, trained on AMDG's Interagency Guideline on Prescribing Opioids for Pain.
- Number of emergency department with protocols in place for providing overdose education and take home naloxone to individuals seen for opioid overdose.
- Number of local health jurisdictions and community-based service organizations that received technical assistance to organize or expand syringe exchange programs.
- Number and types of access points in which persons can receive medication assisted therapy, such as EDs, SUD and mental health settings, correctional settings or other non-traditional community based access points.

Project Performance Measures

- Antidepressant Medication Management
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- **Inpatient Hospital Utilization**
- Medication Management for People with Asthma (5 – 64 Years)
- Mental Health Treatment Penetration (Broad Version)
- **Outpatient ED Visits per 1000 Member Months**
- Plan All-Cause Readmission Rate (30 Days)
- Substance Use Disorder Treatment Penetration
- Percent Homeless (Narrow definition)
- Percent Arrested
- **Medication Assisted Therapy (MAT): With Buprenorphine or Methadone**
- **Patients on high-dose chronic opioid therapy by varying thresholds**
- **Patients with concurrent sedatives prescriptions**
- **Substance Use Disorder Treatment Penetration (opioid)**
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)

Accountability Measures

Addressing Opioid Use Public Health Crisis



Source: Health Care Authority and DSHS-RDA
Measurement period 10/1/2015-9/30/2016

Initiative Matrix

Initiative	Chelan/Douglas	Grant	Okanogan
Prevention			
Treatment			
Overdose Prevention			
Recovery			

Next Steps – Project Planning

Project Plan Application Due November 16th

- Preliminary Evidence based Approaches and Target Populations
- Signed Membership Agreement (email to crystal.eshelman@cdhd.wa.gov)

Project Implementation Planning Timeline

- Read Evidence Based Approaches & review data for Target Populations
- Ensure Alignment with other Demonstration Projects

Nov 2017 – Feb 2018

- Assess current regional capacity
- Select Target population
- Select Evidence-Based Approach(es)

March 2018 – June 2018

- Identify implementation partners and binding letters of intent
- Financial Sustainability, Workforce, Population Health Management strategies

June 2018 – Sept 2018

Completed
Implementation Plan
***Prefer completion by
July 2018***



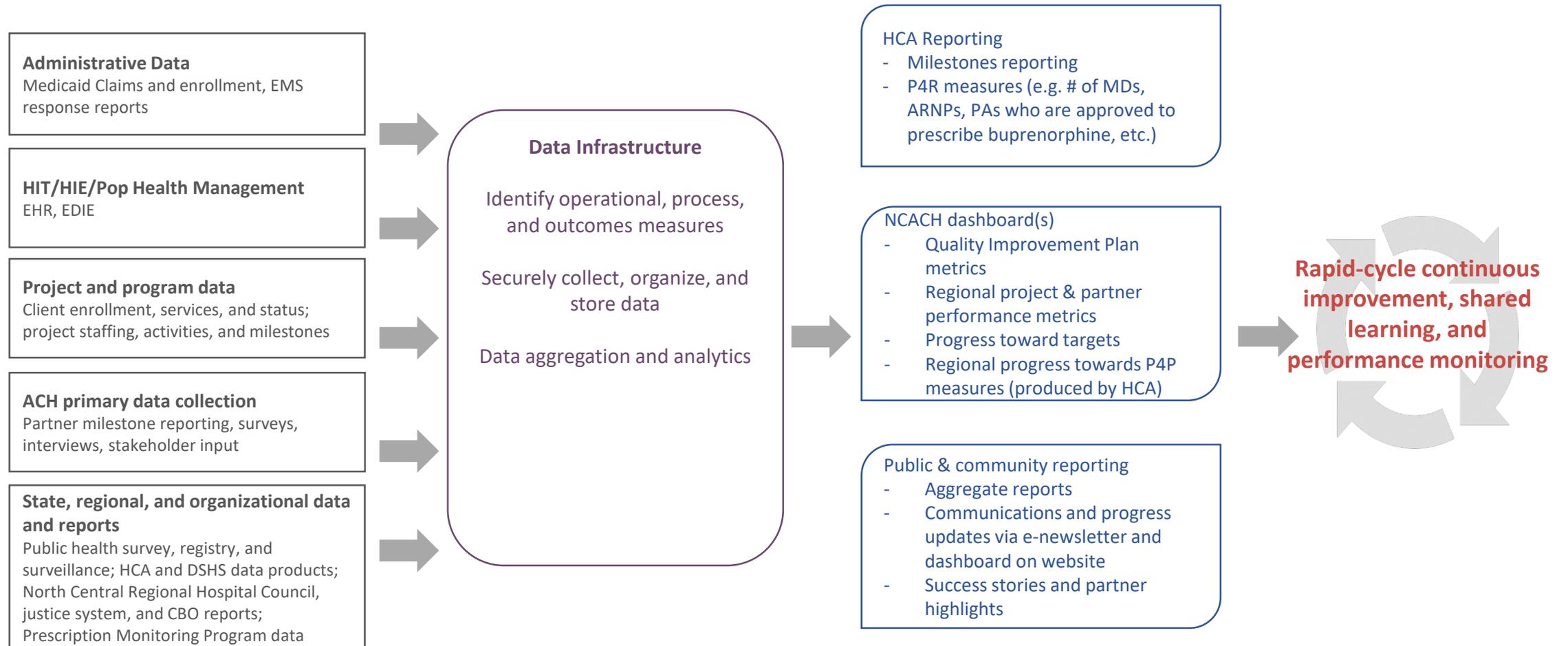
North Central Accountable
Community of Health

Contact

Christal Eshelman, Opioid Project Lead

email: christal.eshelman@cdhd.wa.gov

Planned approach for monitoring and continuous improvement



SECTION II: PROJECT-LEVEL

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

Transformation Project Description

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

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

Project Selection & Expected Outcomes

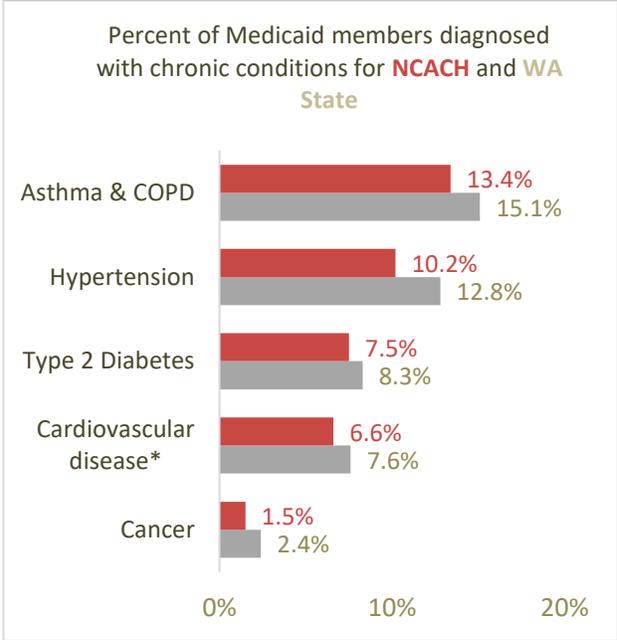
The scope of the project may be preliminary and subject to further refinement. In Demonstration Year 2, the ACH will be required to finalize selections of target population and evidence-based approaches, and secure commitments from partnering providers.

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

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

ACH Response

Overall, the NCACH region has lower rates of chronic conditions than the statewide average. The prevalence and management of chronic conditions, however, varies across the region. Both qualitative and quantitative data highlight areas of need and opportunities for improvement. In a survey of community stakeholders (we received a total of 323 responses from three outreach events in August and September 2017), obesity was identified as the second most important health problem affecting the community. This was consistent with prior data collected through our Community Health Needs Assessment (CHNA) in 2016, which resulted in the identification of 16 potential health needs in the community. Obesity, a driver for other chronic diseases including diabetes and heart disease, was ranked fourth when 39 community leaders (including representatives from the health and social services sector) convened to prioritize these CHNA needs based on a set of criteria.



Source: DSHS ACH Profiles produced by RDA, North Central Current State spreadsheet.

Overweight and obesity rates are high in the region, with 65% of adults being overweight or obese¹. Based on 2013-15 data, our region has the second highest rate of all ACH regions for obesity in the state (30.7% compared to 26.7% for the state), with Douglas and Grant counties exhibiting the highest rates (34.4% and 34.2% respectively)². Data for specific demographic groups highlight disparities in health outcomes. For example, Hispanics in our region have the highest incidence of obesity compared to other races (36%). Obesity is most prevalent for people between the ages of 35-44 and 45-54 (37.7% and 39.1% respectively)—the highest rates in the state—and about 6% above the state average for both age brackets³.

In 2015, diabetes was one of the top ten most common causes of acute hospitalizations in our region, even though diabetes did not make it on the top ten list for Washington State⁴. Over the 2013-15 time period, nearly 10% of adults in the region reported having diabetes, the highest rate compared to other ACHs, which was 2% above the statewide average. Diabetes rates are highest in Grant and

¹ Chelan-Douglas Health District, 2016 Community Health Needs Assessment, “Appendix D: Potential Health Needs Fact Sheets.” http://www.cdhd.wa.gov/Health%20Data/Docs/Appendix_D.pdf

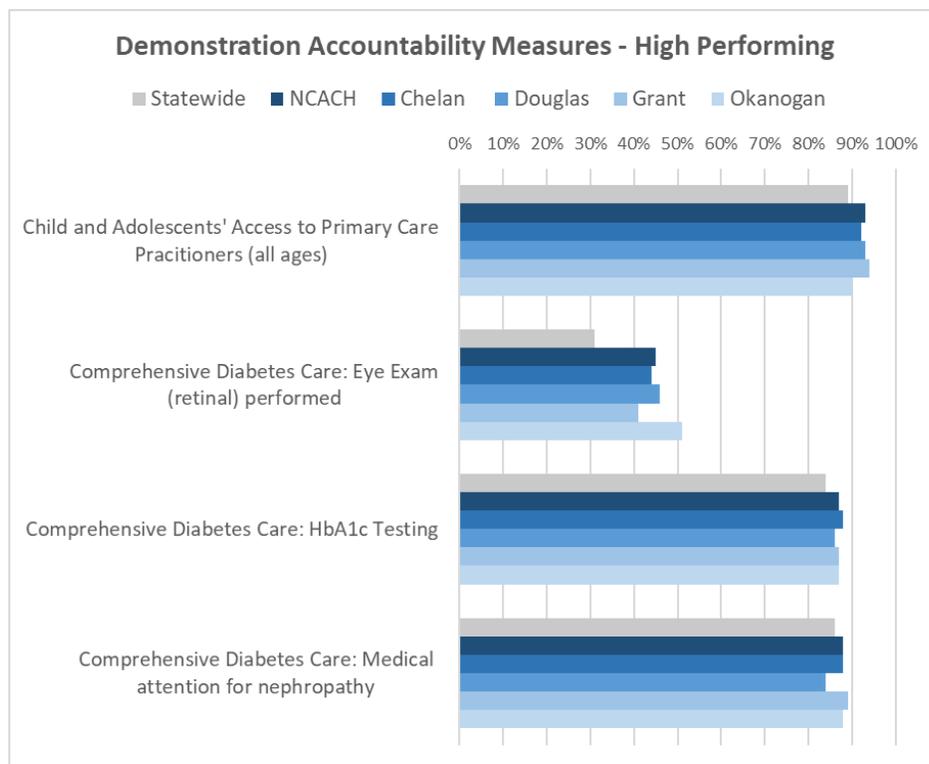
² HCA RHNI Start Kit, *Prevalence Estimates – Overall* tab. Based on the annual Behavioral Risk Factor Surveillance System (BRFSS) using three years combined data (2013-2015). The data is derived from self-reported weight and heights, where body mass index (BMI) >30.

³ Ibid

⁴ HCA RHNI Starter Kit, “Top Ten Most Common Causes of Statewide Acute Hospitalizations Among Medicaid Recipients, Excluding Pregnancy and Child Delivery Related Hospitalizations, During Jan 1, 2015-Oct 31, 2015”.

Okanogan counties (12% and 11% respectively)⁵. Data for specific demographic groups continue to highlight disparities in health outcomes. For example, Hispanics in our region have twice the rate of diabetes compared to Whites (17.7% versus 8.6%). The prevalence of diabetes is also greatest among people with a high school degree or less. While rates for our region are the highest in the state for this sub-population (13%), the general trend of higher rates of diabetes for people with low educational attainment holds across ACH regions, indicating a correlation with socioeconomic status. Specific to our Medicaid population, as of June 2016, 7.6% presented with a diagnosis of Type 2 diabetes (6,390 individuals), while about 1% presented with a diagnosis of Type 1 diabetes⁶.

The good news is that we are the top performing ACH based on all three comprehensive diabetes prevention measures, and we are above the 90th percentile measures for HbA1c testing and nephropathy (kidney disease) screening⁷. Some variations exist by county, indicating potential practice opportunities that can be shared by providers in high performing counties.



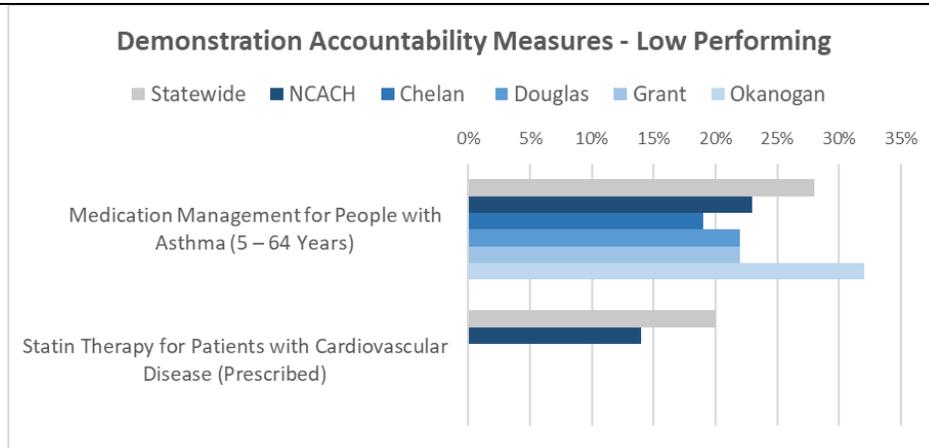
Source: Healthier Washington Dashboard, "Measure Explorer" tab (Oct 2015-Sep 2016)

Measures associated with asthma management and cholesterol management (which is linked to heart disease) for the period between October 2015 and September 2016 show room for improvement in our region, as we are the lowest performing ACH in the state.

⁵ HCA RHNI Starter Kit, *Prevalence Estimates – Overall* tab. Based on the annual Behavioral Risk Factor Surveillance System (BRFSS) using three years combined data (2013-2015).

⁶ DSHS Research and Data Analysis Division, ACH Profiles updated 02.28.17. North Central Current State spreadsheet, *Diagnoses* tab. Measurement period based on a 24 month lookback period from June 2016.

⁷ Healthier Washington Dashboard, *Measure Explorer* tab. Based on October 2015-September 2016 measurement period.



Source: Healthier Washington Dashboard, “Measure Explorer” tab (Oct 2015-Sep 2016)

It appears that providers practicing in Okanogan County may have best practices to share with the rest of the region regarding asthma management. While our region has lower rates of asthma diagnosis for Medicaid beneficiaries compared to the state (3% versus 4%), Okanogan and Grant counties have higher rates (4% each)⁸. For the broader population in our region, we have an estimated rate of 10.1% for asthma prevalence (compared to 9.5% for the state), though disparities exist for specific demographic populations⁹. For example, the prevalence of asthma for Native Americans in our region is 21.2%. Alarmingly, despite having comparable asthma rates compared to the state, respiratory infections were the fourth most common cause of acute hospitalizations for Medicaid recipients in our region, accounting for 6% of all acute hospitalizations. Across Washington State, respiratory infections only accounted for 3.6% of hospitalizations and are ranked ninth for Washington State¹⁰. Pulmonary issues like viral pneumonias, chronic bronchitis, asthma and COPD accounted for the second highest diagnosis rate (13.4%) for Medicaid beneficiaries in our region, out of all diagnoses flagged through the Chronic Illness & Disability Payment system¹¹. Diseases of the respiratory system also accounted for 11% of emergency department visits (the third most common cause) during the October 2015 to September 2016 time period¹².

⁸ Healthier Washington Dashboard, *Measure Explorer* tab. Based on October 2015-September 2016 measurement period.

⁹ HCA RHNI Starter Kit, *Prevalence Estimates – Overall* tab. Based on the annual Behavioral Risk Factor Surveillance System (BRFSS) using three years combined data (2013-2015).

¹⁰ HCA RHNI Starter Kit, “Top Ten Most Common Causes of Statewide Acute Hospitalizations Among Medicaid Recipients, Excluding Pregnancy and Child Delivery Related Hospitalizations, During Jan 1,2015-Oct 31,2015”.

¹¹ DSHS Research and Data Analysis Division, “ACH Profiles updated 02.28.17” file. North Central Current State spreadsheet, *Diagnoses* tab.

¹² Health Care Authority, “ED utilization by Facility” data set, *North Central* tab (Oct 1, 2015 - Sep 30, 2016)

Rank	Cause of Acute Hospitalization	Count	%	State Rank
1	Injury and Poisoning	266	12.1	2 (9.4%)
2	Mental and Behavioral Disorders	171	7.8	1 (18.2%)
3	Diseases of Heart	135	6.1	4 (5.7%)
4	Respiratory Infections	132	6.0	9 (3.6%)
5	Diseases of the Musculoskeletal System and Connective Tissue	115	5.2	5 (4.5%)
6	Substance Use Disorder	105	4.8	6 (4.6%)
7	Septicemia	105	4.8	3 (7.4%)
8	Cancer/Malignancies	102	4.6	8 (3.6%)
9	Diabetes	94	4.3	
10	Diseases of Liver, Biliary Tract, and Pancreas	84	3.8	7 (3.7%)

Source: HCA RHNI Starter-Kit, “Top Ten Most Common Causes of Statewide Acute Hospitalizations Among Medicaid Recipients, Excluding Pregnancy and Child Delivery Related Hospitalizations, During Jan 1,2015-Oct 31,2015”.

As we refine our project implementation plan over the next eight months, we plan on exploring more detailed data on hospitalizations and emergency department visits to pinpoint causes that might be better treated or prevented in a primary care setting. We will also further explore demographic disparities for those Medicaid beneficiaries who have behavioral health conditions (substance use disorders and/or mental health disorders) co-occurring with chronic conditions. Preliminary analyses show a larger number and percentage of Medicaid beneficiaries who have a behavioral health condition and more than one chronic condition. For example, 71% of Medicaid beneficiaries with a substance use disorder (SUD) diagnosis also have one or more chronic conditions (e.g., diabetes, asthma, COPD, cardiovascular issues), while 66% of beneficiaries with a mental health diagnosis and 79% of with co-occurring SUD/mental health diagnoses also have one or more chronic condition¹³.

Sharing and reviewing this data will be critical as we continue to refine our project plan, and it will dovetail nicely with the planning of our community-based care coordination project targeting populations with chronic disease conditions and/or behavioral health needs (particularly those with high emergency department utilization). North Central Accountable Community of Health (NCACH’s) Whole Person Care Collaborative (WPCC)—which is taking the lead on our region’s Bi-Directional Integration Project efforts as well as this Chronic Disease Project—is a critical element of our community feedback and planning mechanism.

The WPCC was established under our State Innovation Model (SIM) grant as a “proof of concept,” creating an ACH-wide structure and process to accelerate a population-based approach to medical care in our region, using Patient-Centered Medical Home (PCMH) concepts. The WPCC is made up of all major primary care and behavioral health care providers serving Medicaid beneficiaries in our region, as well as other entities who share and support our vision of whole person care (MCO representatives as well as representatives from emergency services and hospitals partners). With the announcement of the Medicaid Demonstration, the WPCC was seen as an ideal way to oversee our Chronic Disease Project, which will require medical and behavioral health provider organizations to

¹³ DSHS Research and Data Analysis Division, “Cat 1 Behavioral Health and Chronic Conditions 09.29.17” data set, NC BH and CC tab.

adapt to new methods of care. The WPCC also will be an important sounding board and partner for the NCACH's Community based Care Coordination Pathways HUB model (Care Coordination Project).

WPCC partners were motivated to join the collaborative for several reasons. First, in September 2016, NCACH elected to become a mid-adopter and to move ahead with Fully Integrated Managed Care (FIMC) beginning in January 2018. While FIMC posed challenges and opportunities for organizations to address both the business as well as the clinical aspects of integration, the NCACH and the WPCC provided a useful framework for addressing the changes collectively. Second, NCACH saw the need to integrate services across organizational boundaries, to adopt population based methods, and adapt to Value-Based Payment suggested a magnitude of change that would be difficult for any single organization. The legacy of collaborative competition in NCACH region will serve the goals of transformation and sustainability well.

Recently, our WPCC partners have been working together to define the scope, approach, and content of a shared learning structure under the assumption that we will be able to move further by working together than working separately. We are in the midst of designing a targeted learning collaborative with assistance from two consulting organizations, which will provide a backbone to catalyze improvements to chronic disease management. As we transition from planning to implementation, we recognize the need to adapt our current WPCC structure. For example, we may need to distinguish between expectations around advisory functions undertaken by the WPCC (e.g. creating and recommending funding processes) versus expectations for implementation partners involved in targeted learning activities (e.g. learning and action networks for peer learning, targeted cohort trainings, and intensive breakthrough series). Our current vision, subject to Board review and approval, is that our WPCC will need to modify its structure in order to encourage broad and inclusive partner engagement (including social service partners), while also differentiating between a WPCC "Steering Committee" responsible for advisory functions and a WPCC "Learning Community" involving partners that will inherently be more clinical in nature.

NCACH has selected a comprehensive approach to practice transformation that will be the foundation for all clinical process improvement efforts—including those targeting chronic disease prevention and control—in both behavioral and physical health organizations. Using the principles of team-oriented, evidence-based practices embodied in the Chronic Care Model (as outlined in the Demonstration toolkit), the WPCC Learning Community is designed to take each organization at its own starting point and move it further along the continuum of whole person care. During the summer of 2017, clinical members of the WPCC completed an evaluation process conducted by a coach/consultant from Qualis Health, to determine their current state of operations relative to an idealized model for population health as defined by the Patient-Centered Medical Home Assessment (PCMH-A) guideline for primary care or the Maine Health Access Foundation (MeHAF) rating scale (consistent with the Bree Collaborative guidelines and Collaborative Care Model) for behavioral health organizations. Building on these evaluations, the WPCC Learning Community will take each organization at its own starting point and move it further along the continuum of chronic disease management and whole person care.

The founding notion is that all clinical practices must transform from an acute, episodic, and reactive model built around a fee-for-service payment system to a population based, pro-active model of care that manages both acute and chronic disease in a value-based payment scheme. In this model, providers will build registries to allow them to identify patients with chronic diseases and ensure

patients receive the evidence-based care necessary for effective disease management and control. Since outcomes are dependent on patient behavior, it is important for care teams to embed patient-centered approaches to support healthy behavior change in their practices. For primary care providers co-located with or embedded in behavioral health agencies, behavioral health and substance use disorders fit well into the chronic care model. For many behavioral health organizations, using registries and screening for co-occurring medical conditions will involve learning new skills and will be part of the WPCC Learning Collaborative.

The changes required for transformation are extremely difficult and require years of committed leadership that can only be achieved with a systematic approach to quality improvement. Some organizations in NCACH have made significant commitments to these improvements and have demonstrated quality improvement in a wide variety of quality measures. Others are at the beginning of this journey. Regardless of where they are on this path, members of the WPCC are committed to making improvement for the sake of improving the health and welfare of the residents of the NCACH region.

To organize and manage this project, the NCACH has contracted with two consulting organizations working together, the Centre for Collaboration, Motivation, and Innovation (CCMI) and CSI Solutions, Inc., who have national experience running large multi-sector learning collaboratives around the country. As described later in this document, they will provide the methodology and infrastructure to organize and manage the way funded partners will undertake improvement projects, measure and evaluate effects, share results with each other, and pursue further improvements. The NCACH recognizes that this effort has the potential to conflict with other improvement projects underway within individual organizations as well as other cross-organizational improvement initiatives.

To minimize the possibility of conflict with intra-organizational improvement projects, the WPCC has been holding monthly meetings since May 2016 with provider groups to ensure the goals and methods of this project are understood. Additionally, with the assistance of the Practice Transformation Hub and Qualis Healthcare, we have undertaken an assessment of all potential participating provider organizations relative to the PCMH-A and MeHAF assessment tools to ensure that the transformation priorities of our Bi-Directional Project are consistent with the transformation needs and goals of each organization. This is particularly important with our Behavioral Health providers who, because we are transitioning to Fully-Integrated Managed Care in January 2018, are having to address basic business functions (e.g. billing & collections) before they can devote full attention to clinical integration and population management.

To minimize potential conflict with other inter-organizational transformation efforts, we have surveyed members to identify other relevant projects underway that could be the source of duplicate or conflicting efforts. Several members are involved with two different *Transforming Care Practice Initiatives* (TCPI), the National Rural Health Care Consortium, and the Pediatric TCPI initiative. We have been in touch with the leaders of these initiatives and have regular contact with them to ensure their work is compatible with ours and will not result in violations of CMS funding guidelines against duplication of services. Also, to the extent these initiatives involve routine collection and reporting of data through a shared facility, we are working to understand how data collection and reporting processes can be made consistent with those for the WPCC.

In addition, the NCACH participates in other forums such as local Coalition for Health Improvement (CHI) meetings and regional rural Washington State Hospital Association (WSHA) meetings to share information and solicit feedback. At least one and usually several NCACH staff members attend all of these meetings and an NCACH update is a regular agenda item to ensure understanding of and alignment with the work.

Finally, the WPCC is working to avoid duplication or conflict with other improvement processes by including all provider groups in the NCACH region in its design. Our intent is to deploy processes and methods consistent with those already in use, and the coordinated learning activities will only serve to accelerate progress on the path provider organizations have otherwise selected. The potential for duplication or conflict exists in the selection of quality metrics, given that those prescribed by the HCA for Medicaid contracting may differ from those used for Medicare contracting, or those required for MCO or commercial payer contracts. However, we are working to crosswalk the quality metrics targeted through the Chronic Disease and Bi-Directional Integration projects (overseen by the WPCC) to minimize the reporting burden on partners.

NCACH's approach to chronic disease management and the preliminary target population under the Chronic Disease Project is strategic in that it addresses core clinical processes necessary to address all chronic diseases, including behavioral health and substance use disorders over time. The goal is to create capable and stable quality improvement processes and systems for population management that are needed to sustain long-term change. Our Chronic Disease Project is also systematic in that it has the potential to include provider organizations who collectively treat 95% or more of the Medicaid beneficiaries in the NCACH region. We hope to eventually reach approximately 30,000 Medicaid beneficiaries suffering from diabetes, respiratory issues, and heart disease. As of June 2016, 11,307 Medicaid beneficiaries (13.4%) were diagnosed with "low" pulmonary issues (including chronic bronchitis, asthma and COPD), and another 2,207 (2.6%) with "medium" pulmonary issues (including chronic obstructive asthma). Hypertension affected 8,594 Medicaid beneficiaries (10.2%). Additionally, Type 2 diabetes affected 6,390 individuals (7.6%), while Type 1 diabetes affected 639 individuals¹⁴. By targeting these chronic conditions, we can reach about one-third of our Medicaid population, but more importantly, we can impact the geographic and demographic health disparities outlined above. By focusing on practice transformation at an operational level with our WPCC, ensuring both medical and behavioral health clinics incorporate basic population management tools into core operations (e.g., use of registries, outreach to affected populations, tracking of indicated interventions, etc.), we believe we can achieve long-term and sustainable improvements to our healthcare delivery system.

The NCACH's approach to chronic disease management depends on three major pillars that will promote broad-reaching, system-wide transformation lasting beyond the Demonstration. The first way NCACH will ensure lasting impacts and benefits to all Medicaid beneficiaries is the early commitment to Fully-Integrated Managed Care (FIMC). The NCACH made this commitment in September 2016 in recognition that this change was imminent and necessary and that the sooner we started on it, the more likely we would be to show improved outcomes during the five-year Demonstration. This set the tone for the region in terms of its ability to step up to considerable challenges and to work through them. FIMC is expected to have a major long-term impact, not just on

¹⁴ DSHS Research and Data Analysis Division, ACH Profiles updated 02.28.17. North Central Current State spreadsheet, *Diagnoses* tab. Measurement period based on a 24-month lookback period from June 2016.

improving behavioral health outcomes but also chronic medical conditions. In 2011, the Robert Wood Johnson Foundation conducted a literature review and analysis using standardized approaches for systematic reviews of the peer-reviewed literature. That study indicated that 68% of patients with mental health disorders also had chronic medical diagnoses that often go undiagnosed and untreated¹⁵. The commitment to integrated financing in 2018 will compel both behavioral health and medical providers to address the needs for clinical integration, which will be supported through the second pillar of impact and sustainability: the WPCC Learning Community.

The WPCC Learning Community is being organized to drive systemic change in clinical practice by focusing on basic operational processes needed to move from an acute, episodic model of care to a proactive, population-based model. Each organization will participate in learning sessions, develop and implement change plans to address key clinical processes, measure and evaluate progress, and report results. Through this process, organizations will learn best practices on evidence-based guidelines as well as from each other. They will commit to developing change plans that incorporate evidence-based practices outlined in the Chronic Care Model. We expect all WPCC Learning Community partners to specifically analyze the prevalence of chronic disease in their patient population, including demographic disparities, and articulate in their change plans how they will address health equity issues. We also intend on leveraging the learning activities of the WPCC to share and review data that might help providers drive some of their own quality improvement efforts. The WPCC Learning Community will also help us explore ways to address workforce issues unique to our region. At this point, eight organizations have signed membership agreements indicating their intent to participate in the learning collaborative, to develop change as an outgrowth of the process, and to implement the change plans during the course of the Demonstration process (See NCACH – Chronic Disease Prevention and Control Project - Attachment A).

The third piece of sustainability is the commitment to value-based payments. The NCACH has been clear that changes in clinical operations during the Demonstration by any provider organization should only be undertaken if they could be sustained through changes in reimbursement once the Demonstration is completed. We are aware of examples of highly successful innovation projects in other states that had to be shut down once grant funds ran out and have cautioned against that here. NCACH has made a point of including MCO representation on our Governing Board and as advisors to the WPCC on sustainability. As the keepers of the purse, the MCOs will need to be convinced of the value of the practice transformation undertaken in this and other projects to ensure they develop the means and the methods to sustain them through Value-Based Payments.

Implementation Approach and Timing

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

- The ACH Project Plan Supplemental Data Workbook includes an Implementation Approach tab for each project. Fill in the appropriate tabs based on the ACH's selected projects.
- In the implementation approach descriptions:

¹⁵ Robert Wood Johnson Foundation, Research Synthesis Report no. 21, [Mental Disorders and Medical Comorbidity, February, 2011.](#)

- Describe the ACHs general approach to accomplishing requirements.
- Include resources to be deployed to support partnering providers, anticipated barriers/challenges and ACH tactics for addressing them.
- Specify which evidence-based approach option(s) will be used for the project.
- If applicable, indicate in italics whether a project milestone can be completed earlier than the required deadline in the Completion Deadline column.

Partnering Providers

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

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

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

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

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

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

ACH Response

NCACH established and has been operating the WPCC as a “proof of concept” through the ACH’s original SIM grant in 2015. Its purpose was to engage provider groups in establishing a learning collaborative through the WPCC to help them adopt the principles of population management and speed transformation toward Patient-Centered Medical Home style practice. With the adoption of the Medicaid Demonstration in January 2017, the WPCC took on responsibility for oversight of our Bi-Direction Integration Project as well as our Chronic Disease Project. Members of the WPCC will also be responsible for implementing clinical practices and processes necessary to support NCACH’s four other projects, including our Care Coordination, Transitional Care, Diversion Intervention, and Opioid Projects.

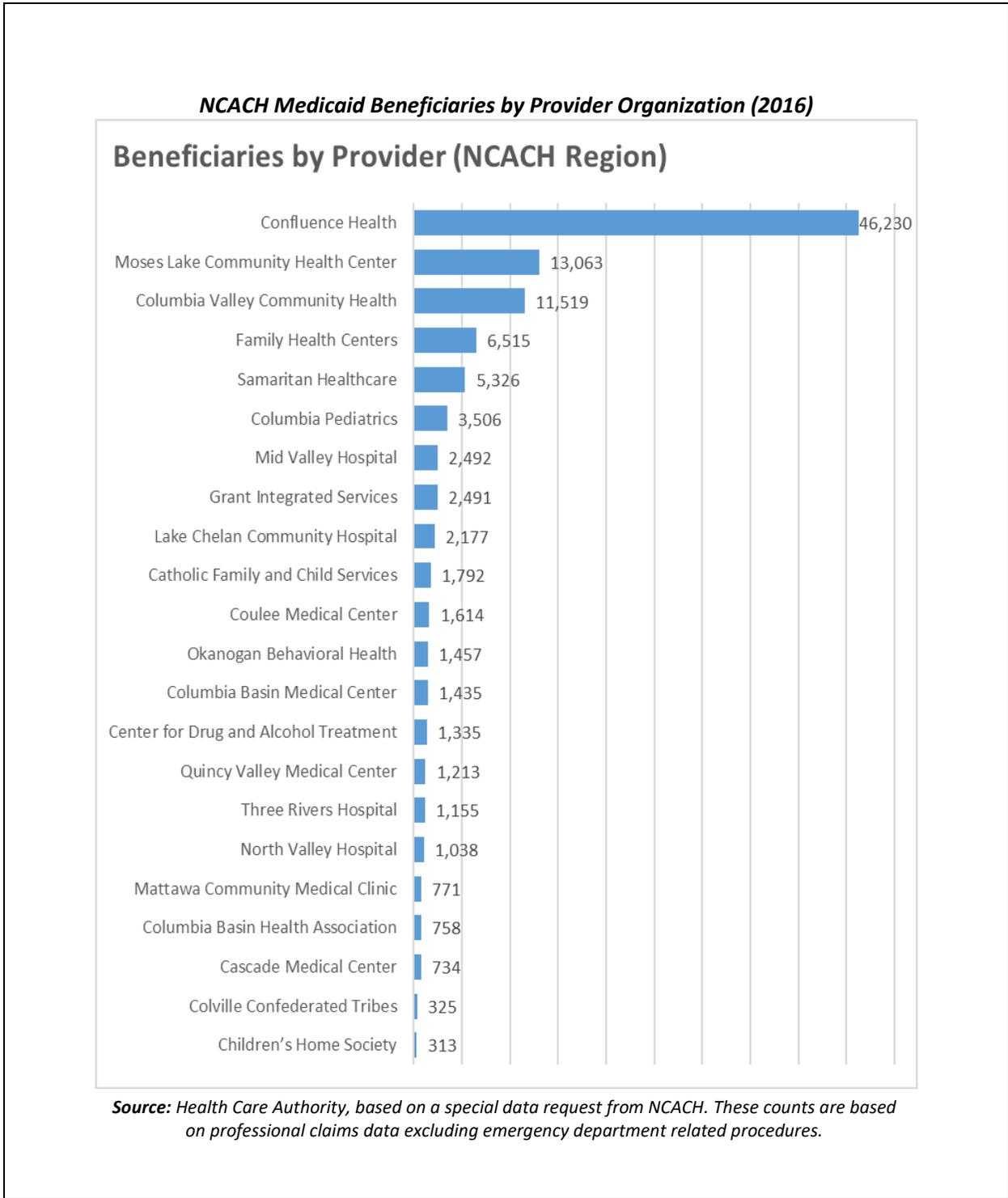
The NCACH has reached out to all major provider organizations, including hospital-based medical groups, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), tribal clinics, and behavioral health providers who provide the vast majority (over 95%) of outpatient professional services to Medicaid beneficiaries in the NCACH region. The members are established organizations who have been serving the Medicaid population, and in many cases, were set up specifically to serve them. Medicaid beneficiaries constitute a significant portion of their business, and there is little question they intend to continue to serve them (see table and chart below). Community-based organizations working on housing, transportation and access to healthy foods and other social determinates of health will be critical partners through the interplay between the WPCC and our Care Coordination Project. Through targeted focus groups, we will be reaching out to related social service providers by the end of January 2018 to learn how best to engage and support them in this work.

Since May 4th, 2016, the WPCC has held monthly meetings of the clinical provider either in person or over the phone. These meetings have been attended by a majority of the physical health and behavioral health providers in our region. As an indication of interest in following through on involvement in the WPCC, organizations were asked to undergo an operational assessment by a Qualis coach/consultant using the PCMH-A or MeHAF assessment tools. These assessments determine where providers are on the path toward the idealized model and will form the basis for their change plans to be developed during quarter 1 and quarter 2 of 2018. As of November 1 2017, 30 sites from 13 organizations have been assessed and several more are scheduled before year end.

A charter for the WPCC describing its purpose, goals, and membership obligations was approved in August 2017 as well as a membership agreement certifying that members understand the charter and agree to participate as indicated in the membership responsibilities (see Chronic Disease Prevention and Control Project - Attachment B). As mentioned earlier, the WPCC will need to modify its structure in order to encourage broad and inclusive partner engagement (including social service partners), while also differentiating between a WPCC “Steering Committee” responsible for advisory functions and a WPCC “Learning Community” involving partners that inherently will be more clinical in nature. Currently, we have eight signed member agreements, with others expressing intent to sign in the near future. As the list of partnering providers involved in implementation becomes clearer, we plan on asking them to assert their commitment to serving the Medicaid population in our funding agreements.

MCO involvement in the NCACH has been a priority given our planned transition to FIMC and there is an MCO designated position on the NCACH Governing Board as they will be the sustaining funders of delivery system transformation efforts beyond the conclusion of the Demonstration. In addition, each of the MCOs have sent representatives to WPCC meetings and regularly provide consultation on the approach the WPCC has taken to the Bi-Directional Integration and Chronic Disease Projects. As discussions continue on the progression toward value-based payment for provider organizations, the MCOs will be asked to participate to ensure alignment of the payment processes with the clinical processes being proposed by the WPCC.

NCACH WPCC Organizations		
Physical Health Providers		
	Organization Name	# of sites in NCW
1	Cascade Medical Center	1
2	Columbia Basin Medical Center (Columbia Basin Family Health Center)	1
3	Columbia Basin Health Association (Wahluke Family Medicine)	1
4	Columbia Valley Community Health	3
5	Colville Confederated Tribes	2
6	Confluence Health	12
7	Coulee Medical Center	2
8	Family Health Centers	6
9	Lake Chelan Community Hospital	1
10	Mid Valley Hospital	1
11	Moses Lake Community Health Center	3
12	North Valley Hospital	1
13	Quincy Valley Medical Center	1
14	Samaritan Healthcare	1
15	Three Rivers Hospital	1
		37
Behavioral Health Providers		
1	Catholic Family and Child Services	7
2	Center for Drug and Alcohol Treatment	1
3	Children’s Home Society	2
4	Grant Integrated Services	1
5	Okanogan Behavioral Health	1
		12
Managed Care Organizations		
1	Coordinated Care	
2	Molina Healthcare	
3	Amerigroup	
Transformation Initiatives & Potential Resources		
1	Qualis Health – Gwen Cox	
2	P-TCPI – Tawn Thompson	
3	NRACC-TCPI - Sue Dietz	
4	AIMS Center - Sara Barker	
5	CCMI - Connie Davis, Mike Hindmarsh	
6	CSI Soutions, Inc. - Kathleen Reims, Roger Chaufournier	
7	Attune Health Parners: Barbara Wall, Michelle Vest	
8	Kaiser Permanente of Washington Research Institute - Michael Parchman, Katie Coleman	



Regional Assets, Anticipated Challenges and Proposed Solutions

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

- Describe the assets the ACH and regional partnering providers will bring to the project.
- Describe the challenges or barriers to improving outcomes and lowering costs for the target

- populations through this project.
- Describe the ACH strategy for mitigating the identified risks and overcoming barriers.

ACH Response

The greatest asset NCACH brings to this project is a large and cohesive group of providers and partners who came together through the WPCC to improve the quality of care to the population. This group includes 20 organizations who have been participating in monthly meetings since May 4th, 2016 to share ideas and to move the WPCC from the conceptual level—where vision, purpose, and principles were agreed on—to specific agreements on how the project will be managed and incentive payments will be awarded.

Our progress to date is attributable to the fact that the original idea for the WPCC was developed during the SIM grant phase of the project; the concept had already been vetted before the Demonstration was announced. The early adoption of the WPCC is also an indication of strong and visionary leadership among our provider organizations, many of whom have experience with learning collaboratives and quality improvement methods. Also, because a large percentage of Medicaid services are provided by a handful of organizations and the leadership of these organizations work well together, consensus to undertake the WPCC was relatively easy to achieve. Note that 80% of Medicaid patients (based on outpatient professional encounters) are served by the top six organizations in the four county region, 43% by a single organization (Confluence Health).

Another asset of the NCACH is that several organizations have been leaders and visible public advocates for many of the actions represented by the Demonstration projects and specifically the six projects chosen by the NCACH. There is considerable experience within the group with bi-directional integration of care, systematic quality improvement, and population management. In addition, there is widespread feeling among the provider groups that the payment system must evolve to support and reward them for improving the health of the community at-large. These voices have been at the table from the very beginning and supportive of NCACH leadership and staff. In short, the Demonstration will support and provide resources to move organizations more quickly in a direction they were already headed.

Having decided to approach this work of establishing a WPCC Learning Community as early as quarter 1 of 2018, the challenge has been to find an organization with sufficient skill and experience to set up and run a learning collaborative of the magnitude we have in mind. After looking for some time, NCACH has had the good fortune to contract with a group of consultants with a national reputation and experience in running large, diverse learning collaboratives. Connie Davis and Mike Hindmarsh from the Centre for Collaboration, Motivation, and Innovation were part of a team that worked with Ed Wagner on the Chronic Care Model before forming a nonprofit organization. Roger Chaufournier and Kathy Reims from CSI Solutions, Inc., also bring a wealth of expertise in the field. All four are Institute for Healthcare Improvement (IHI) faculty and are currently working with us to design our WPCC Learning Community.

Earlier this year, NCACH recognized a gap in data and analytic capacity. Over the past several months, we have addressed this gap in a variety of ways: (1) hired a full-time data analyst to do in-house data analysis, (2) contracted with Providence Center for Outcomes Research and Education (CORE) to provide technical assistance and consultation to assist NCACH with data-related needs for the project planning process (3) formed a Health Information Technology/Health Information Exchange (HIT/HIE)

Workgroup to address regional population health management systems and information exchanges that can be expanded, enhanced, or initiated, and (4) contracted with CCMI and CSI Solutions, Inc. for technical support in developing a WPCC Learning Community as well as performance monitoring software, tools, dashboards, and processes. The steps we have taken to address a previously identified weakness have not only turned data and analytic capacity into an area of strength for NCACH, but demonstrate that we can rapidly and systematically address future identified challenges.

In addition, the fact that the County Commissioners of Grant, Chelan, and Douglas Counties opted to move ahead with Fully Integrated Managed Care (FIMC) in 2018 provided a level of urgency to bring providers to the table more quickly. The desire on the part of our WPCC members to move quickly has helped us to jumpstart other work. NCACH was the first to sign up for and use the services of the Practice Transformation Support Hub, which we deployed during the spring and summer of 2017 to assess the capabilities of all our provider organizations. Using the Patient-Centered Medical Home Assessment (PCMH-A) and the Maine Health Access Foundation (MeHAF) assessment tools, our Qualis consultant logged over 20,000 miles to visit over 13 organizations and approximately 30 sites during the past six months. The result is that we have a good sense of the capabilities and improvement opportunities for our WPCC members that will allow us to target learning sessions and improvement strategies within the WPCC Learning Community.

Challenges and Barriers

One of the great challenges facing the NCACH is the scope and scale of our Demonstration projects. At this point, while all provider groups have not officially signed up for our WPCC Learning Community, we have the potential to sign up as many as 20 provider organizations with 49 sites across an ACH, an area requiring nearly four hours of drive time from end to end. The differences in size, scope of services, and sophistication with quality improvement and population management methods, and a diversity of interests will require management skills to keep all parties engaged and moving forward. Fortunately, we have consulting help from two organizations (CCMI and CSI Solutions) with the skill, experience, and technology (e.g., they have their own web portal for monitoring progress and reporting results) to manage a learning collaborative of this type. Some of the decisions to be made early in the design phase of the WPCC have to do with segmentation of the providers into appropriate learning groups and to determine the frequency of web-based and in-person learning sessions. We also have expertise from within the WPCC group which we plan to leverage. The goal of the WPCC is not to get every organization to the same place, but to improve each one from its assessed starting point. We plan to negotiate reasonably ambitious expectations with each provider group and work to provide the supports needed for them to succeed.

Lack of outcome data availability at the provider level is a challenge and a barrier to managing progress. At the outset of the project, we had expected to have provider level outcome data available to establish accountability at the organization level. In order for NCACH to be able to accept responsibility for aggregate ACH accountability, it needs to be able to identify sources of variation in performance and to manage them accordingly. The goal is simply to ensure that each provider organization is committed, is doing the right work, and can show progress in moving the population-based outcome metrics. To address this need, we will continue to work with the HCA, fellow ACHs, and MCOs to obtain provider specific outcome data. In the short-term, we will rely on the learning collaborative web portal and self-reported process to demonstrate each organization's adherence to the process they have committed to improve in their change plans and track improved outcomes. We

will need to demonstrate the link between the data we capture and report internally, and data that comes to the ACH via the HCA when it's reported some months later.

Another challenge in moving forward consistently across providers is the differential impact on the behavioral health providers of moving to FIMC. For the past 12 months, behavioral health providers' first priority has been to build the financial and business systems capacity necessary to bill for and collect payment from MCOs for services previously paid through the counties. Clinical integration, including adapting processes to increase coordination with primary care providers around non-SUD/MH chronic conditions, may have to take a back seat while behavioral health providers stabilize business processes once they go live with FIMC in January 2018. With our consultants, we'll assess this situation and determine whether differential treatment of the behavioral health providers is warranted in quarter 1 and 2 of 2018. The WPCC has a sub-group of behavioral health providers working to ensure that the overall approach to our change plans and Learning Community adequately addresses their needs. To mitigate this risk, NCACH will also utilize our consultants Centre for Collaboration, Motivation, and Innovation (CCMI) and CSI Solutions, Inc. to work directly with each behavioral health provider to determine the appropriate time for them to submit change plans and make any adjustments to the scoring methodology that will ensure that it best addresses their business model. In addition, the AIMS Center (Advancing Integrated Mental Health Solutions) has agreed to work as a subcontractor to our WPCC Learning Community contractors in the design of the WPCC Learning Community. These steps, as well as the strong support of the behavioral health providers, will help keep behavioral health actively engaged in the Demonstration.

Workforce shortages, particularly in behavioral health are a chronic problem in North Central Washington and will be continue to present challenges in improving chronic care in primary care and behavioral health organizations. Based on population/primary care provider ratios, workforce shortages are most prevalent in Grant and Okanogan counties¹⁶. The top five Primary Care Service Areas experiencing shortages include: Royal City, Carlton, Coulee City, Tonasket, Moses Lake. Because our entire region is designated as a Health Professional Shortage Area (HPSA) for dental health, mental health, and primary care, we will leverage the WPCC Learning Community to explore workforce solutions for our region. To further mitigate this risk, NCACH will also work with local community colleges and assess best practices for behavioral health recruitment within our community (i.e. organization base preceptor programs for behavioral healthcare professionals) to come up with a robust workforce strategic plan in quarter 3 of 2018.

Reducing unnecessary utilization of the medical system will help improve access to care with existing resources. One of the goals of the WPCC in managing chronic illness will be to make greater use of other community services to reduce reliance on the health care system. Programs like Health Homes, Chronic Disease Self-Management Education, and the Pathways HUB will help to ensure patients get supports they need to increase adherence to treatment regimens and to improve self-reliance and reduce unnecessary use of the medical system. In addition, the integration of behavioral health and physical health through the Bi-Directional Integration Project will reduce waste and redundancy in the care of patients with both medical and behavioral co-morbidities.

Monitoring and Continuous Improvement

¹⁶ Health Resources & Services Administration (HRSA) Data Warehouse. <https://datawarehouse.hrsa.gov/>

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

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

ACH Response

The NCACH Chronic Disease Project will be managed through the Whole Person Care Collaborative (WPCC). Members currently eligible for funding through the Demonstration include providers who are ready and able to participate in the WPCC Learning Community by quarter 2 of 2018. Involvement will include participating in joint learning sessions and implementing mutually agreed-upon improvement activities based on the Chronic Care Model.

During the initial phases of the WPCC Learning Community beginning in February 2018, our CCMI and CSI Solutions consultants will provide contextual learning sessions to set the ground rules for participating in the WPCC Learning Community and to verify each organization's baseline for leadership engagement, quality improvement, and population management. These are foundational issues necessary for organizations to sustain any operationalize changes undertaken during the Demonstration. Undertaking a change process without systems to regularly evaluate, monitor, and continuously improve is often wasted energy and this WPCC Learning Community will make sustainability a high priority. Once baseline performance has been determined, the focus of the WPCC Learning Community will shift to setting each organization's improvement priorities depending on their capability to address change and where they fall on the PCMH-A (primary care) or MeHAF (behavioral health) assessment scales.

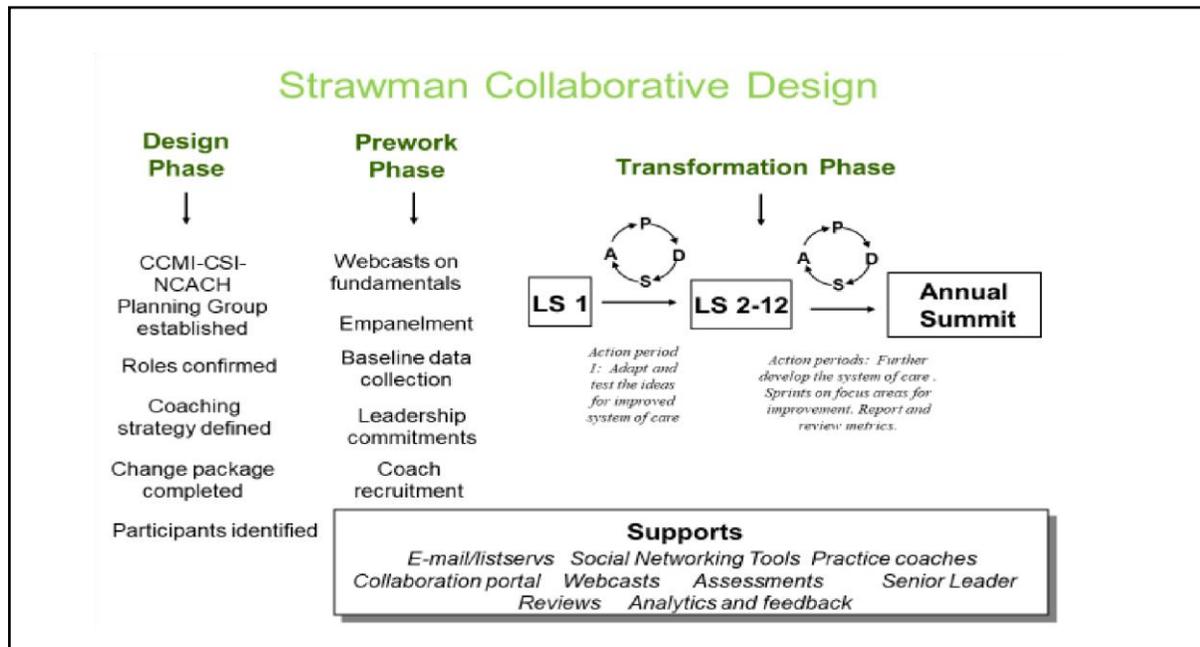
While the exact mechanism and timing for activities of the WPCC Learning Community will be finalized in January 2018, the learning process will involve:

- A variety of peer learning activities and opportunities of varying intensity and specificity, virtual and in-person to meet goals of participating organizations
- Coaching follow-up with the practice teams to support quality improvement and development of change plans;
- Quarterly meetings and annual summits to share progress, and,
- Monthly reporting progress on process metrics through the Learning Community's web portal.

These activities will allow NCACH to keep abreast of work being done on a week-to-week basis and to work with providers on problem identification and resolution. Delays will be dealt with according to the nature and extent of the delay and the level of engagement of the parties involved. Generally speaking, NCACH will need to differentiate between:

- Delays due to provider-specific problems in execution which might be remedied through additional support, selective re-negotiation of timelines, or ultimately withholding incentive payments if compliance cannot be established through other means; and,
- Delays that are systemic and widespread because of project design or changes in the environment that affect more than a few providers. To the extent the delays are widespread, NCACH may need to make modifications to the project scope, expectations or find creative ways to meet them.

Our Governing Board and WPCC have a good track record of collaborative problem solving. They are committed to the goals of the project and can walk the fine line of holding each other accountable. Overall, the NCACH Board and WPCC are skilled in pushing for results and acknowledging when something is not working and engaging in a collective problem-solving process. With the help of our contractors from CCMI and CSI Solutions, we will develop and implement continuous improvement (CI) processes based on best practices for clinical and health systems improvement, bringing in expertise from contractors and partners where needed (see diagram below or NCACH – Chronic Disease Prevention and Control Project - Attachment C). This framework draws on learning series involving Plan-Do-Study-Act (PDSA) cycles outlined by the Institute for Healthcare Improvement. We are also looking into using a customized web portal developed by CSI Solutions (Healthcare Communities) that would serve multiple functions, including learning communities, document sharing, tracking of process measures through reporting and surveys, and tracking of clinical measures through a dashboard.



Project Metrics and Reporting Requirements

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

- Reporting semi-annually on project implementation progress.

- *Updating provider rosters involved in project activities.*

YES	NO
X	

Relationships with Other Initiatives

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

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

YES	NO
X	

Project Sustainability

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

ACH Response

Operational Sustainability

One of the main reasons NCACH adopted the Whole Person Care Collaborative as the backbone strategy for improving chronic disease management and control is to address project sustainability. Change of the magnitude envisioned by the practice transformation goals of the HCA will be profound and disruptive for many providers. In the experience of the NCACH leadership and the WPCC Steering Committee, this type of change requires a certain infrastructure to be sustainable. It requires organizational leadership and a culture of resiliency to change as well as commitment to the goals or reasons for changing. In an environment such as the NCACH region – where many organizations are small, fragile, and geographically isolated – it can be hard to move beyond the needs of day-to-day survival. While being part of a large organization can be helpful, for smaller organizations, a supportive community of like-minded organizations can help provide the moral support and intellectual capital needed to sustain long-term change.

The WPCC Learning Community is designed to create community. It has been and will continue to provide a forum where leaders can develop mutual trust and commitment to common goals on behalf of the broader community. If managed well, these relationships and the experience of having worked

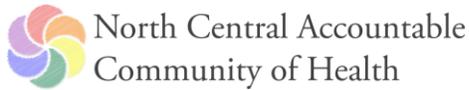
through difficult problems together will be a pillar of sustainability that will continue whether or not there is an ACH to support it.

Secondly, the WPCC structure will provide joint learning opportunities for leaders exposed to best practices that have been demonstrated to be successful in other areas (other ACHs or other regions) or by other providers within the region. Professional isolation and inability to know what others are doing can lead to a vision deficit that the WPCC can help address. It can be inspiring and threatening, but in either case, motivating, to realize others have achieved what one thought impossible. Collaborative learning will provide the material, the inspiration, and the peer accountability for performance that will raise the bar among all providers. The term “co-opetition” (competition + collaboration) has been tossed around in some circles and describes what we aim to achieve.

A third component of sustained operational of change is a stable and capable quality improvement process. Many in leadership have the experience of pushing change into an operational setting without the ability to monitor and manage it. When strategies fail, it can be hard to distinguish between a bad idea and a good idea poorly implemented, or not really implemented at all. The WPCC Learning Community will work to create an ongoing quality improvement infrastructure and processes within all the member organizations as a first order of business. Based on a review of our assessments to date, some providers have robust processes in place; however, most do not. The contract with our CCMI and CSI Solutions consultants will result in a design for the WPCC Learning Community by the end of February 2018. It will likely involve segmentation of providers into affinity groups based on capability. We expect that most organizations will have to work to establish or improve their quality improvement processes and work can begin at that time.

Financial Sustainability

From the beginning of the Demonstration, NCACH leadership has been clear that any operational improvements resulting from the Demonstration must be designed with long-term funding sources to sustain them. The obvious source of funding will be the evolution of MCO value-based payment (VBP) practices with providers. NCACH has a representative on the HCA Medicaid Value-Based Action Team overseeing the state-wide process and is in the process of developing a regional oversight group made up of the CFOs of regional provider organizations during quarter 1 of 2018. The intent of the latter group is to ensure common understanding of the VBP and that all organizations are optimizing revenue under these payment structures and are budgeting appropriately. Given that these payment processes are still evolving, we plan to be diligent at every step of the way. Beyond VBP, NCACH will also be looking for other funding opportunities to support innovation or to extend some of the Demonstration projects that may need a little more time to develop.



For review and approval by WPCC 10/2/2017

Investing in Change Through the Whole Person Care Collaborative (WPCC)

Theory of Change and the Role of the Whole Person Care Collaborative

Background

The North Central Accountable Community of Health has elected to address health improvement through six different Medicaid Demonstration Projects that will involve a broad array of organizations well beyond medical care as will be described in future documents. However, because many purposes of the Medicaid Demonstration Projects cannot be addressed without changes in the care of patients, clinical provider organizations have a major role to play and many of the Demonstration dollars will be invested in them.

The NCACH board has designated the Whole Person Care Collaborative (WPCC) as the workgroup to coordinate and fund provider organizations' improvement activities affecting all 6 demonstration projects. WPCC will directly manage projects 2a (bi-directional integration of physical and behavioral health care) and 3d (chronic disease prevention and control) and will also coordinate provider involvement with the workgroups managing the other 4 projects. Project plans will describe how other projects not directly covered by the WPCC (2b-Care Coordination, 2c-Transitional Care, 2d-Diversion, and 3A-Opioid Use) will be organized and funded. **This document describes the process through which Demonstration investments in provider organizations could be made in an accountable, effective and transparent manner.**

The core activity of the Collaborative is to plan and implement evidence-based practices necessary for provider organizations to improve effectiveness in two ways:

- **Clinically**, by providing Whole Person Care that integrates behavioral and physical health care, and more proactively identifies and addresses the medical and social health needs of the population to mitigate their negative health effects, and;
- **Financially**, by aligning clinical practices around the significantly different incentives and demands of new payment methods (mainly Value-Based Payment or VBP) now being implemented.

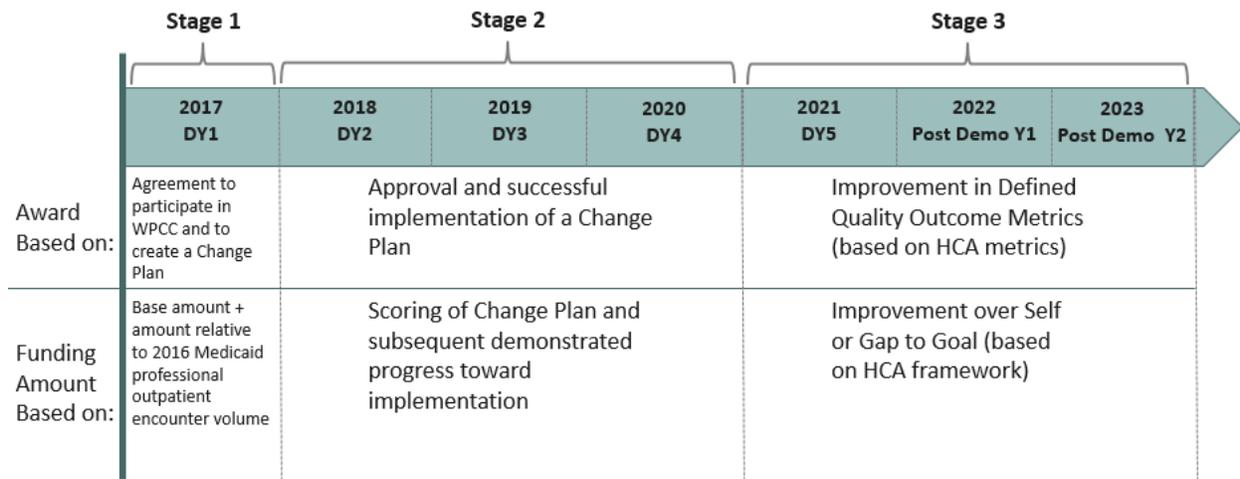
Because Medicaid Demonstration ends in 2021 (with incentive payments based on performance potentially coming in through 2023), the WPCC can support only improvement activities that can be sustained through Medicaid value-based payment mechanisms in the long run. Similar new payment approaches are being implemented in Medicare under MACRA and commercial payers, so changes developed under the Demonstration should be relevant to a large proportion of most providers' patient populations.

It is important to emphasize that the purpose of Demonstration funds is not simply to help pay the operating costs of provider organizations during the life of the Demonstration, leaving a shortfall when Demonstration dollars are gone. The point is to help provider organizations make the investments needed to reconfigure their organizations and practices so that by the end of the Demonstration, they will be able to function effectively without subsidy from Demonstration dollars.

Stages for Creating Sustainable Change

The effort to create sustainable change of that kind has three stages:

1. Development of a *Change Plan*.
2. Implementation of that plan, using specific structure and process metrics to measure progress along the way.
3. Sustaining and demonstrating improvement in clinical outcomes specific to each organization.



Participating organizations can expect Demonstration funds to be used to support them in the planning, implementation, and sustaining of changes through the Demonstration period. Demonstration funding is substantial – *depending on a variety of performance measures*, our region can potentially earn up to \$50 million dollars over the course of the 5-year demonstration (2017-2021.) **The overall effort to provide integrated Whole Person Care is the highest priority of the Demonstration.**

Ongoing Work of the Collaborative

The WPC Collaborative should become very effective as a learning collaborative for member organizations. For that to work, we will have to maintain some trust and transparency among WPCC members, so that we can learn from each other’s challenges as well as our successes. At the same time, we are all accountable for the way Demonstration dollars are used, and the Demonstration projects must be implemented in an accountable and transparent manner. WPCC would be the collection point for information on progress in implementing change plans. Both of these purposes – an effective learning collaborative, and accountability for public funds in order to earn further Demonstration dollars – will push us to cultivate openness and sharing of information among WPCC members.

Stage 1: Developing Change Plans

During the last part of 2017, all organizations in the NCACH region (Chelan, Douglas, Grant and Okanogan Counties) providing primary health care or behavioral health and who have undergone operational assessments to identify where they stand on the road to Whole Person Care are invited to submit Change Plans. Change Plans must be high in quality to justify significant investment of Demonstration funds in their implementation.

It is expected that the plans of different organizations will differ considerably; there is no one plan or pattern that fits every provider organization in this region. Although organizations in our region vary a great deal in size and in the degree to which they already achieve whole person care, none are so perfect that significant improvements cannot be made. In recognition that each organization is in a different place relative to an idealized model of Whole Person Care, the funding process is designed to support and fund improvement rather than reward or penalize organizations based on their current state.

It is not quick or easy to develop plans of this kind, if only because they require significant involvement by several parties including front-line providers who are also busy doing their normal work. Development of a workable change plan costs money, at a minimum in the form of substantial staff time. Many organizations will benefit from outside expertise on change management and plan development, and may have limited experience with VBP and the new options for care delivery it enables. Demonstration funding can support the cost of consultants to support effective change planning.

Timeframe for Stage 1 Change Plan Development

Oct-Dec 2017 Stage 1 Change Planning Awards made

Jun 2018 Change plans due by the end of June 2018

Potential uses of Stage 1 Change Planning Awards

- Consultants or temporary staff support for change management, VBP, IT, or other topics
- Payments to providers and other staff for participation in Change Plan development
- Cost of staff time used in plan development instead of revenue-producing activities, including part time or replacement staff to support current operations.
- Costs for staff involvement in other activities necessary for plan development

Change Plan Application

Application for Stage 1 funding will require the following:

1. Completing the Qualis assessment relative to MeHaf or PCMH-A standards and submitting a *Preliminary Improvement Plan* resulting from the assessment. The Preliminary Improvement Plan should describe the results of the assessment and indicate the operational priority areas to be targeted in the Change Plan (these can be subject to change in the final Change Plan.)
2. A budget indicating how the funds will be used in the development of the Change Plan.
3. Signing and submitting a signed Membership Agreement to participate in the Whole Person Care Collaborative, indicating understanding and acceptance of the purpose and participation requirements for the Collaborative.
4. A signed Memorandum of Understanding with the NCACH addressing terms and conditions, including reporting requirements, for use of NCACH funds. (TBD)

Allocation of Demonstration Funds for Stage 1 Change Planning Awards

Although provider organizations will face many of the same challenges in developing Change Plans regardless of size, the level of Medicaid activity by each organization will influence the cost of Change Planning. As such, Stage 1 Change Planning Awards will be allocated to WPCC member organizations using the following **Base-Plus methodology**.

Base

Every WPCC member organization will receive a base Change Planning Award of \$75,000

Plus

Additional funds will be based on the organization's rank relative to its 2016 Medicaid professional outpatient encounter volume

Top quintile	+ \$30,000
Second quintile	+ \$25,000
Third quintile	+ \$20,000
Fourth quintile	+ \$15,000
Bottom quintile	+ \$10,000

Using this Base-Plus methodology, **WPCC member organizations should expect an award between \$85,000-\$105,000 to boost and catalyze change planning during Stage 1.**

Stage 2: Evaluating and Scoring Change Plans

Change Plans will be the basis for allocation of additional Demonstration funding during 2018-2020.

This section previews the topics to be addressed by every Change Plan, and indicates the number of points that can be earned for each topic out of a total of 100 points. The scoring of Change Plans will be done by a neutral third party, with support from NCACH staff if needed. **The change plan framework, including criteria, scoring, and questions to guide change plan development will be finalized before Stage 1 awards are made. Reporting requirements during Stage 2 will also be clarified.**

At this time we know it is likely that several million dollars will be available annually for Stage 2 Implementation Awards, but the exact amount available to NCACH is not yet known because it depends on HCA's evaluation of project plans to be submitted in November 2017 and subsequent reporting requirements. **As a result, Stage 2 award amounts on the basis of Change Plan scores cannot be determined yet.** As the amount of funding for Stage 2 awards becomes clear, the Executive Committee will develop an allocation method and propose it to the Governing Board for review and approval.

The following table describes the topics to be addressed in sections of the Change Plan, and provides a preliminary indication of the number of points (out of a total of 100) that can be earned by each section. Each section of the Change Plan should define metrics by which progress in change plan implementation should be measured. For example, if use of telehealth for mental health services is planned, agreements with telehealth providers could be documented early on, and later the provider organization could report how many such encounters occurred during implementation. We need ways to track actual implementation of the plan, and will favor metrics that are as practical and convenient as possible when it comes to data collection and reporting. Inclusion of appropriate implementation metrics in each section will be considered in scoring. **This table is a "draft" only** but provides a preliminary indication of the information that will be required to link change plans to the evidence based approaches to not only projects 2a and 3d, but all projects undertaken by the NCACH.

#	Criteria	Description	Points
1	Demonstrates organizational readiness and commitment to transforming care	Traditional models of healthcare are generally reactive, encounter-based and designed to treat discrete and acute episodes of care that are site or provider specific. Transition to models of care that are pro-active, population based and coordinate care across a continuum of sites and providers will require a long-term commitment to change. The Change Plan should demonstrate the organization possesses the necessary foundations of leadership commitment, a durable and capable system of quality improvement, and systems for empanelment and population management necessary to undertake this journey. The proposal should describe the organization's capabilities in this area <u>and/or</u> plans to develop and improve them. Changes Plans will be scored based on how well they demonstrate an understanding and commitment to the change process, how it will be managed, how progress will be tracked, measured, and reported. Additionally, organizations should describe how providers and their clinical teams would have significant involvement in guiding the change process.	15

2	Addresses most important improvement opportunities identified in the assessment phase	<p>The Change Plan demonstrates an understanding of the organization's current state relative to evidence-based and idealized models (e.g. PCMH-A or MeHAF) of whole person care as well as its most significant opportunities for improvement toward that model. The proposal should cite evidence of a self-assessment (Qualis or other) as well as qualitative data to support the priorities for improvement and approach taken. Changes Plans will be scored based on how well they demonstrate linkages between proposed process improvements and the way they proactively address the planned/necessary care needs of patients with chronic disease in both primary care and behavioral health agency settings, particularly those with depression, cardiovascular disease, diabetes, and asthma.</p> <p>Demonstration resources</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic Care Model www.improvingchroniccare.org 	25
3	Promotes the bi-directional integration of Physical and Behavioral Health	<p>A Change Plan should address bi-directional integration of physical and behavioral health, as it will be implemented in this organization, including any cooperative arrangements to be made with partners. The plan should be detailed and practical and should include measures not only to conveniently access BH and medical providers in the same facilities (whether through co-location, telehealth, or other means), but also measures to change the practices of front-line providers in such a way that medical and BH providers collaborate effectively on the care of patients. For primary care practices, Change Plans will be scored based on how well they address the Bree Collaborative's Behavioral Health Integration Report and Recommendations, or the AIMS Collaborative Care Model. For behavioral health agencies, Change Plans should demonstrate how the unique health care needs of people with serious mental illness and or substance use disorders will be addressed (e.g. multi co-existing chronic conditions, poor access to primary care, reduced life expectancy) through off-site enhanced collaboration, co-located enhanced collaboration, or through co-located integrated care.</p> <p>Demonstration resources</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bree Collaborative "Standards for Integrated Care" http://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf <input type="checkbox"/> Collaborative Care Model: http://aims.uw.edu/collaborative-care <ul style="list-style-type: none"> o AIMS Center/WA Council for Behavioral Health Project 2A Resources: https://www.thewashingtoncouncil.org/training-technical-assistance/ <input type="checkbox"/> Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness http://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf <p>Other Resources</p> <ul style="list-style-type: none"> <input type="checkbox"/> SAMHSA-HRSA Center for Integrated Health Solutions http://www.integration.samhsa.gov/integrated-care-models <input type="checkbox"/> Approaches to Integrating Physical Health Services into Behavioral Health Organizations http://www.integration.samhsa.gov/Approaches_to_Integrating_Physical_Health_Services_into_BH_Organizations_RIC.pdf 	20
4	Addresses the Opioid Epidemic	<p>The Change Plan should address the organization's capacity and intentions to help address the Opioid epidemic. This could include adoption of regional and state prescribing guidelines regarding opioids and benzodiazepines, increases in the number of suboxone prescribers among the organization's prescribers, or other measures appropriate for the organization. It should also include the designation of a point person for the organization to participate in county and regional opioid related initiatives.</p> <p>Demonstration resources</p>	5

		<ul style="list-style-type: none"> • AMDG’s Interagency Guideline on Prescribing Opioids for Pain, http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpoidGuideline.pdf • CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016 https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm • Substance Use during Pregnancy: Guidelines for Screening and Management, http://here.doh.wa.gov/materials/guidelines-substance-abuse-pregnancy/13_PregSubs_E16L.pdf 	
5	Addresses methods for addressing social determinants of health	The essence of more effectively addressing the social determinants of health – those outside-the clinic factors that greatly influence health and the effectiveness of health care – is to connect patients with resources that can help them deal with those factors. Many of those resources are community agencies and services that address factors such as employment, housing, nutrition & food sufficiency, education, childcare, chronic disease self-management. The proposal should describe the organization’s plans to refer patients to and coordinate care with agencies in support of patient wellness.	5
6	Financial Sustainability through Value-Based Payment	The demonstration project can provide change management support and short-term investments in innovative approaches to care. However, any changes in care must have a plan for funding through future value-based payment mechanisms beyond the demonstration period. The Change Plan should provide a budget showing as much detail as possible about the costs of implementing the planned changes between now and the end of 2021. To the extent these operational changes will require Demonstration Project funding to implement, describe how they will be sustained through value-based payment arrangements beyond the demonstration period.	10
7	Care Coordination, Transition and Diversion	<p>An important aspect of population health is the management of care across the continuum of providers, facilities, organizations and agencies involved in a patient’s care. The Change Plan should describe how care both within the organization and outside can be coordinated to ensure unnecessary lapses in or duplication of care can be avoided, with particular attention to strategies for addressing psychiatric admissions, readmissions, and Emergency Room visits. The Change Plan should address how proactive population management will ensure care is provided at the right time and in the right place to avoid unnecessary use of Emergency Rooms and Hospitals (Diversion) and how patients treated in those settings receive appropriate follow up care to address avoidable readmission (Transition.) Also, the NCACH Pathways Care Coordination HUB project is designed to make connections with community resources relatively quick and easy for providers, and to provide a framework for coordinating and funding care coordination. The Change Plan should discuss how any current care coordination efforts provided by the organization could become part of the HUB effort. At a minimum (since it will take some time for the HUB to reach the entire region) the plan should demonstrate an understanding of the HUB concept and indicate a willingness to cooperate with the HUB when it becomes available to the organization’s patients or clients.</p> <p>Demonstration resources</p> <ul style="list-style-type: none"> • Pathways Community HUB https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf • The Care Transitions Intervention® (CTI®), http://caretransitions.org • Care Transitions Interventions in Mental Health http://www.integration.samhsa.gov/Care transition interventions in mental health.pdf • Emergency Department (ED) Diversion, http://www.wsha.org/quality-safety/projects/er-is-for-emergencies/ 	10

		<p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038086/ - a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.</p> <ul style="list-style-type: none"> Community Paramedicine Model, http://www.emsa.ca.gov/Media/Default/PDF/CPReport.pdf - an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. Additional resources include: http://communityparamedic.org/, http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf, and https://www.ruralhealthinfo.org/topics/community-paramedicine. Law Enforcement Assisted Diversion, LEAD® http://www.leadbureau.org/ 	
8	Access to Care	<p>North Central Washington is underserved in terms of common provider/population ratios that make it difficult for patients to visit a provider. Additional barriers, including insurance coverage, lack of after hours coverage, geography, weather, transportation, and language can reduce timely access to appropriate care and result in unnecessary exacerbations of readily preventable or treatable conditions. Fortunately, improvements in technology and innovative approaches to access, including telemedicine, e-medicine, phone visits, nurse triage/advice lines, and case management services can be effective in leveraging traditional provider visits and are increasingly reimbursed by insurers. The Change Plan should describe innovative approaches the organization is taking to improve access to in-person care with providers as well as other innovative approaches to respond to patient needs.</p>	10
	Total		100

A few elements may be required but are not scored separately:

- The plan should indicate the extent (if any) to which the physical infrastructure of the organization may need to be altered to accommodate expected changes. For example, offices might need to be reconfigured to allow for co-location of BH or primary care providers, or for members of an expanded care team. Costs for such changes should be included in the budget.
- A discussion, especially for smaller providers, of the way the applicant plans to use collaboration among provider organizations to make more efficient use of funds. For example, two or three smaller organizations could share the same Change Management consultant in plan development. IT consultants could be shared. Or multiple organizations could cooperate on 24/7 nurse call lines which would not be affordable to any single small organization.
- The plan must indicate a commitment to share plans, metrics, results, problems and experiences with other members of the Whole Person Care Collaborative in an open learning-oriented manner to support an effective learning collaborative. If the applicant expects to withhold certain kinds of information (such as proprietary business information) this section should explain how it will be possible to achieve a meaningful learning collaborative without sharing information of that kind.

- The plan should give a concise description of the member’s services, staffing, facilities and patient population to assure reviewers have a good understanding of the organization.
- The applicant may add other elements to the Change Plan to clarify its approach to Demonstration work, though there is no reward for quantity.

Timeframe for Stage 2 Evaluation and Implementation

Jul-Sep 2018

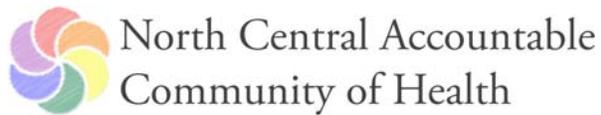
After evaluation of change plans, the first installment of Stage 2 Change Implementation Awards will be made

Oct-Dec 2018

Change Plan implementation begins. Subsequent Implementation Awards will be based on demonstrated progress as reported in semi-annual reports to the NCACH.

Stage 3: Sustaining Change and Demonstrating Improvement in Outcomes

In order for the NCACH to achieve its goal of health improvement, all organizations must improve regardless of their starting point. It’s therefore the intent of the Collaborative is to challenge each organization equally and to reward incremental improvement and to avoid penalizing or rewarding organizations for their current state. The WPCC will work with the HCA and the member organizations to define each organization’s baseline performance on some or all of the clinical outcome measures which can be substantially improved through the Change Plans. (See attached *Approved Project Metrics Appendix*) Incentive payments to participating WPCC members will be based on their relative contribution to aggregate ACH improvement in these clinical outcomes and amounts will be subject to incentive funds awarded to the ACH by the HCA.



Whole Person Care Collaborative Charter

Background

In order to participate in the State Innovation Model (SIM) grant program and prepare for fully integrated Medicaid contracting by 2020, the North Central ACH Governing board selected whole person care as the primary project under SIM. A Primary Care Transformation Workgroup was formed and in the fall of 2016 the workgroup adopted a broad vision of whole person care and formed the Whole Person Care Collaborative. The term “collaborative” was used because the ACH Board intends to create organized and standardized systems to better integrate care between provider organizations across North Central Washington (NCW) and the Board believes the collective and cooperative efforts of these organizations will provide the most effective means to achieve this aim.

Charge

The Whole Person Care Collaborative (WPCC) will promote alignment of provider transformation efforts in the North Central Region with a shared vision of whole person care. The region’s vision of whole person care is for patients to receive care that integrates behavioral and physical care, and effectively connects patients to resources that can help mitigate the negative effects of social determinants of health. The work of WPCC will also strive to deliver Whole Person Care in a way that is financially sustainable for provider organizations.

NCACH plans to use WPCC as the primary means through which to allocate Demonstration funding to provider organizations. The WPCC will create a structured and systematic process for participating provider groups in NCW to collaborate on and receive funding to support adoption of evidenced-based and other innovative practices that will:

- Enable primary care and behavioral health providers in NCW to better integrate behavioral health and medical care,
- Better integrate and coordinate care activities with organizations addressing social determinants of health,
- Achieve the population-based clinical outcome goals of the Medicaid Demonstration project relevant to the projects addressed by the Collaborative as outlined by the HCA in the Demonstration Project Toolkit, and;
- Adapt successfully to value-based payment initiatives across payers (e.g., MACRA) by supporting participating practices in delivering effective whole person care and thriving economically under evolving incentives and reimbursement models.

Composition

The Whole Person Care Collaborative is open to organizations in Grant, Chelan, Douglas, and Okanogan Counties. Representatives from the following sectors will be encouraged to participate as members, and will be broken into the following categories:

Members who are able to receive Demonstration funding through the Collaborative:

- Behavioral Healthcare Provider Organizations
- Primary Healthcare Provider Organizations

Members who are active partners in Demonstration work through the Collaborative, including but not limited to the following:

- Managed Care Organizations
- Emergency Service Organizations

A member organization is one who has signed a membership agreement, referenced in this charter, which describes the benefits, duties, and obligations of members with respect to the quality improvement work of the collaborative. The WPCC is a sub-committee of the ACH board, and will be chaired by the director of the Whole Person Care Collaborative.

Meetings

Meetings are open to the public and all interested organizations are welcome to attend. WPCC meetings are normally held one time a month. An effort will be made to hold meetings in each of the counties throughout the year. All meetings will have an option to participate via teleconference for those unable to attend in person. The NCACH WPCC Chair, Governing Board Chair, and staff shall be responsible for establishing the agendas. Notes for all meetings will be provided by NCACH staff within 2 weeks of each meeting. All meeting materials (agendas, notes, presentations, etc.) will be publicly available on the NCACH website under the WPCC page.

Member Obligations

1. Every WPCC member organization will conduct its own baseline assessment (using Qualis or the consultant of their choice) to establish their current operational state relative to the PCMH- A tool for Primary Care and MeHAF tool for Behavioral Health, and improvement opportunities to be addressed in the transition to whole person care and value-based payment.
2. Every WPCC member organization will work with the consultant of its choice (or its internal experts if available) to develop its own Change Plan. WPCC will provide a Change Plan template, but each organization must develop its own internal plan. This plan should be as specific as possible in identifying necessary changes in arrangements for behavioral health integration, changes in staffing patterns, IT changes, care coordination arrangements, and other measures that will be needed to provide whole person care. The plan should include a budget reflecting the costs of this transition to be supported by demonstration funding and how the changes will be sustained through value based payment beyond the period of the demonstration. The Change Plan should also include a timeline for an implementation plan identifying who in the organization will be involved in shaping and implementing these changes. The Change Plans will be submitted to the WPCC for evaluation and recommendations and they will be the basis for most of the Demonstration funding allocated to provider organizations.
3. Every WPCC member organization commits to be part of a learning collaborative structure that includes collecting and sharing their Change Plan results and progress toward implementation with other members of the collaborative.

WPCC Roles and Responsibilities

1. WPCC will develop Change Plan methodology and make recommendations to the NCACH Governing Board on plan details that will be supported through the Medicaid Demonstration.
2. WPCC will work with member organizations as needed to improve plans, using Demonstration funds if needed, and as available, to enable the organization to acquire needed clinical resources.
3. The WPCC will, as directed by the NCACH Governing Board:
 - a. Provide mechanisms for measuring performance of the ACH, sub-regions, and member organizations and progress over time.
 - b. Provide opportunities for members to share best practices, engage in peer learning, and leverage available statewide practice transformation resources
 - c. Provide training and coaching opportunities as needed to address organizational change and clinical practice improvement.
 - d. Evaluate and recommend improvements in shared systems as necessary to improve care across organizations (*e.g. 24/7 nurse advice systems, health information exchange/interoperability, care management systems, other IT solutions*)
4. The WPCC will evaluate the progress of individual members relative to project work plans, Demonstration milestones, and progress toward achievement of relevant clinical quality metrics associated with the WPCC improvements. It will provide the board with regular monthly updates on the contribution of the WPCC toward meeting the Demonstration Project objectives and on changes or adjustments to the strategies that may be necessary.

Authority

The WPCC is an advisory body that will inform decision-making and ensure regional priorities and local considerations are incorporated in program design decisions. Recommendations and input developed by the WPCC will be shared in regular monthly progress reports to the NCACH Governing Board.

Footnote: *NCACH performance on HCA's Demonstration metrics will have a part in determining the amount of Demonstration funding available. In Demonstration Years (DY) 1 and 2, funding allocations will be determined by ACH performance on a series of pay-for-reporting (P4R) measures. In DY 3-5, funding allocations will be determined by ACH performance on a combination of P4R and pay-for-performance measures.*

**North Central Accountable Community of Health
Whole Person Care Collaborative
Membership Participation Agreement**

Organization Name

commits to participate in the NCACH Whole Person Care Collaborative as a member according to the following terms of agreement:

1. We have read and understand the Whole Person Care Collaborative (WPCC) Charter and agree to the terms and conditions outlined therein, including the Charge, Member Obligations, and the Role and Responsibilities of the WPCC.

2. We agree to designate a representative to participate in the regular meetings of the WPCC and to provide guidance and support for the effort.

3. For the purposes of understanding sources of variation across the region and improving the health and well-being of the entire population of NCH, we agree to share organization-specific health outcome data (*non-PHI identifiable and not provider specific*) relevant to the Demonstration Project with the ACH.

Signature

Date

Name and Title

Strawman Collaborative Design

