



**Healthier Washington Medicaid Transformation
North Central Accountable Community of Health
Semi-annual Report
*Reporting Period: July 1, 2018 – December 31, 2018***

January 30, 2019

ACH contact information

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

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Section 1. Required milestone reporting (VBP Incentives)

This section outlines questions specific to **value-based payment (VBP) milestones** in support of the objectives of Domain 1 (Health and Community Systems Capacity Building), to be completed by DY 2, Q4.

Note: For VBP milestones only, the reporting period covers the full calendar year (January 1 through December 31, 2018). Where applicable, ACHs may use examples or descriptions of activities that may have been included in previously submitted reporting deliverables. Regardless, activities must reflect efforts that occurred during DY 2.

A. Milestone: Inform providers of VBP readiness tools to assist their move toward value-based care.

- Attestation:** The ACH has informed providers of and/or disseminated readiness tools to assist providers to move toward value-based care in the region.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
x	

- If the ACH checked “No” in item A.1, provide the ACH’s rationale for not informing providers of and/or disseminating readiness tools. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response:

Not Applicable

- In the table below, list three examples of how the ACH has informed the following providers of VBP readiness tools: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 full time equivalents (FTEs) or fewer), and 3) behavioral health providers.

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
Outpatient behavioral health and primary care providers including large and small providers (17 organizations total)	<ul style="list-style-type: none"> • Emailed to providers via a listserv • Shared via a PowerPoint presentation at a Whole Person Care Collaborative (WPCC) Learning Community Meeting 	11/6/18 11/5/18	<ol style="list-style-type: none"> JSI/ NACHC Payment Reform Readiness Toolkit: https://www.jsi.com/JSIInternal/Inc/Common/download_pub.cfm?id=14950&lid=3 AMA Steps Forward – Preparing your practice for value-based care: https://www.stepsforward.org/mo-dules/value-based-care#section-references

VBP readiness tool dissemination activities			
Intended audience	Communication method	Date	Specific tools provided
	<ul style="list-style-type: none"> Posted on the WPCC Learning Community Portal 	11/1/18	3. Rural Health Value Team's comprehensive Value-Based Care Strategic Planning Tool: http://cph.uiowa.edu/ruralhealthyalue/TnR/VBC/VBCTool.php
Outpatient behavioral health and primary care providers including large and small providers (17 organizations total)	Provided an Empanelment Learning Sprint for primary care providers in the North Central region.	12/7/18 (First Session)	Empanelment Learning and Action Network Learning Series (Webinars are stored on the WPCC Learning community portal) As part of the sprint, participants completed homework that was reviewed by faculty to assist those organizations in helping develop processes to empanel their patients.
Outpatient behavioral health and primary care providers including large and small providers (17 organizations total)	Assessments were completed by outpatient primary care and behavioral health providers as part of engagement in the NCACH WPCC. Assessments were either completed by organizations or practice facilitators who were onsite to assist with assessments.	1/2018 - 7/2018	<ul style="list-style-type: none"> Patient Centered Medical Home Assessments (PCMH-A) Maine Health Access Foundation (MEHAF) Assessment Note: Tools help prepare providers to better take care of patients through population health management practices.

4. **Attestation:** The ACH conducted an assessment of provider VBP readiness during DY 2.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
x	

5. If the ACH checked “No” in item A. 4 provide the ACH’s rationale for not completing assessments of provider VBP readiness during DY 2. If the ACH checked “Yes” in item A.4, respond “Not applicable.”

ACH response: Not Applicable
(Note: Assessment was part of an overall provider assessment and not an independent VBP readiness questionnaire)

B. Milestone: Connect providers to training and/or technical assistance offered through HCA, the Practice Transformation Hub, Managed Care Organizations (MCOs), and/or the ACH.

1. In the table below, list three examples of how the ACH connected providers to training and/or technical assistance (TA) offered through HCA, the Practice Transformation Hub, MCOs, and/or the ACH or ACH contractors. Provide examples, including the recipients of the training and/or TA, identified needs, and specific resource(s) used.

Connecting providers to training and/or technical assistance		
Recipient of training/TA	Identified needs	Resources used
<p>Behavioral Health in to Primary Care Learning and Action Network (LAN)</p> <ul style="list-style-type: none"> • Columbia Basin Family Medicine • Columbia Basin Health Associates • Columbia Valley Community Health • Coulee Medical Center • Family Health Center • Lake Chelan Community Hospital and Clinics • Mid Valley Clinic • Moses Lake Community Health Center • Parkview Medical Group • Samaritan Healthcare <p>Primary Care into Behavioral Health LAN</p> <ul style="list-style-type: none"> • Catholic Charities • Children’s Home Society of Washington • Columbia Valley Community Health • Confluence Healthcare • Grant Integrated Services • Okanogan Behavioral Healthcare • The Center for Drug and Alcohol Treatment 	<p>Behavioral Health into Primary Care</p> <p>Support primary care providers who want to integrate behavioral health into primary care as part of achieving the goals of Project 2A Bi-Directional Integration</p> <p>Primary Care into Behavioral Health</p> <p>Support behavioral health providers who want to integrate primary care into behavioral health as part of achieving the goals of Project 2A Bi-Directional Integration</p>	<p>NCACH partners with the Centre for Collaboration, Innovation and Motivation and the University of Washington AIMS Center to provide two LAN activities to NCACH partners:</p> <ol style="list-style-type: none"> 1. Primary Care into Behavioral Health 2. Behavioral Health into Primary Care <p>These activities provide faculty members to coach organizations on how to complete each process, assign homework that the faculty reviews, and offer additional practice facilitation for organizations that need further support.</p>
<p>Empanelment Sprint Participants</p> <ul style="list-style-type: none"> • Columbia Basin Family Medicine • Lake Chelan Community Hospital • Confluence health • Parkview Medical Group • Family Health Center • Coulee Medical Center • Moses Lake Community Health Center 	<p>As a building block of Patient Centered Medical Home, empanelment supports population health management, allowing care teams to manage the preventive care, disease management and acute care for a set panel of patients. Several clinics scored low on empanelment on the PCMH-assessment.</p>	<p>NCACH partnered with the Center for Collaboration, Innovation and Motivation to provide an Empanelment Sprint.</p> <p>This activity provides faculty members to coach organizations on how to complete each process, assign homework that the faculty reviews, and offer additional practice facilitation for organizations that need further support to help providers create processes to better empanel their patients.</p>

Connecting providers to training and/or technical assistance

Recipient of training/TA	Identified needs	Resources used
<p>More Intensive Practice Coaching:</p> <ul style="list-style-type: none"> • Moses Lake Community Health Center • Children’s Home Society • The Center for Alcohol and Drug Treatment • Grant Integrated Services • Catholic Charities • Family Health Centers • Coulee Medical Center <p>Basic Practice Coach (as needed):</p> <ul style="list-style-type: none"> • Columbia Basin Family Medicine • Samaritan Healthcare • Mid-Valley Hospital • Parkview Medical Group • Lake Chelan Community Hospital 	<p>Organizations needed additional practice facilitation coaching within their clinics to help them individually progress with their process improvement plans.</p>	<p>NCACH utilized practice facilitation coaches from Quails Health (Washington State Practice Transformation Hub), Shift Consulting, and the Centre for Collaboration, Motivation, and Innovation (CCMI). In addition, NCACH staff provided direct support as needed.</p>

C. Milestone: Support assessments of regional VBP attainment by encouraging and/or incentivizing completion of the state provider survey.

1. In the table below, list three examples of the ACH’s efforts to support completion of the state’s 2018 provider VBP survey. The ACH should indicate any new tactics, compared to tactics employed in prior years, to increase participation.

State provider VBP survey communication activities		
Tactic	Incentives offered? (Yes/No)	New tactic? (Yes/No)
<p>Emailed survey to provider groups to encourage completion. Providers were able to email NCACH if they had any questions about the VBP survey, and NCACH directed them to the HCA if needed.</p>	<p align="center">No</p>	<p align="center">No</p>
<p>Informed providers at meetings of the NCACH WPCC and Board that the survey was active and encouraged them to complete the survey before the due date.</p>	<p align="center">No</p>	<p align="center">No</p>

State provider VBP survey communication activities		
Tactic	Incentives offered? (Yes/No)	New tactic? (Yes/No)
Sent individual communication to providers who have not completed assessment during the survey period. This included additional follow-up from the Executive Director to agencies that had not completed the survey closer to the due date.	No	No

Note: Although no financial incentive was given to providers to complete the Washington State Value Based Purchasing Survey, NCACH had one of the highest percentages of local providers responding to the survey.

D. Milestone: Support providers to develop strategies to move toward value-based care.

1. In the table below, provide three examples of how the ACH has supported providers to develop strategies to move toward value-based care. Examples of ACH support include direct TA or training, provision of TA or training resources, monetary support, development of an action plan, etc. The ACH must provide an example for three unique provider types: 1) providers with low VBP knowledge or significant barriers/challenges, 2) small providers (25 FTEs or fewer), and 3) behavioral health providers.

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
Behavioral Health Providers	Education on how to develop contracts with managed care organizations (MCOs) and technical assistance to help provider IT departments to prepare their health records systems to be ready to bill MCOs.	Provided technical assistance in the following: Education to providers on ways they can engage payers in the contracting discussion (including individual technical assistance provided upon request).	Providers who have never negotiated contracts for Medicaid learned tactics they can use to ensure they are able to develop appropriate contracts with payers. Providers were able to receive support when	Technical assistance has been provided to providers.

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
		IT assistance to help behavioral health providers make adjustments to their electronic health records to be ready to bill MCOs.	they made adjustments to the electronic health records system to reduce errors in billing after they transitioned to Fully Integrated Managed Care (FIMC).	
Small Clinical Provider	Small providers do not have the funds and internal resources to support a clinical change plan in their organization.	NCACH has hired consultants and is hiring internal practice facilitation coaches to assist providers in making the needed clinical process improvement changes in their organizations. During the behavioral health integration LAN activities, small providers also received additional individualized technical assistance from LAN faculty.	Providers will receive additional support from outside of their agency to evaluate how clinical process improvement efforts that are established will support VBP contracting in the future.	Practice coaching has been provided to partners.
Providers with low knowledge of VBP and clinical processes to achieve VBP	Partnering providers lacked the capacity to internally develop the resources necessary to make clinical process improvements that would make them successful as they transition their practices towards value-based care.	NCACH provided initial funding, learning activity, QI workshop and additional TA to assist partners with developing capacity and/or infrastructure needed to be successful throughout the Medicaid Transformation Project. 1. Stage 1 funding to develop initial infrastructure that would support work during the Medicaid Transformation Project.	Base funding is provided annually to partners to help support infrastructure needed throughout the course of the Medicaid Transformation Project. Change Plans are updated quarterly and reviewed annually for progress so that NCACH can continue to support practices as they progress in their	Providers developed a Change Plan that helps them improve clinical process over the Medicaid Transformation Project that will make them successful in future value-based contracting.

ACH provider support activities				
Provider type	Provider needs (e.g., education, infrastructure investment)	Supportive activities	Description of action plan: How provider needs will be addressed (if applicable)	Key milestones achieved
		2. In partnership with the Centre for Collaboration, Motivation and Innovation, NCACH provided organizations with Change Plan LAN and Quality Improvement workshops that would assist them in developing a clinical process improvement plan for the Medicaid Transformation Project.	practice transformation efforts.	

Section 2. Required milestone reporting (Project Incentives)

This section outlines questions specific to **project milestones** in support of the objectives outlined in the Medicaid Transformation Project Toolkit by DY 2, Q4. This section will vary each semi-annual reporting period based on the required milestones for the associated reporting period.

A. Milestone: Support regional transition to integrated managed care (2020 regions only)

1. **Attestation:** The ACH engaged and convened county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to discuss a process and timeline for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
NA	NA

- a. If the ACH checked “No” in item A.1, provide the rationale for having not discussed a process and timeline for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response: Not Applicable – NCACH is a mid-adopter

2. **Attestation.** The ACH, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners developed a plan and description of steps that need to occur for regional transition to integrated managed care. Place an “X” in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
NA	NA

- a. If the ACH checked “No” in item A.2, provide the rationale for having not developed a plan for regional transition to integrated managed care. Describe the steps and associated timelines the ACH will take to complete this milestone. If the ACH checked “Yes,” to item E.1 respond “Not applicable.”

ACH response: Not Applicable – NCACH is a mid-adopter

3. Has the region made progress during the reporting period to establish an early warning system (EWS)?

- a. If yes, describe the region’s plan to establish an EWS Workgroup, including:

- i. Which organization will lead the workgroup
- ii. Estimated date for establishing the workgroup
- iii. An estimate of the number and type workgroup participants

- b. If no, provide the rationale for not establishing an EWS. How has the ACH identified the process to monitor the transition to FIMC and identify transition-related issues for resolution?

ACH response: Not Applicable – NCACH is a mid-adopter

4. Describe the region's efforts to establish a communications workgroup, including:
 - i. Which organization will lead the workgroup
 - ii. Estimated date for establishing the workgroup
 - iii. An estimate of the number and type of workgroup participants

ACH response: Not Applicable – NCACH is a mid-adopter

5. Describe the region's efforts to establish a provider readiness/technical assistance (TA) workgroup, including:
 - i. Which organization will lead the workgroup
 - ii. Estimated date for establishing the workgroup
 - iii. An estimate of the number and type of workgroup participants

ACH response: Not Applicable – NCACH is a mid-adopter

6. What provider readiness and/or TA needs has the ACH identified for Medicaid behavioral health providers transitioning to integrated managed care? Has the ACH identified steps to address TA needs?

ACH response: Not Applicable – NCACH is a mid-adopter

7. What **non-financial** technical assistance has the ACH identified that HCA could provide to the ACH to help address provider readiness needs?

ACH response: Not Applicable – NCACH is a mid-adopter

8. How has the ACH engaged MCOs, the regional behavioral health organization, consumers, and other affected stakeholders in planning for the transition to integrated managed care?

ACH response: Not Applicable – NCACH is a mid-adopter

B. Milestone: Identified HUB lead entity and description of HUB lead entity qualifications (Project 2B only)

NOTE: This milestone pertains ONLY to Project 2B. If the ACH is not implementing this project, respond "Not applicable."

The ACH may insert or include as an attachment supporting graphics or documentation for the questions below, though this is not required.

1. Identify the Project 2B HUB lead entity, and describe the entity's qualifications. Include

a description of the HUB lead entity's organizational structure and any relationship to the ACH. Describe any shared staffing and resources between the HUB lead entity and the ACH.

ACH response: As the result of a Request for Proposals that NCACH issued, the NCACH Governing Board approved Community Choice dba Action Health Partners (AHP) as the Pathways Community HUB lead agency in June 2018.

Qualifications:

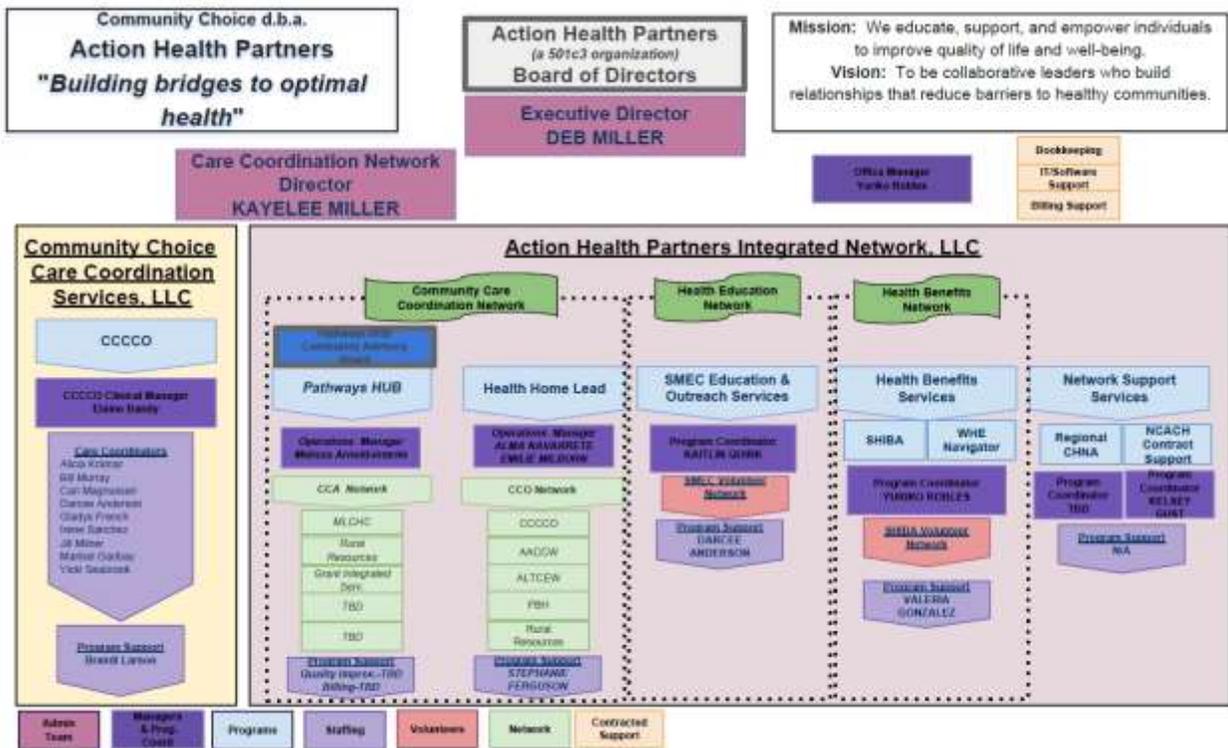
AHP has worked collaboratively for 20 years to improve the accessibility and quality of healthcare in Chelan, Douglas, Grant, and Okanogan counties. The current mission of AHP is to support, educate, and empower individuals to improve their quality of life and well-being. The AHP vision is to be collaborative leaders who build relationships that reduce barriers to healthy communities. In alignment with this vision, AHP supports a number of programs that allow the organization to be well-positioned to support the objectives of the Pathways Community HUB. Those programs include the following:

- AHP has been a qualified Health Homes Lead Organization for 11 eastern Washington counties under the WA Health Homes MFFS Demonstration Project for the last four years. In this role, AHP works with five care coordination organizations throughout the 11-county region providing referrals, technical assistance, client management, billing, and oversight. AHP also serves as the Lead for Amerigroup's Apple Health Managed Care Health Homes clients in the 11-county region. AHP and contracted organizations have achieved a 25% engagement rate compared to a statewide average of 17%. Both Health Homes and the Pathways Community HUB model have many elements in common including contracting with care coordination agency partners throughout the region.
- As a Health Homes Lead Organization and the HUB lead agency, AHP is able to provide a staffing model that can more efficiently coordinate care and reduce duplication of services delivered by care coordinators.
- AHP provides direct care coordination services through its Care Coordination Services team to nearly 6,100 Medicaid enrollees in the region.
- AHP provides health education and outreach services, including Chronic Disease Self-Management Education.
- AHP operates health benefit programs such as the Statewide Health Insurance Benefits Advisor program and the Washington Health Exchange Navigator program.
- AHP participates in regional efforts focused on evaluating regional data and increasing partner collaboration, such as performing the region's Community Health Needs Assessments and supporting the NCACH's Coalitions for Health Improvement (CHI).

Organizational structure and relationship to the ACH:

AHP is a 501c3 organization that is not affiliated with NCACH. After AHP was selected as the HUB lead agency, AHP formed a wholly owned nonprofit subsidiary to provide separation from its direct Health Homes care coordination services. This was intended to proactively address any potential questions about AHP’s ability to maintain neutrality when allocating patients to care coordination agencies and to ensure that AHP is eligible to become a certified Pathways HUB. This structure also allows AHP to create a HUB Advisory Board to oversee the operation and performance of the HUB without disrupting the governance of the parent organization.

As shown in the organizational chart below, the Pathways Community HUB is a program of AHP, and is supported by the infrastructure of the larger organization. With this approach, AHP is able to provide shared governance, executive leadership, finance, billing, human resources, and other needed functions of the HUB within its overall organizational structure. Currently, AHP outsources its IT infrastructure support to Key Methods. As the Pathways HUB continues to expand, AHP will evaluate the need to add additional resources to meet the fiscal and billing requirements for the HUB.



Last updated: 09-19-2018

Shared staffing and resources:

The NCACH and AHP have no shared staffing or resources. NCACH and AHP have entered into deliverable-based MOUs for the design and implementation of the HUB in North Central Washington. In 2019, NCACH and AHP will enter into performance-based payer contracts in addition to a continued start-up MOU.

2. Has the Project 2B HUB lead entity decided to move forward with HUB certification?
 - a. If yes, describe when it was certified, or when it plans to certify.
 - b. If no, describe how the HUB lead entity plans to maintain oversight of business, quality and clinical processes.

ACH response: The HUB lead entity is currently moving forward with certification. As AHP has been developing and launching the HUB, AHP staff have been intentional about being in accordance with national certification prerequisites and standards. Certification is an NCACH milestone in the implementation plan, with level 1 certification expected by DY4, Q4 (the end of 2020).

3. Describe the Project 2B HUB lead entity's role and processes to manage the appropriate HUB information technology requirements. Include a description of data governance (including clinical and administrative data collection, storage, and reporting) that identifies access to patient level data and health information exchange for HUB and care coordination staff, and referring or other entities.

ACH response: AHP Pathways HUB has developed a policies and procedures manual that outlines how the organization governs and protects information to maintain HIPAA compliance. This manual covers the following:

1. HIPAA General Policies and Procedures and definitions
2. Training and Confidentiality Pledge with form
3. Privacy Standards/Business Associate Agreement for Community Specialist Services Agencies (CSSAs), MCOs with form
4. Privacy Standards/Business Associate Agreement for CSSAs with form
5. Complaint and Reporting Policy with form for privacy/HIPAA violation investigations
6. Breach Notification Policy and Breach Log
7. Disciplinary Action Policy for Privacy/HIPAA Rule Violations
8. Disclosure to Health Oversight Agencies and Tracking log
9. General HIPAA Security Policy
10. Risk Analysis and Risk Management
11. Physical Safeguards
12. Information Systems Activity Review
13. Information Access Management
14. Security Incident Response and Reporting
15. Contingency Plan
16. Evaluation Plan
17. Physical Safeguards
18. Technical Safeguards

AHP has designated a Care Coordination Network Director for AHP, the HIPAA/Compliance officer, and an IT director. This position ensures that all policies and procedures outlined in the manual are implemented within the organization.

All information sent to or from CSSAs, MCOs, Pathways Community Specialists (PCSs), referral agencies and others involved in the Pathways HUB that contains protected health information are sent through encrypted email during transmission and while stored. All the CSSAs, PCSs, referral partners, and MCOs are required to use encryption when sending private information.

The referring agency sends AHP written referrals through an encrypted fax, which then comes to AHP through a third-party vendor via printer/fax machine.

Client information is collected and stored within the Care Coordination Systems platform, which is a certified HIPAA compliant system. Access to this platform is limited, controlled by the HUB staff, and has three levels of permissions available (HUB manager, supervisor, and PCS). The Care Coordination Systems platform is used for all documentation and reporting for the Pathways Community HUB.

AHP's computer network is supported by a third-party vendor to provide robust monitoring and maintenance of the agency computer network. Systems are in place that provide IT security including but not limited to password protocols and firewalls. AHP is currently in the process of having a third-party vendor complete an IT/data evaluation and vulnerability scan on all Pathways HUB systems. After this comprehensive evaluation is completed, AHP will be following any recommendations to improve policy and procedures, IT security, and areas of vulnerability that might be found. This evaluation and recommendations should be completed by end of February 2019.

Additional Information:

Host Security (Endpoints)	
Firewall	Windows Firewall for Windows OS Machines
Anti-Virus	Webroot on Windows Machines
Network Security	
Firewall	Fortigate Firewall 30E
Intrusion Detection/Prevention	Not Configured
Anti-Virus	Built-in to Fortigate 30E (Scans HTTP, SMTP, POP3, IMAP, and FTP)
Email	
Provider	Microsoft Office 365
Anti-Spam	Microsoft Office 365
Encryption	Microsoft Office 365
SPF / DKIM / Other Protections	N/A
Mail Relay Settings (Authenticated, whitelist, etc.)	Whitelist
Network Management Monitoring/Reporting	
SIEM	N/A
Firewall Logging	Yes
Performance Monitoring	None

Device Type	Workstation OS	Password Rotation	Room Cat	Room Type	Lock Type	Locked?	Access Records
Desktop	Linux	Annual	Data Center	Data Only	Physical Key	Yes	None
Laptop	Windows XP	Quarterly	De-Marc	Telecom Only	Cypher (Keypad)	No	Access Control System
Tablet	Windows Vista	As Needed	IDF	Data/Telecom	Prox/Mag/Fob	Unlocked Business Hours	Paper Records
Other	Windows 7		Core Switch	D/T + Storage	Biometric	Unsecured Key	Central Sign in
	Windows 8		Telcom	D/T + Utility	No Lock	Other	Other
	Windows 10		Other	D/T + Multi-Use	No Door	N/A	N/A
	Mac OS		N/A	Rack / Cage	Other		

C. Engagement/support of Independent External Evaluator (IEE) activities

1. **Attestation:** During the reporting period, the ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to:
 - ACH participation in key informant interviews.
 - Identification of partnering provider candidates for key informant interviews.
 - Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.

Place an "X" in the appropriate box.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked "No" in item C.1, provide the ACH's rationale for not supporting IEE activities for evaluation of Medicaid Transformation. If the ACH checked "Yes," to item C.1 respond "Not applicable."

ACH response: NCACH has not been contacted by the IEE during the reporting period, but since the IEE was first announced in spring 2018, the NCACH staff has

received a few updates. During a Transformation Alignment call at the end of August, the NCACH staff heard from the IEE staff about their plans, including interviewing ACHs (which they thought might begin in fall 2018.) In October 2018, the NCACH staff heard an update during a monthly HIT Operational Plan Update (convened by the HCA) that the IEE had started reading materials, submitted an IRB application, and that they would be conducting key informant interviews for the qualitative aspect of their evaluation. NCACH intends to support and engage in IEE activities after receiving direct feedback from the evaluators at Oregon Health & Science University's (OHSU's) Center for Health Systems Effectiveness.

Section 3: Standard reporting requirements (Project Incentives)

This section outlines requests for information included as **standard reporting requirements** for the semi-annual report. Requirements may be added to this section in future reporting periods, and the questions within each sub-section may change over time.

ACH-level reporting requirements

A. ACH organizational updates

1. **Attestations:** In accordance with the Medicaid Transformation's Special Terms and Conditions and ACH certification requirements, the ACH attests to complying with the items listed below during the reporting period.

	Yes	No
a. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	x	
b. The ACH has an Executive Director.	x	
c. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: primary care providers, behavioral health providers, health plans, hospitals or health systems, local public health jurisdictions, tribes/Indian Health Service (IHS) facilities/ Urban Indian Health Programs (UIHPs) in the region, and multiple community partners and community-based organizations that provide social and support services reflective of the social determinants of health for a variety of populations in its region.	x	
d. At least 50 percent of the ACH's decision-making body consists of non-clinic, non-payer participants.	x	
e. Meetings of the ACH's decision-making body are open to the public.	x	

2. If unable to attest to one or more of the above items, explain how and when the ACH will

come into compliance with the requirements. If the ACH checked “Yes,” to all items respond “Not applicable.”

ACH response: Not Applicable

3. **Attestation:** The ACH has completed an organizational self-assessment of internal controls and risks using the attached template or a similar format that addresses internal controls, including financial audits.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Place an “X” in the appropriate box.

Yes	No
x	

- a. If the ACH checked “No” in item A.3, describe the ACH’s process to address the self-assessment components contained within the checklist, including financial audits. If the ACH checked “Yes,” to item A.3 respond “Not applicable.”

ACH response: Not Applicable

4. Key Staff Position Changes: Please identify if key staff position changes occurred during the reporting period. Key staff changes include new, eliminated, or replaced positions. Place an “X” in the appropriate box below.

	Yes	No
Changes to key staff positions during reporting period	x	

If the ACH checked “Yes” in item A.4 above:

Insert or include as an attachment a current organizational chart. Use ***bold italicized font*** to highlight changes, if any, to key staff positions during the reporting period.

Submitted as NCACH.SAR2 Attachment A. 1.31.19

B. Tribal engagement and collaboration

1. **Attestation:** The ACH attests to ongoing compliance with the [Model ACH Tribal Collaboration and Communication Policy](#).¹

Note: the IA and HCA reserve the right to request documentation in support of attestation.

¹ <https://www.hca.wa.gov/assets/program/Model-ACH-Tribal-Collaboration-Communication-Policy.pdf>

Place an “X” in the appropriate box.

Yes	No
X	

2. If the ACH checked “No” in item B.1, describe the rationale for the ACH not being in compliance with the Model ACH Tribal Collaboration and Communication Policy. If the ACH checked “Yes,” to item B.1 respond “Not applicable.”

ACH response: Not applicable

3. If tribal representation or collaboration approaches have changes during the reporting period, please explain. If there have been no changes, respond “Not applicable.”

ACH response: NCACH has been working to engage its tribal partners, the Colville Confederated Tribes, as Medicaid Transformation efforts continue. NCACH staff attended the Coulee Medical Center Wellness Powwow in September 2018, which resulted in some local connections among tribal agencies and other NCACH partners. As a result of NCACH’s community engagement efforts at the Wellness Powwow, six tribal agency representatives attended the Okanogan CHI meeting in October 2018 who had not been attending these meetings previously. Additionally, NCACH was able to bring a Molina representative, Jeannie “JJ” McMinds, to a Governing Board retreat in October for a tribal healthcare training, which contributed to ongoing tribal and cultural training for the NCACH Governing Board and staff. NCACH also coordinated a similar training for healthcare providers in the NCACH region with HCA staff, Jesse Dean, Lena Nachand, and Lucilla Mendoza.

In November 2018, NCACH staff attended the American Indian Health Commission for Washington State’s Tribal Leaders Summit, where they participated in a two-day conference focusing on tribal healthcare priorities. NCACH staff were invited to provide an overview of the ACH’s activities at the Summit, which resulted in a few key connections with the Colville Confederated Tribes Business Council. On November 19, 2018, NCACH was formally invited to attend the Colville Confederated Tribes Business Council Health and Human Services Committee meeting. This is the first time that NCACH representatives had the chance to formally appear in front of tribal councilmembers. After the meeting, NCACH sent a detailed summary of projects and opportunities for more formalized partnership and funding. To date, NCACH has not heard back from the Council, but is continuing to find ways to engage and connect with tribal partners and agencies.

C. Integrated managed care status update (early- and mid-adopters only)

1. During the reporting period, what work has the ACH done to assist Medicaid behavioral health providers transitioning to integrated managed care?

ACH response: NCACH is a transition region, meaning that Chelan, Douglas, and Grant counties transitioned to FIMC on January 1, 2018; Okanogan County chose to wait to transition until January 1, 2019.

To assist Okanogan County providers during the reporting period, NCACH utilized CHI meetings in Okanogan County for broad stakeholder engagement and communications about preparations for the FIMC transition. In addition to the Okanogan CHI meetings, NCACH facilitated monthly Okanogan County FIMC provider meetings. Providers and MCOs were invited to a meeting the second Tuesday of each month to plan for the transition. Topics covered during the reporting period included presentations by the MCOs, development of a communications plan, early warning system indicator identification, behavioral health ombudsman, crisis response plan, and FIMC vs. fee for service reimbursements for the American Indian/Alaskan Native population.

Specific to behavioral health providers, Okanogan County has only one Spokane Behavioral Health Organization contracted provider, Okanogan Behavioral Healthcare (OBHC). OBHC completed the self-assessment tool provided in the Billing and Information Technology Toolkit for Behavioral Health Providers by Qualis Health, Washington Department of Health, and Healthier Washington. NCACH contracted with Xpio Health to provide IT technical assistance to OBHC. OBHC and Xpio used the billing and IT self-assessment to develop a work plan to ensure that OBHC was prepared for financial integration on Jan 1, 2019.

In regard to contracting, NCACH provided contracting technical assistance to OBHC (along with other WPCC members) by hosting a one-day training that was led by Adam Falcone of Feldesman Tucker Leifer Fidell LLP. This training provided tips to the behavioral health providers to aid them in developing sustainable contracts with their managed care partners. For partners that needed additional support (including OBHC), Feldesman Tucker Leifer Fidell LLP provided consulting support to review basic contract templates that partners had with MCOs.

To support statewide adoption of FIMC, NCACH hosted an FIMC Peer Learning Session in July 2018. This was an opportunity for providers from other ACH regions to hear from NCACH providers on lessons learned, barriers, challenges, and best practices related to the transition to FIMC. All NCACH behavioral health agencies participated in this learning session.

2. Describe how the ACH has prioritized, and will continue to prioritize incentives to assist Medicaid behavioral health providers transitioning to integrated managed care. Include details on how Medicaid behavioral health providers and county government(s) have and will continue to participate in discussions on the prioritization of incentives.

ACH response: Integration incentive funding will be distributed to partners based on NCACH's overall funding principles. Every dollar received through the Medicaid Transformation Project goes into a global budget, which is then distributed based on recommended allocation strategies approved by the Governing Board. NCACH does not distinguish funding distributed to partners based on how those dollars were earned. Behavioral health providers participate in determining funding distribution through their sector representation on the NCACH Governing Board, involvement in the WPCC, and representation in NCACH project workgroups.

Through the funding principle outlined above, behavioral health provider organizations have received funding through their engagement in the NCACH WPCC. As part of the WPCC, behavioral health providers submitted independent process improvement change plans. These change plans help providers make the clinical changes needed to help them better adapt to FIMC billing, prepare for VBP, and complete the integration work needed to provide better care for their patients. In addition to these measures, NCACH is reviewing the option to utilize funding to enhance interoperability between electronic health records of behavioral health and physical health providers. If implemented, this will allow for better communication among providers and ensure true integration among organizations.

Although NCACH does not distinguish between the source of funds when distributing funding to partners, the NCACH Governing Board has approved funding for integration-specific work based on the needs that were brought forward by the region's behavioral health providers. Below are examples of approved integration funding:

1. NCACH contracted with Feldesman Tucker Leifer Fidell LLP to provide contracting technical assistance and review for behavioral health providers with limited experience contracting with MCOs.
2. NCACH provided IT and billing technical support through Xpio to behavioral health providers that needed assistance in making adjustments to their medical record systems to be better able to bill MCOs for services provided.
3. NCACH has provided staffing support to coordinate the partners through the FIMC process to ensure that providers have the resources to be successful under FIMC.

As additional integration-specific needs arise for providers, NCACH will evaluate and address those needs with the NCACH Governing Board for support (funding or other), as appropriate.

To ensure that all county commissioners stay informed about Medicaid Transformation Project status, the NCACH Executive Director attends board of health meetings (the boards of health are composed of county commissioners and local elected officials) in the three local health jurisdictions (Chelan-Douglas, Grant, and Okanogan) semiannually. As Okanogan County adopts FIMC (January 2019), NCACH has met with county commissioners to ensure open communication and that the transition occurs smoothly

for behavioral health providers. This model for engagement of behavioral healthcare providers and county government has received support from all local agencies in NCACH's community.

3. Describe the decision-making process the ACH used and will continue to use to determine the distribution of Behavioral Health Integration incentives. Include how the ACH verified and will continue to verify that providers receiving assistance or funding through the Behavioral Health Integration incentive funds will serve the Medicaid population going forward.

ACH response: NCACH does not categorize funds based on the source of DSRIP funding (e.g., design funds, integration funds, and VBP incentive funds). Therefore, stewardship and transparency of every fund type of the Medicaid Transformation will be upheld by the same principles and policies of all NCACH funds. Funding transparency is achieved by having motions for funding allocations occur at public Governing Board meetings. NCACH's Governing Board has the final approval of all Medicaid Transformation funds that are distributed by NCACH. Meeting minutes are published on the NCACH webpage and distributed to community partners.

In order for providers to participate as an NCACH funded partner in the bi-directional integration project, they must join the WPCC Learning Community. In March 2018, the NCACH Governing Board approved the WPCC Learning Community Charter eligibility requirements to stipulate that the agency must serve a minimum of 300 Medicaid beneficiaries and have at least 1,000 Medicaid encounters annually. NCACH staff verify eligibility annually at the time that HCA provides updated beneficiary and encounter data. If a provider falls below the eligibility requirements, they will be allowed to continue to participate in the learning activities, but will not receive funding to do so.

4. Apart from the distribution of incentives directly to behavioral health providers, how has the ACH supported Medicaid behavioral health providers to address business administration and/or operational issues *after* the transition to integrated managed care?

ACH response: During the reporting period, NCACH has provided a point of contact for all questions pertaining to the integration transition for Chelan, Douglas, and Grant County providers that transitioned on January 1, 2018. In early 2018, the providers identified a need to have an "MCO Symposium" post-integration. NCACH facilitated this symposium in May 2018. It was so successful that MCOs have identified it as a best practice and intend to offer a similar opportunity for 2019 and 2020 transitioning regions. In addition, NCACH provided funding post-integration for two behavioral health providers to support additional needs identified for their IT and billing capabilities.

NCACH is participating in weekly rapid response calls with Okanogan County providers. The rapid response calls provide an opportunity to respond to systemic issues or questions that may stem from FIMC, which need immediate attention or resolution. In addition, NCACH will be hosting the Early Warning System webinars that will start in

February 2019. NCACH continues to have an identified point of contact for Okanogan County to direct all questions regarding the transition.

5. **Complete the items outlined in tab 3.C of the semi-annual report workbook.**

D. Project implementation status update

Implementation Plans are “living documents” that outline key work steps an ACH plans to conduct across the timeline of the Medicaid Transformation. The ACH’s Implementation Plan (workplan) is a key resource that allows HCA to understand how the ACH is moving forward and tracking progress, and also provides information for HCA to monitor the ACH’s activities and project implementation timelines.

As such, the ACH must submit an **updated implementation plan** that reflects *progress made during the reporting period* with each semi-annual report.²

- There is no required format, but the updated implementation plan must allow for the IA to thoroughly review progress made during the reporting period, as outlined in question 1 below.
 - If the ACH has made substantial changes to the format of the workplan from that originally submitted as part of the implementation plan in October 2018, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes.
1. Provide the ACH’s current implementation plan that documents the following information:
 - a. Work steps and their status (in progress, completed, or not started).
 - b. Identification of work steps that apply to required milestones for the reporting period.

Required attachment: Current implementation plan that reflects progress made during reporting period.

2. At the portfolio level, provide the top three achievements and risks (including planned mitigation strategies and estimated timing for resolution) identified during the reporting period.

ACH response:

TOP 3 ACHIEVEMENTS

1. **Funds distributed to partners across all six selected projects:** This is an

² Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan.

overarching achievement for the reporting period. After much planning by NCACH's various workgroups, one of the biggest milestones was having MOUs in place, marking the implementation of various strategies across the entire project portfolio.

- a. NCACH signed Stage 2 MOUs and distributed additional funding to 17 primary care and behavioral health providers, primarily focusing on efforts associated with Project 2A Bi-Directional Integration and Project 3D Chronic Disease (while also contributing to other project objectives).
 - b. NCACH signed 11 MOUs and funded 10 agencies that submitted Rapid Cycle Opioid Applications supporting drug abuse prevention, overdose prevention, and recovery efforts.
 - c. NCACH entered into a contract with AHP, the lead agency responsible for implementation and scaling of the Pathways Community HUB in the North Central region.
 - d. NCACH signed MOUs with and funded 7 hospital partners to implement selected transitional care and diversion intervention approaches. All of these partners are critical access hospitals. NCACH also signed an MOU with North Central Emergency Care Council, which is coordinating and overseeing practice transformation efforts as they relate to diversion interventions in the region.
2. **Pathways Community HUB launched:** The NCACH Pathways Community HUB officially launched on October 1, 2018, after an extensive planning period in 2017-18, including the selection of AHP as the lead agency implementing the Pathways Community HUB. The HUB is currently serving residents receiving (or eligible for) Medicaid benefits in Moses Lake, Washington, who have visited the emergency department three or more times in the past 12 months. Plans for expansion are currently underway as HUB staff incorporate lessons learned from pilot implementation.
3. **First topical LAN offered to WPCC members:** A LAN is a multi-month webinar series formed around a specific topic, allowing for subject matter expert faculty to provide content and enable peer sharing; participants commit to actions they intend to execute in between webcasts. After offering a LAN to help the WPCC learning community understand the change plan and its associated evidence-based approaches, the NCACH staff was excited to open registration for two Bi-Directional Integration LANs in late 2018. These were directly related to helping providers implement elements of their change plans. Overall, 57 individuals (11 organizations) participated in the Behavioral Health into Primary Care LAN, and 47 individuals (7 organizations) participated in the Primary Care into Behavioral Health LAN.

TOP 3 RISKS

1. **Making initial contact with people referred to the Pathways HUB:** An early and ongoing challenge for care coordinators is locating people who meet the eligibility criteria for the HUB (residents of Moses Lake with more than three emergency department visits). In partnership with Samaritan Hospital, the care

coordinators have identified 391 people in October and November who are eligible for HUB services. To date, care coordinators have only been able to enroll and engage 21 of those people; others declined services (42), some met Health Homes eligibility criteria and were referred there instead (84), and others could not be located (71). AHP staff implemented quality improvement efforts from the start by initiating a Plan-Do-Study-Act (PDSA) cycle with the goal of improving care coordinator contact with referred clients to improve engagement and enrollment. Action steps being used or in progress include developing a welcome letter with a self-addressed prepaid postage envelope for individuals interested in the Pathways HUB program, creating a door hanger that can be left at the addresses provided for the potential clients, stationing care coordinators at the hospital so that they can make immediate contact with eligible patients, and testing a text-to-referral process because many people are more likely to respond to a text than a phone call.

2. **Low engagement of community-based organizations:** Guided by the majority of the performance metrics and the evidence-based approaches available in the NCACH project portfolio, the majority of NCACH's funded partners in 2018 were clinical partners. The NCACH staff will work to increase engagement of non-clinical partners in 2019, and the staff anticipates learning from the successes and challenges of other ACHs on this front. The NCACH staff is in the midst of developing a process for CHIs to distribute funding in their subregions (this funding allocation was approved by the NCACH Board in December 2018). This is a significant opportunity for engaging and funding non-clinical partners that can contribute to the Medicaid Transformation project objectives. In addition, the role of the Capacity Development and Grant Manager (who joined the NCACH team in September 2018) is designed to strengthen relationships with non-clinical partners, with a focus on transportation and housing (social determinants of health that were prioritized in the North Central region based on community feedback).
3. **Lack of access to actionable data:** This risk has implications for ACHs and providers. For ACHs, receiving timely data products from the HCA that allow ACH staff to plan and monitor projects and adjust as needed has been a challenge. During the reporting period, actionable data resources and tools were not being rolled out fast enough to keep up with the faster pace of project planning and implementation. The NCACH staff understands that HCA-ARM has been working to fill several vacancies and anticipate receiving data more regularly in the future, including data associated with emergency department utilization (which is relevant to all projects). To promote more actionable data products, ACH data leads worked together to identify and prioritize data products that have been most useful and submitted this feedback to HCA-ARM/RDA staff, as well as inviting them to join a few data lead calls to discuss this issue. NCACH leaders are also exploring alternative data sources with the help of data analytics partners at Public Health Seattle King County that might supplement HCA data products and inform project implementation strategies. For providers, barriers to health information exchange and lack of internal data analytics capacity could affect the underlying care coordination and integration goals of projects. To mitigate this risk, NCACH is hiring practice facilitators in early 2019

and relying on consultants to help clinical providers work with their HIT systems to extract meaningful data while building their quality improvement capacity. NCACH is continuing to work with MCOs to identify where their quality improvement and data analytics tools could be shared with providers and/or the ACH to support practice transformation efforts. NCACH staff also scheduled a meeting with OneHealthPort in December to better understand whether and how the Clinical Data Repository (CDR) and health information exchange services could help providers with some of their real-time and population health data needs. NCACH leaders continue to view Collective Medical technology platforms as an opportunity for real-time health information exchange that can promote care coordination across the North Central region.

3. **Did the ACH** make adjustments to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period?

Place an “X” in the appropriate box.

Yes	No
	X

4. If the ACH checked “Yes” in item D.3, describe the adjustments made to target populations and/or evidence-based approaches or promising practices and strategies during the reporting period. Include the adjustment, associated project areas, rationale, and anticipated impact. If the ACH checked “No,” to item D.3 respond “Not applicable.”

ACH response: Not applicable

Portfolio-level reporting requirements

E. Partnering provider engagement

1. List three examples of ACH decisions or strategies during the reporting period to avoid duplication across ACHs (e.g., assessments, reporting, training) and/or align with existing provider requirements as defined by MCOs and other health plans (e.g., reporting, quality initiatives, and practice transformation programs).

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
<i>Strategy – Identify the types of quality reports MCOs can share</i>	The Medicaid Transformation Project quality metrics (i.e.,	NCACH confirmed that Molina generates a value-based care

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
<i>with providers, and understand which providers would have access to this information</i>	P4P) have been a challenge for some providers because they are unable to see all of the data elements behind the metric specifications. Where MCOs already generate this data for providers, NCACH's objective is to make sure providers know that this resource can assist with their internal quality improvement efforts and their change plan measure reporting (in alignment with MCO quality reporting).	report package for provider groups that are in value-based care arrangements. These reports allow providers to filter data by location, members, and assigned primary care providers. In the North Central region, five providers have entered or are entering in VBP arrangements with Molina. NCACH has shared this information with some of the providers, given that key contacts were not aware that this information was being provided to their agency (internal coordination issue).
<i>Strategy – Dedicate time and lean on outside facilitation to coordinate with other ACHs</i>	Outside facilitator will ensure that cross-ACH coordination meetings are focused and structured to make efficient use of limited time.	All ACH staff are balancing many facets of coordination, including regional project implementation, internal coordination, and cross-ACH coordination (including distinct meetings of program leads, data leads, and executive directors). This can become overwhelming and having outside organizers and facilitators from OHSU has been critical to maintaining focus and momentum. Topics at a December meeting, for example, included sharing experiences, strategies, and practices for managing interactions with community-based organizations, value-based payments, and implementation strategies. MCO engagement and sustainability were also discussed.
<i>Strategy – Communicate and coordinate with other ACHs around training and technical assistance needs specific to</i>	NCACH staff will learn from other ACHs and share resources to accelerate onboarding of providers with	Staff from SWACH have taken the lead on developing a structure to help coordinate capacity-building efforts statewide to help providers

ACH Decisions/Strategies to Avoid Duplication and Promote Alignment		
Decision or Strategy Description	Objective	Brief description of outcome
<i>Collective Platforms: Emergency Department Information Exchange (EDie and PreManage)</i>	EDie and PreManage (aka Collective Platform) and coordinate for providers that cross ACH boundaries.	utilize the Collective Platform. A charter for a statewide learning community was drafted in late 2018 and shared with ACH executive directors in early 2019. Having a more formal structure and shared purpose will enhance the opportunities for ACHs and other partners to share best practices and create efficiencies whenever possible for Collective Medical technology implementation (an important HIT/HIE strategy.)

2. During the reporting period, how has the ACH engaged providers and community partners that are critical to success but had not yet agreed to participate in transformation activities (due to limited capacity, lack of awareness, etc.)? If the ACH has not engaged these providers during the reporting period, respond “Not applicable.”

ACH response: The past reporting period involved activities that will prepare NCACH to build bridges with partners that can contribute to the success of the overarching project objectives in 2019. The following is a sampling of efforts to contact and engage community partners that are not yet formally involved (funded) through current project and funds flow mechanisms. Also, please reference the response to Question F.3 because it is also relevant to this question.

- In December 2018, the NCACH Board of Directors approved allocation of funds for the CHIs. Although the CHIs were kept apprised of project planning, they had relatively little engagement with projects within the Medicaid Transformation Project or with project workgroups during 2018. In an effort to empower the CHIs to address regional health needs, the NCACH Board of Directors approved a \$450,000 funding allocation in 2019 for the three CHIs to invest in local health and wellness projects that reinforce the Medicaid Transformation Project. This funding is intended to strengthen community-clinical linkages, and would have limitations for partners that are already receiving NCACH funding for other Medicaid Transformation projects and initiatives. The NCACH Communications and Engagement Manager is in the process of forming a CHI Advisory Group with diverse representation from each coalition to design a community investment process.
- Most of the Medicaid Transformation Project performance metrics are

healthcare metrics, although two reflect the HCA's expectations for addressing social determinants of health specific to homelessness and arrests. Based on workgroup feedback, NCACH did not select any of the evidence-based approaches linked to transitions from jail or law enforcement-assisted diversion. However, regional data indicate underlying needs for individuals experiencing incarceration, and NCACH remains committed to engaging criminal justice partners. To that end, one NCACH project manager played an integral role in creating the North Central Community Partnership for Transition Solutions (CPTS), which officially formed in August 2018 (making North Central the 11th CPTS formation in Washington State). The purpose of the North Central CPTS is to convene various stakeholders who are committed to working together to support successful transitions and better coordinate services for people reentering communities after incarceration. NCACH and Okanogan County WorkSource have partnered to provide staff support to coordinate and facilitate this group. The NCACH has engaged many essential partners including K-12 education, community colleges, criminal justice, law enforcement, local elected officials, healthcare, behavioral health, drug court, workforce development, the Department of Social and Health Services' Division of Child Support, and others. NCACH is continuing to work to expand the network to engage these critical partners. This is an exciting opportunity that aligns with the NCACH Whole Person Health vision, while supporting the overarching objectives of NCACH's transitional care, diversion intervention, and opioid projects.

- Some of the opioid workgroup funding allocated for 2019 is helping in efforts to engage new partners. During the reporting period, NCACH staff began planning for the North Central WA Opioid Response Conference scheduled for March 15, where the theme will be prevention. This conference will be based on a Distributed Conference Model developed by the Washington State University extension program, which promotes remote participation and action planning across a large geographic region. NCACH staff want to increase the participation of school staff and students by holding the conference at different school sites. NCACH staff are also planning a four-hour Dental Opioid Prescribing Workshop during Spring 2019, following the format of the April 2018 Dental Pain Conference organized by the Bree Collaborative and the Washington State Department of Labor and Industries (L&I). NCACH staff are working with Bree Collaborative, L&I, and Washington State Dental Association staff to plan this training and offer continuing education credits. Dentists are an important contributor to opioid prescribing in the North Central region, but are not part of the network of partners to date.
- One of NCACH's project managers began participating in the North Central Recovery Coalition, a newly formed grassroots recovery coalition in the region. NCACH leaders plan to form a recovery committee of the Opioid Workgroup to help plan for utilization of the allocated workgroup funding to effectively support recovery efforts. To date, very few NCACH partners receiving opioid funding have been focused on recovery, and NCACH leaders would like to strengthen

these linkages in 2019.

3. Describe how the ACH supported active MCO participation to allow for MCO input and to send common signals to providers within the context of Medicaid Transformation, e.g., aligning performance expectations, VBP readiness support, billing and IT readiness support for FIMC, etc.

ACH response: MCOs continue to hold a seat on the NCACH Board of Directors, while sending representatives to participate in the WPCC, Opioid Workgroup, and Transitional Care and Diversion Intervention Workgroup. By having MCOs at the table along with providers, NCACH leaders are trying to promote transparency and avoid any mixed signals. During the reporting period, NCACH staff contacted all three MCOs to better understand how they would like to be involved in capacity-building efforts specific to Collective Medical technology platforms (EDie and PreManage) for purposes of improving transitions and care coordination, including providing more intentional follow-up care. Because MCOs offer connectivity to contracted providers at no subscription cost, NCACH leaders wanted to coordinate with them about training/technical assistance and preferences for which of the providers they would sponsor (if one provider has contracts with more than one MCO). NCACH staff engaged with MCOs on specific performance measures that showed opportunities for improvement in the North Central region. NCACH staff asked MCO representatives to share any asthma-related data to help inform a conversation with the WPCC about potential gaps in care. NCACH staff continue to coordinate with MCOs to access data or aggregate analyses that would pinpoint needs or gaps in the North Central region. NCACH staff anticipate connecting more with MCOs on the issue of VBP readiness support.

F. Community engagement and health equity

1. **Attestation:** The ACH has conducted communication, outreach and engagement activities to provide regular opportunities for community members to inform transformation activities during the reporting period.

Note: the IA and HCA reserve the right to request documentation in support of attestation.

Yes	No
X	

2. If the ACH checked “No” in item F.1, provide the rationale for not conducting communication, outreach and engagement activities to support community member input. If the ACH checked “Yes,” to item F.1 respond “Not applicable.”

ACH response: Not applicable

3. Provide three examples of the ACH's community engagement³ and health equity⁴ activities that occurred during the reporting period that reflect the ACH's priorities for health equity and community engagement.

ACH response: NCACH has continued to participate in several agency networking meetings, local groups, and coordinated efforts across the region to engage the broader community. In efforts to bring more awareness to grassroots groups and programs that promote health and wellness, NCACH began offering storytelling as a resource through a blog series in 2018. Called "Community Spotlights," the blog features local groups and programs that help to foster whole-person health. Since the inception of Community Spotlights, NCACH has published one to two blogs featuring local efforts every month. This has, in turn, increased community awareness and engagement with NCACH and the CHIs. For example, a blog published in September 2018 for a newly formed recovery coalition has been NCACH's most visited webpage to date.

In October 2018, the Chelan-Douglas CHI hosted an employment and transportation meeting. This meeting was developed based on input gathered from local agencies that reported their clients experienced difficulty getting to and from job interviews in the local community. The forum sparked a community-wide discussion about access to employment as a determinant of health, and led to "Chelan-Douglas Rides to Work: An Employment and Transportation Forum." This event was supported by NCACH staff, and has resulted in several subcommittees of the Chelan-Douglas CHI that are currently developing employment-related transportation solutions including a community fund that can be accessed for transportation needs, and a focus group that will help accurately capture the true need for employment-related transportation in the greater Chelan-Douglas area.

In September 2018, the NCACH hired a Capacity Development and Grant Manager (CDGM) to help build capacity through demystifying grant research, application, and administration for local community-based organizations to sustain or build pertinent programs centered on social determinants of health. This position was created as a response to regional feedback that community organizations want the NCACH to provide training and education on grant funding. Once hired, the CDGM began exploring community views on specific funding needs to better understand short-term and long-term needs for all social determinants of health, with a heavier focus on transportation and housing as the two most commonly community-identified needs in the NCACH's four-county region. These exploratory conversations have been a framework for assessing the state of current resource awareness (asset mapping) and current attitudes and processes for referrals as they relate to successes and challenges in community-clinical linkages. The goals of this project, some of which are in motion as of the date this report was written, are as follows:

³ Community engagement is defined as outreach to and collaboration with organizations or individuals, including Medicaid beneficiaries, which are not formally participating in project activities and are not receiving direct DSRIP funding but are important to the success of the ACH's projects.

⁴ Health equity is defined as reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.

- Collect meaningful data on gaps within the referral system through strategic conversations with key stakeholders across sectors (healthcare providers, referral agencies, patients/clients with firsthand experience being referred)
- Update and enhance current regional partner and service provider directories; increasing connectivity to resources and services through awareness of current inventory of (often unmarketed) resources
- Evaluate a variety of platforms specializing in closed-loop referrals that also have capacity to be a trusted self-referral service (i.e., act as a comprehensive resource map)
- Provide a summary of recommendations to NCACH leadership and governing board (e.g., contract with a vendor to implement in the region; fund platforms already used by the region, such as WIN211)

The CDGM position is currently focused on activities to attain a more comprehensive plan for community-clinical linkages, but this work will strongly support the position's future activities to assist community partners in funding programs to address barriers to health. These future activities will be to assist organizations in assessing their current capacity and future funding goals; hold grant writing and management trainings; help to facilitate coordination and collaboration between community entities; and convene a cohort of grant staff to provide capacity-building support within the region. This position's objectives are critical to the work of the Medicaid Transformation Project, as the NCACH is actively encouraging funded providers to employ social determinants of health screening tools and address them within internal protocols.

Overall, the CDGM's goal is to facilitate improved community connections (through the CHI and other convened groups within and outside the NCACH), increase awareness of organizational services offered, build capacity for smaller or unengaged community-based organizations to fund and administer their important community programs, and assist in developing a supportive environment for cross-sector collaboration. To this end, the CDGM is working internally and externally to improve funding processes through education, research, and technical assistance and through targeted outreach to entities that serve primarily underserved and/or marginalized populations to gather critical information on the scope of the need related to social determinants of health.

Moving into 2019, NCACH leaders believe that efforts to engage with non-funded partners are important to support with DSRIP funding. At the December 2018 Board meeting, the NCACH Board approved a new initiative to fund local and regional health and wellness projects in 2019. This funding is to be distributed through a community investment process developed with input from the three CHIs (Chelan-Douglas, Grant, and Okanogan).

G. Budget and funds flow

Note: HCA will provide ACHs with a semi-annual report workbook that will reflect earned incentives and expenditures through the Financial Executor Portal as of December 31, 2018.

1. Design Funds

Complete items outlined in tab 3.G.1 of the semi-annual report workbook.

2. Earned Project Incentives

Complete items outlined in tab 3.G.2 of the semi-annual report workbook.

3. Describe how the ACH's Health Systems and Community Capacity investments intend to achieve short-term goals and/or broader transformation goals. Potential investments could include VBP training/technical assistance and/or the acquisition/use of certified EHRs by behavioral health, long-term care providers, and/or correctional health providers. Provide at least three examples, including how providers benefited from these investments.

ACH response: Health system and capacity-building resources were invested in trainings for partners that gave them the expertise to continue process improvement efforts in the future, establishing a system to better coordinate care coordination (through the Pathways HUB), and helping providers utilize their resources to better exchange information across provider types. Below are three examples of how this was achieved in the North Central region during the reporting period:

1. ***Establishment of the WPCC Learning Community*** (Funding identified under Project Management Use Category in the Washington State Financial Executor Portal):

NCACH set up an online portal through CSI Solutions Inc. (healthcarecommunities.org) that allows WPCC Learning Community partners to access resources and trainings (local and national), share best practices, and communicate with colleagues in the region when their organization is having difficulty with a specific process improvement effort. NCACH also invested in national and regional expertise through the Centre for Collaboration, Motivation and Innovation; Qualis Health; Shift Consulting; and other consultants to engage providers in practice transformation. NCACH has shared VBP tools through the portal and offered integration learning activities to help teams think through new roles, functions, and processes that have workforce implications. These capacity-building efforts are designed to develop skills and expertise that will set providers up for success under value-based arrangements and allow their efforts to be sustained after Medicaid Transformation in North Central Washington.

2. ***Establishing a North Central Washington Pathways HUB*** (Funding identified under the Health Systems and Capacity Building Use Category in the

Washington State Financial Executor Portal):

NCACH dedicated a significant portion of its funds to develop a regional infrastructure to better coordinate care coordination through the Pathways HUB model and the Care Coordination Systems platform. NCACH identified a lead HUB entity (Community Choice dba Action Health Partners) to build the HUB platform in the region, recruit care coordination agencies, and train Pathways HUB care coordinators. Funding within this category supported three main aspects of the HUB system:

1. Infrastructure build of the Care Coordination System Platform
2. Support to pay for infrastructure cost of the HUB lead agency
3. Support to pay for initial cost of hiring and staffing care coordinators at each care coordination agency

NCACH and AHP have agreed that these initial infrastructure investments will slowly decrease during the course of the Medicaid Transformation Project as the HUB pursues other funding sources to sustain its services into the future.

3. *Integration of the Collective Medical platform in partner Electronic Health Record Systems* (Funding identified under the Provider Engagement Participation and Implementation Use Category in the Washington State Financial Executor Portal):

During the reporting period, NCACH focused health information exchange efforts on increasing partner utilization of the Collective Medical platforms (EDie and PreManage). Funding was disbursed to build capacity for partners to integrate the Collective Medical platforms with their electronic health records systems, and to develop workflows that will optimize this tool in their organizations for purposes of care coordination and transition planning. Building this health system capacity should positively affect patients as providers increase communication across care settings and share an understanding of the patient's long-term care plan.

4. If the ACH has elected to establish a community health fund or wellness fund, briefly describe the use or intended use of these funds to address social determinants of health and/or long-term health improvement strategies. Please describe how these strategies are linked to Medicaid Transformation goals.

ACH response: Not Applicable

Section 4: Provider roster (Project Incentives)

A. Completion/maintenance of partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts in partnership with the ACH (e.g., implementing Medicaid Transformation evidence-based approaches or promising practices and strategies).⁵

The provider roster will be a standard component of future semi-annual reporting, requiring ACHs to report any changes in partnering provider participation in transformation activities throughout the Medicaid Transformation. *Note: While the roster is a standard component, the requirements will evolve based on evaluation and assessment needs (e.g., provider participation at the clinic/site-level).*

ACHs are to include the list of providers in the Provider Roster tab of the semi-annual report workbook. ACHs are encouraged to use the initial provider list submitted in the first semi-annual report as a starting point and modify as needed.

1. In tab 4.A of the semi-annual report workbook, identify:
 - a. All active partnering providers participating in project activities.
 - b. Project participation by active partnering provider. Place an “X” in the appropriate project column(s).
 - c. Start/end of partnering provider engagement in transformation activities by indicating the quarter and year.

Complete item 4.A in the semi-annual report workbook.

2. Has the ACH established mechanisms to track partnering provider participation in transformation activities at the clinic/site-level? For example, does the ACH understand within each partnering provider organization which sites are participating? If not, please describe any barriers the ACH has identified related to tracking site-level participation, and how the ACH intends to overcome those barriers.

ACH response: For NCACH’s network of 17 outpatient providers (behavioral health and primary care), NCACH has built its reporting template to allow for site-level reporting. NCACH is allowing each organization to decide how to approach change management (e.g., testing all changes at one site before scaling, testing and reporting different changes across different sites). At this stage, NCACH does not have any formal mechanism for identifying specific sites within partnering provider organizations that are participating in change plan implementation. Change plan implementation has just begun and as NCACH employs whole-person-care practice facilitators (i.e., coaches) to assist providers and continue to do site visits, this information should become available. NCACH staff can also encourage providers to identify specific sites in their quarterly

⁵ Provider is defined as traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

narrative reports.

Section 5: Integrated managed care implementation (Integration Incentives)

A. Implementation of integrated managed care (mid-adopters only)

1. **Attestation:** The ACH region implemented integrated managed care as of January 1, 2019.

Note: the IA and HCA reserve the right to request documentation in support of milestone completion.

Yes	No
X	

2. If the ACH checked “No” in item A.1, provide the ACH’s rationale for not implementing integrated managed care in its region on January 1, 2019. If the ACH checked “Yes” in item A.1, respond “Not applicable.”

ACH response: Not Applicable

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