



Healthier Washington Medicaid Transformation
North Central Accountable Community of Health
Reporting period: January 1, 2019 - June 30, 2019
SAR 3.0

Semi-annual report submission and assessment timeline

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

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

Contact information

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

ACH contact information

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

ACH name:	North Central Accountable Community of Health
Primary contact name	John Schapman
Phone number	509-886-6425
E-mail address	john.schapman@cdhd.wa.gov
Secondary contact name	Linda Evans Parlette
Phone number	509-886-6438
E-mail address	linda.parlette@cdhd.wa.gov

Section 1. ACH organizational updates

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

Attestations

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

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

¹ <https://wahca.box.com/s/nfesjaldc5m1ye6a0bhiouu5xeme0h26>

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

Attachments

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

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

ACH Response: See Attachment – NCACH.SAR3.Attachment A.7.31.19

10. Budget/funds flow.

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

ACH Response: No additional information needed.

Documentation

The ACH should provide documentation that addresses the following:

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

ACH Response:

- Example 1: The Confederated Tribes of the Colville Reservation has become an active partner in NCACH's Opioid Project efforts during this last reporting period. The Tribe hosted a site in Nespelem during the Opioid Response Conference: Pathways to Prevention in March 2019. The Nespelem site drew more than twenty participants to the site who then developed opioid-focused community action plans. Following the conference, the Tribes entered a formal contract with NCACH to host opioid overdose response trainings and distribute Narcan (naloxone) overdose response kits for use. The opioid overdose response training is slated to occur in the second half of 2019.

- **Example 2:** One NCACH partnering provider, Coulee Medical Center (CMC), who serves many Colville tribal members, has also been an active member in our Opioid Project, Transitional Care and Diversion Intervention work (TCDI), and Whole Person Care Collaborative (WPCC) efforts. In March 2019, CMC met with the Colville Tribal Behavioral Health/Chemical Dependency programs as well as Nespelem Indian Health Services and instituted a direct referral process for referring eligible patients to Colville Tribal Behavioral Health/Chemical Dependency programs. Additionally, after successfully applying for Rapid Cycle Opioid Project funding, CMC used the funds to host an opioid use disorder treatment training for Colville’s IHCPs staff in April 2019

Looking ahead, NCACH plans to update strategic priorities regarding our tribal partners and relationships with IHCPs to create more inclusive pathways for IHCP and tribal community involvement in NCACH initiatives.

12. Design Fund Questions.

- Provide the ACH’s total Design Fund expenditures to date and an outline of how those funds have been used, by Use Category or other ACH-specific identifiers.

Earned Design Funds	Estimated Design Fund expenditures	Remaining Design Fund balance
\$6,000,000	\$2,111,411.98	\$3,888,588

Use Categories	Design Fund Expenditures	Expenditure details (narrative)
Administration	\$1,106,155	Administrative funds were utilized to pay for basic staffing and other expenditures that are not directly related to workgroups and their projects (HR, finance, rental space, insurance, etc.). Generally, these are items that are required to maintain and run an organization. Due to estimates, there may be some cross over with project management expenses.
Community Health Fund	\$-	NA
Health Systems and Community Capacity Building	\$224,029	These funds were utilized for initial consulting costs to establish the Pathways HUB, assisting with initial evaluation of regional data, and providing infrastructure support to enhance NCACH’s county-specific coalitions of stakeholders, the Coalitions for Health Improvement (CHI).
Integration Incentives	\$10,456	These funds were utilized to bring a contracting specialist to our region to hold a full day seminar to teach our behavioral health providers tips for when they start developing contracts with insurance companies.

Project Management	\$770,772	These funds were utilized to pay for staffing, contracted consultants, and general resources needed to manage project work of implementation partners throughout the 6 designated Medicaid Transformation Projects.
Provider Engagement, Participation, and Implementation	\$-	NA
Provider Performance and Quality Incentives	\$-	NA
Reserve/Contingency Fund	\$-	NA
Total	\$2,111,412	

- If the ACH has not expended the full amount of earned Design Funds, describe the planned use for these funds. ACHs may identify future expenditures by Use Category, or other ACH-specific identifiers.

ACH Response: NCACH is utilizing the remaining Design Funds to pay for expenses that are not partner or contractor specific and need to be paid through NCACH directly instead of through Public Consulting Group (Washington State Financial Executor). This includes project management staff cost (major expense), meeting expenses, travel, hosting services through Chelan-Douglas Health District, and community outreach. NCACH anticipates expending all Design Funds by the end of 2021. The Design Funds currently left in the bank account are expected to pay primarily for project management and administration with a small amount going to health systems and capacity building.

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

- The ACH’s current fund flow methodology and structure, including the decision-making process for the distribution of funds. Please note substantive changes within the attachments or describe within this section.

ACH Response: NCACH has not made any substantial changes to the funds flow and decision-making process since the implementation plan. All funds flow decisions are first reviewed at the organization’s workgroup level with input provided by key stakeholders and community members. This review includes the total funding organizations will receive and the type of work that the organization is responsible for completing to receive those funds. Based on that review, workgroups then provide recommendations to the Governing Board for final approval prior to NCACH distributing funding to partners. Revenue earned is pooled into a “global budget”. NCACH then utilizes the funds earned to distribute to partners that are focused on achieving the regional aims of the Transformation project (e.g., Integrated Managed Care, Opioid Prevention, Clinical Practice Transformation).

The largest change in the funding distribution during Quarter 1 and 2 of 2019 was the

development of Community Initiatives Funding. This funding is meant to be utilized for a broader range of NCACH partners (e.g., Community-Based Organizations) that will support the current goals of NCACH’s Implementation Plan. The funding is being developed and will be managed through a Community Initiatives Advisory Group. Funding will begin to be distributed by Quarter 4 of 2019.

In January 2019, NCACH started developing post-Transformation vision and goals. This process will help NCACH establish the organization’s priorities that extend beyond the Transformation. This discussion will impact the current financial modeling we have established as an organization to ensure we are aligned with our future goals. NCACH plans to start the financial modeling process in Quarter 3 of 2019. We will start the process by understanding how we can leverage the Transformation project with the future goals of the organization and the sustainability of NCACH.

- Decision-making process for incentives held in reserve (e.g., community funds, wellness funds, reserve funds) if applicable. Please note substantive changes within the attachments or describe within this section.

ACH Response: Not Applicable. NCACH has not allocated money to community funds, wellness funds, or other reserve funding at this time.

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

- Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.
- ACHs may use the table below or an alternative format as long as the required information is captured.
- Description of use should be a brief line item (not narrative).

Use of incentives to assist Medicaid behavioral health providers		
Use of incentives (narrative)*	Expenditures (\$)	
	Actual	Projected
Contract with Feldesman Tucker Leifer Fidell LLP to provide technical assistance and review of contracts for behavioral healthcare providers who do not have contracting experience with Managed Care Organizations.	\$35,275.00	\$55,000.00
IT technical support through Xpio to behavioral health providers who needed assistance in making adjustments to their medical record systems to bill Managed Care Organizations for services provided. <i>Note: Prior to integration in January 2018, approximately \$200,000 was spent on behavioral healthcare providers for technical assistance support by Xpio.</i>	\$23,146.66	\$42,700.00

Stage 1 funding through the Whole Person Care Collaborative (WPCC) to help behavioral health organizations develop a change plan. The change plans provide a road map for partnering providers to address bi-directional integration and contribute to all 6 Medicaid Transformation Projects selected by NCACH. Included in this funding was a Learning and Action Network where providers received assistance in developing components of their change plan.	\$557,500.00	\$557,500.00
Stage 2 Funding that will go to behavioral healthcare providers for participating in the Whole Person Care Learning Community from 2019 - 2021 and completing the deliverables outlined as part of being a Learning Community member. This funding will support the continued progression of tactics outlined in the behavioral healthcare providers' change plans.	\$270,000.00	\$1,897,500.00
Advising and cost of learning activities provided by consultants who support the Whole Person Care Collaborative. This work will help both behavioral healthcare providers and physical health providers move closer to bi-directional integration. The projected cost accounts for what would be the behavioral healthcare providers' share of this work if split evenly across organizations. However, the contractor is paid directly from NCACH.	\$137,846.00	\$ 780,000.00
Contract with the UW AIMS center to help emphasize the behavioral health component of bi-directional integration. This contract was through 2018 but could be extended in the future (which would include additional costs).	\$27,564.00	\$48,000.00
Funding may go to WPCC providers such as Rural Health Clinics and Federally Qualified Health Centers to help expand the behavioral healthcare services they provide in the region. Funding may also go to behavioral healthcare providers to help in the training of workforce and enhancing information exchange between providers (i.e. PreManage). Exact dollar amounts are currently not determined.	\$-	\$2,424,449.00
<i>Total</i>	\$1,051,332	\$5,840,149

Section 2. Project implementation status update

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

Attachments

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

15. Implementation work plan

Implementation plans are “living documents” that outline key work steps and plans to be conducted within the time frame of the Medicaid Transformation. The ACH's implementation plan (work plan) is a key resource that allows HCA to understand how the ACH is moving

forward and tracking progress. These plans provide HCA with the information required to monitor the ACH activities and project implementation timelines.

The ACH must submit an **updated implementation plan** reflecting *progress made during the reporting period*.²

- The updated implementation plan must clearly indicate progress made during the reporting period. The ACH may decide how to indicate progress, so long as it allows for the IA to review and understand implementation progress, specifically:
 - Work steps and their status.
 - At minimum, work steps should be updated as either in progress, completed, or not started. The ACH may provide a work step status legend that defines and indicates the different work step statuses defined by the ACH. Recommended work step status options include:
 - Completed, Deliverable Met: The work step deliverable has been completed. The ACH is able to provide supporting documentation regarding the completion of the deliverable upon request.
 - Fulfilled for Quarter, Remains in Progress: Actions were taken toward achieving the work step deliverable, but the deliverable has a target end date in the future. The ACH is able to provide supporting documentation regarding activities fulfilled in the quarter upon request.
 - Delayed, Remains in Progress: Work step deliverable is past due. Work step was scheduled to be complete, but the ACH is still working towards completion.
 - Not Started: Work step has not been started.
 - The ACH is to add a “Work Step Status” column to the work plan between the “Work Step” column and the “Timing” column. This column should reflect the status assigned to the work step.
 - The ACH is to assign a status for each work step provided in the implementation plan work plan. This applies to work steps that have yet to be started.
- If the ACH has made minor changes for any work step from their originally submitted work plan, the ACH is to indicate this change through highlighting/asterisks for each applicable work step/milestone.
- If the ACH has made substantial changes to the work plan format used in the October 2018 submission, the IA may request an opportunity to discuss the format with the ACH to provide an orientation to the changes. All required elements of the work plan must be preserved.

² Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan. Semi-annual reporting guidance
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ACH Response: See Attachment – NCACH.SAR3.Attachment B.7.31.19

16. Partnering provider roster

ACHs are to maintain a partnering provider roster as part of semi-annual reporting. The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.³ ACHs are to indicate partnering providers that are taking action on the ground to implement tactics and/or making substantive changes or enhancements to care processes to further local, regional and state progress towards the following Project Toolkit objectives per the STCs:⁴

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

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

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

A high-level overview of the process:

- To facilitate the process, the state will generate an initial list of potential sites (“potential site list”), based on ACH SAR 2.0 partnering provider roster submission.
- HCA will provide the expanded list of potential partnering provider sites (“potential site list”) to ACHs no later than **April 15, 2019**.
- ACHs will review the ACH-specific “potential site list” to identify the sites that are participating, and add identifying information as available (e.g., addresses for partners that are not successfully matched with state administrative data systems).
- For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
 - Whether the partnering provider site is pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Place an “X” in the appropriate project column(s).
 - When the partnering provider site starts and ends engagement in transformation

³ Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are traditionally reimbursed by Medicaid; non-traditional Medicaid providers are not traditionally reimbursed by Medicaid.

⁴ <https://www.hca.wa.gov/assets/program/Medicaid-demonstration-terms-conditions.pdf>

activities according to project area by indicating the quarter and year.

ACH Response: See Attachment – NCACH.SAR3.Attachment C.7.31.19

Documentation

The ACH should provide documentation that addresses the following:

17. Quality improvement strategy update

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

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

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

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

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

ACH Response: See Attachment – NCACH.SAR3.Attachment D.7.31.19

Narrative responses.

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

18. General implementation update

- *Description of partnering provider progress in adoption of policies, procedures and/or protocols.* Implementation of transformation approaches require the development or adoption of new policies, procedures and/or protocols to define and document the steps

required. Partnering providers may be in varying stages of completing this process, depending on selected transformation approach and the organization.

- Provide a summary of partnering provider progress in the adoption or adaptation of policies, procedures and/or protocols to date. How do ACHs know that successful adoption occurred?

ACH Response:

Summary of Provider Progress: NCACH has tracked partnering provider progress in the adoption or adaptation of policies, procedures, and/or protocols through the reporting processes developed by NCACH workgroups.

For Partners participating in the WPCC, the latest iteration of the quarterly report demonstrated that organizations have developed policies, procedures and/or protocols as they pertain to Opioid prescribing, co-location of a primary care provider in a behavioral health clinic, development of a County-wide opioid treatment network, adoption of a new EHR with the development of new workflows, and giving EHR access to a behavioral health organization to facilitate shared care planning and referrals.

The Pathways Community HUB lead agency has developed and adopted the Action Health Partners Pathways Community HUB General Operations Policies and Procedures Manual. This includes policies and procedures, documentation protocols, HUB Monitoring and Quality Improvement protocols, HUB operations, and contracts and forms. The Manual was reviewed and approved by the Pathways Community HUB Advisory Board and adopted by the HUB before launching the HUB on Oct. 1, 2018.

Organizations participating in the Transitional Care and Diversion Intervention (TCDI) workgroup received formal training in the transitional care management and Emergency Department Diversion processes from January – April 2019. This included onsite training at Confluence Health for our regional Transitional Care Management process, online trainings from Collective Medical Technology in the Emergency Department Information Exchange (EDie) platform, and Certified Ambulance Documentation Training for Emergency Medical Service providers. After formal training, organizations participated in Quality Improvement training. Every quarter, each partner is required to document the current status of implementation of the policies and procedures in submitted reports to the NCACH. To date, each partner has established basic procedure and protocols in their work. As partners continue to engage in the quality improvement process, partners will continue to identify small changes that need to be made.

Finally, NCACH has provided funding for Rapid Cycle Opioid Awards. This is intended to provide seed money to organizations to launch initiatives to address the opioid epidemic through prevention, treatment, overdose prevention, and recovery. Two Rapid Cycle Opioid Applications, described below, have proposed to develop regional policies. Lake Chelan Community Hospital applied for funding to develop a protocol to equip Basic Life Support first responders with intranasal naloxone. After

developing the protocol it was then adopted by 17 EMS agencies in Chelan and Douglas Counties who were then trained on and equipped with intranasal naloxone. The North Central Educational Services District (NCESD) is currently funded to support the development of a policy for schools to have Narcan available on-site. Once developed, the NCESD will provide technical assistance to implement the policy within schools. Through this approach, we are promoting a consistent protocol across partners.

Successful Implementation of Policies, Procedures, and Protocols:

NCACH does not directly go into an organization to audit that they have correct policies and procedures in place. Instead, NCACH monitors successful adoption of policies through the following mechanisms:

- Asking partners to provide updates through their regular reporting process on the implementation of policies and procedures by asking them to attest to implementation status and asking them narrative questions on the successes and challenges to implementation. This reporting process could be monthly, quarterly, or semi-annually based on the specific project. This is meant to give NCACH a window into the work that is being done and identify any areas where we may support them to ultimately be successful in their projects.
 - Utilizing Practice Facilitators to work directly with organizations that need assistance in quality improvement, measure definition, or any other clinical work associated with the Transformation Project.
 - Asking partners to share policies and procedures with other partners throughout the course of the year either (1) at regularly scheduled meetings of the workgroup or (2) during trainings organized by NCACH.
 - Requiring WPCC partners to submit annual change plans with quarterly reports that lay out a long-term plan with AIM statements and drivers and tactics (how they are going to accomplish the AIM). Quarterly reports also act as an update for the NCACH, serving to outline the change status for all secondary drivers listed in an organization's change plan.
 - For the Pathways HUB, NCACH assures that successful adoption is occurring through various communication gateways including HUB Advisory Board meetings, regular staff check-ins with the HUB staff, MOU deliverables, and contracting with the Center for Community Health and Evaluation (CCHE) to conduct a rapid assessment of Pathways Community HUB implementation.
- Are there examples of partnering providers sharing policies, procedures and/or protocols? If so, describe.

ACH Response: North Central Accountable Community of Health has established a number of mechanisms for partnering providers to share the processes they are going through within their respective organizations. Examples of this include the following:

- Incorporating time within regularly scheduled workgroup meetings for partners to provide project updates and discuss specific topics/processes that

cross all partners. The intent of these presentations is to share information, exchange ideas, and foster collaboration.

- Developing trainings specific to quality improvement and process development in which partners can actively participate. These include quality improvement trainings, Learning and Action Networks, and affinity groups (as outlined below).
 - Through the WPCC Affinity groups, learning activities and practice facilitators, we have developed a system of transparency and sharing. To date, we have connected two medical directors who wanted to learn the other's staffing models and workflows. One organization spoke about implementation of a new EHR and a second organization noted they are currently using the same system and would be willing to help. Through that connection, the second organization learned the 1st organization was hosting group visits successfully, thus igniting another conversation and shared learning opportunity. Finally, during our bidirectional learning activity led by the UW AIMS Center, behavioral health organizations learned different approaches to incorporate physical health into a behavioral health setting. Due to the success of a new workflow and process for risk stratification, one behavioral health organization was able to present with Dr. Kern at the June Behavioral Health Conference in Vancouver.
 - Our practice facilitators noted that several organizations are utilizing Centricity EHR, but only one of them is able to successfully extract data. The practice facilitators are in the process of forming an affinity group to allow the five organizations to come together to share and learn from each other.
 - The Policies and Procedures developed by the Action Health Partners (AHP) were intended to be both internal policies for AHP staff as well as policies for Care Coordination Agencies to utilize and therefore be consistent across Care Coordination Agencies. Additionally, AHP has shared protocols between the Health Homes Program and the Pathways Community HUB when appropriate. For example, the Pathways Community HUB needed to develop a due diligence policy. Health Homes had a tried and tested due diligence policy that was able to easily be adapted for the Pathways Community HUB program.
- Describe any challenges faced by partnering providers in the adoption of policies, procedures, and or protocols for selected transformation approaches. How did the ACH support partnering providers to overcome challenges to adoption?

ACH Response:

- One challenge in NCACH is the ability of our partners to create policies, procedures, and protocols around bidirectional integration due to the

workforce shortage (e.g., behavioral health professionals) and the difficulty to recruit to the rural areas. There is workflows partners would like to implement if they could get the correct staff to complete the work.

- The high turnover rate of quality improvement staff, or the lack of an established quality improvement team, makes it difficult for rural clinics to have a well-established process for updating policies and procedures and documenting them in a format that is easy to manage. NCACH has been working with organizations through our practice facilitators to help establish small quality improvement teams at each organization to help facilitate this process.
 - Developing and implementing a complete set of policies and procedures for a new program such as the Pathways Community HUB can be very daunting. NCACH supported AHP in developing and adopting these procedures by contracting with Foundation for Healthy Generations, Pathways Community HUB Institute, and Care Coordination Systems to provide technical assistance in developing and implementing the policies and procedures for the newly formed Pathways Community HUB.
 - Some harm reduction methods that address the opioid epidemic (e.g., syringe exchange programs) still have mixed reviews within certain communities, therefore, developing and adopting policies can be difficult when an agency has to take into consideration influence outside of best practices. NCACH has been working with organizations to help educate partners across the region about these policies and procedures so people can make an informed decision about what is best for their community.
- Describe the key challenges or risks identified in implementing selected transformation strategies, including potential impacts and mitigation strategies for specific transformation project areas or Domain I strategies. Include impacts across projects as well as within a specific project area.

ACH Response: The challenges associated with project implementation are strongly influenced by Domain I Strategies. For this section, NCACH has chosen to highlight the challenge around Domain 1 strategies as they related to the whole project portfolio and individual projects.

HIT/HIE Challenges and Strategies:

- **Challenges:** There are several organizations within our region who find it difficult or too costly to extract data from their EHR system. A few organizations are pulling data manually to fulfill the NCACH reporting requirements. Others have stated that they have spoken with their vendor and the cost to produce a report is impractical. Specific to information exchange: barriers continue to exist (e.g., disparate landscape of EHRs, IT capacity) and the state's vision and timelines around HIE are unclear. ACHs are currently trying to coordinate strategy, but it is difficult to figure out where/how we can contribute as an ACH within our limited budget, capacity, and timelines. Barriers to information exchange existed before MTP, and they continue to undermine underlying MTP goals around whole person care and care coordination.

On top of these two issues, variable reporting requirements from each MCO to partners are continuing to burden organizations that contract with multiple entities. Finally, specific to the Pathways Community Hub Model, though the Washington State Duals Health Home Model is recognized as a Medicaid Provider Program, the Pathways Community HUB is only considered a project and therefore not eligible to access vital data and supports that will allow strategic alignment for optimal success.

- **Mitigation strategies:** To assist these organizations in their EHR system issues, NCACH has contracted with Comagine to provide EHR technical expertise to organizations who are struggling. We have also deployed practice facilitators to help navigate the challenges and connect organizations with each other to share in successes and challenges. On top of the technical expertise in EHRs, NCACH continues to work with partners to develop formal linkages between behavioral health and primary care organizations that enable them to share data to improve referral processes and access to care. A lot of this success has been realized because the NCACH created a system that allows 17 primary care and behavioral health agencies to interact and learn from each other through various monthly meetings, ad hoc linkages, and formal learning activities that promote transparency. Finally, NCACH is partnering with Collective Medical Technology to utilize their pre-established platform to help partners develop a certain level of health information exchange between acute care and outpatient providers and across outpatient providers.

Workforce Challenges and Strategies:

- **Challenges:** It is well known that there is a behavioral health professional workforce shortage, especially in rural communities. This is exacerbated by the fact that there is no funding for recovery coach positions and that SUD peer counselor training currently does not exist. As well, NCACH has identified a lack of Chemical Dependency Professionals (CDP) as a major issue in the region. NCACH staff conducted an assessment in 2018 focused on CDP barriers to employment. The results showed low wages, lack of awareness and access to educational programs as the two highest barriers to expanding the CDP workforce. Above behavioral health professional workforce shortages, quality improvement continues to be an issue as higher turnover rates in rural positions makes it difficult to sustain QI changes. The Pathways Community HUB has struggled to identify a consistent, cost-efficient training program for the Community Health Workers for Care Coordination Agencies.
- **Mitigation Strategies:** NCACH recognizes there continues to be workforce issues that it still needs to address. To alleviate provider shortages, some organizations are contracting with other organizations to provide telehealth, however, this effort brings mixed reviews from local providers and patients. The main success NCACH has recognized in the region is identifying the opportunity to support the CDP Workforce pipeline by allocating funding to the development of a CDP Apprenticeship. We are working with and following the model developed by the Washington Association for

Community Health for the Medical Assistant and Dental Assistant apprenticeships. AHP is exploring many options to be able to provide the necessary training in a cost-effective manner, however, consistency across the state may suffer as each HUB finds their own alternative solution.

VBP Challenges and Strategies:

- **Challenges:** A number of smaller partners struggle with determining what the change in reimbursement means for their organization (e.g., VBP and Multi-payer model). This is further exacerbated by the fact that payment is different for RHC, FQHC and the changes to clinical structures to address the whole person does not address the unique reimbursement structures of those organizations. Therefore, organizations do not have a clear picture of how they will move into VBP contracting and what will be expected of them from MCOs. Specific to the Pathways HUB, contract negotiations with MCOs is limited due to funding restrictions created by HCA/Medicaid contracting rules restricting use of per member per month (PMPM) to pay for either of the current community-based care coordination models recognized in our state. As well, the HUB program evaluation timing will make it difficult to show value in time to attract payers prior to end of MTP. Since longer-term outcomes (cost and utilization) are dependent on the All-Payer Claims Database APCD, and there is a significant lag time in the APCD data, we won't have those evaluation results until 2022 or 2023.
- **Mitigation Strategies:** NCACH continues to provide training and facilitation in practice transformation to local partners to ensure their organizations are set up for value-based care. This includes trainings in empanelment and working with partners to better learn how they can utilize data for quality improvement efforts. On top of that, to help partners make sense of the current state of value-based care and the Rural Multi Payer Model, NCACH had HCA staff come to North Central Washington on April 1st, 2019 to present on the two models and allow providers to ask questions on how those models relate to their organization. NCACH and AHP are working with potential payers to identify shorter-term outcomes as a proxy for longer-term outcomes while we are waiting on the evaluation results.

19. Regional integrated managed care implementation update

- **For 2019 adopters,** list the date in which the ACH region implemented, or will implement, integrated managed care.

ACH Response: Okanogan County implemented integrated managed care on January 1, 2019. Chelan, Douglas, and Grant Counties implemented integrated managed care on January 1, 2018.

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

ACH Response: Okanogan County had only one Spokane Behavioral Health Organization contracted provider, Okanogan Behavioral Healthcare (OBHC). Okanogan County had relatively few and minor challenges through the implementation of integrated managed care. Despite this, NCACH made available a number of supports to Okanogan County Providers. These included the Early Warning System, technical assistance from Xpio Health, and technical assistance from Feldesman Tucker Leifer Fidell LLP.

- *Early Warning System:* NCACH facilitated a monthly Early Warning System call with Okanogan County providers, Health Care Authority (HCA), Managed Care Organizations (MCOs), and the Behavioral Health – Administrative Service Organization (BH-ASO). These started in February 2019 and will conclude in July 2019. These calls have proven useful for individuals to connect on some issues, though overall, the data that has been reported and reviewed has not raised any concerns.
 - *Technical Assistance from Xpio Health:* In preparation for integrated managed care, OBHC completed the self-assessment tool provided in the Billing and Information Technology Toolkit for Behavioral Health Providers by Qualis (Comagine) Health, Washington Department of Health, and Healthier Washington. NCACH contracted with Xpio Health to provide IT technical assistance to OBHC both prior to integration and for several months after integration. OBHC was well positioned for integration and used only a small fraction of the resources allocated to them since they simply did not need the support.
 - *Technical assistance from Feldesman Tucker Leifer Fidell LLP:* As a follow-up to a managed care contracting, a one-day training was facilitated by Adam Falcone of Feldesman Tucker Leifer Fidell LLP in 2018. NCACH also provided consulting support through Feldesman Tucker Leifer Fidell LLP to review basic contract templates that behavioral health partners had with MCOs. Okanogan Behavioral Healthcare fully utilized this resource.
- For **2020 adopters**, briefly describe progress made during the reporting period on the development and participation in the region’s early warning system, communications workgroup, and provider readiness/technical assistance workgroup.
 - For **2020 adopters**, briefly describe behavioral health provider readiness and/or technical assistance needs (financial and/or non-financial) the ACH has identified as it pertains to integrated managed care. What steps has the ACH taken to address these needs?

Attestations.

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

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

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

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

Documentation.

21. P4R Metrics (updated May 2019)

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

Related resources and guidance:

- For important points to consider when collecting and reporting P4R metric information, refer to the following resource: [How to read metric specification sheets.](#)
- Full P4R metric specifications are available on the [Medicaid Transformation metrics](#) webpage, under *ACH pay for reporting metrics.*
- P4R metric responses are gathered at the site-level. Each P4R metric is specified for response at the level of the practice/clinic site or community-based organization. Practice/clinic sites are defined as sites that provide physical and behavioral health services paid by Medicaid. Community-based organizations and other providers are defined as any participating sites that are not Medicaid-paid providers.

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

- It is HCA’s expectation that ACHs will facilitate participation of practice/clinic sites and CBOs, and strive for as much participation as possible of practice/clinic sites and CBOs. HCA has not set a specific minimum response rate. However, the state would like the ACH to summarize the number of respondents by provider type for each reporting period.

Instructions:

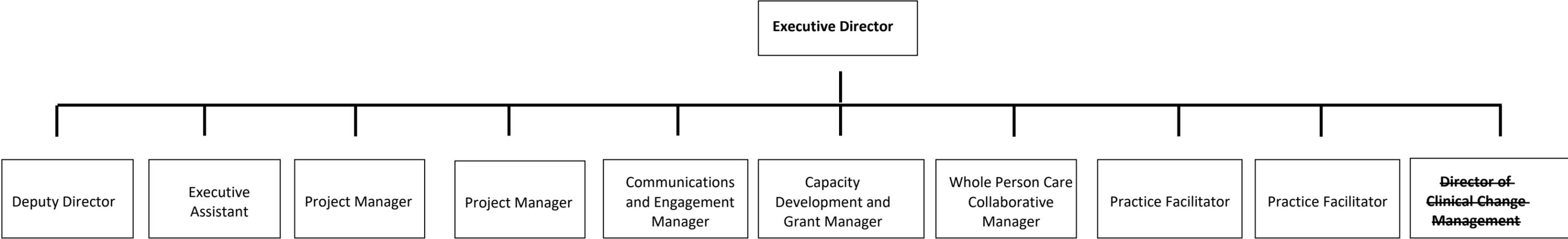
- Submit aggregate summary of P4R metric responses collected from partnering provider sites (e.g., count of sites that selected each response option).
- Provide a summary of respondents overall, by Project (2A/3A), and stratified by site-level provider characteristics as specified in the [reporting template](#).

Format:

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

ACH Response: See Attachment – NCACH.SAR3.Attachment E.7.31.19

NCACH Staff Organizational Chart (Updated 6.30.2019)



Staff Positions Breakdown			
Position	FTE	Staff Member	Duties by FTE
Executive Director	1.0 FTE	Linda Parlette	1.0 FTE: Overall oversight of the organization including communicating with Statewide partners
Deputy Director	1.0 FTE	John Schapman	0.5 FTE: Oversight/Lead of Transformation Projects and general operations 0.5 FTE: Lead of Transitional Care (2C) and Diversion Intervention (2D) Projects
Executive Assistant	1.0 FTE	Teresa Davis	1.0 FTE: Supports Executive Director and NCACH staff on general administrative functions and meeting prep
Project Manager	1.0 FTE	Caroline Tillier	0.5 FTE: Data collection, analysis, and reporting for Transformation Project 0.5 FTE: Quality Improvement Strategy lead; Health Information Exchange staff lead
Project Manager	1.0 FTE	Christal Eshelman	0.1 FTE: Lead of Integrated Managed Care work 0.2 FTE: Lead of Community Care Coordination Project (2B) 0.5 FTE: Lead of Addressing the Opioid Public Health Crisis Project (3A) 0.2 FTE: Workforce development and other emerging community initiatives
Communications and Engagement Manager	1.0 FTE	Sahara Suval	0.5 FTE: Oversight/lead of community outreach including CHI and Tribal relations 0.5 FTE: Lead of organization wide communications (i.e. webpage, branding, marketing materials)
Capacity Development and Engagement Manager	1.0 FTE	Tanya Gleason	1.0 FTE: Lead staff on engaging and helping community organizations focused on transportation and housing obtain and capitalize on external funding. Provides support on any work of the Transformation Project associated with regional Social Determinants of Health.
Whole Person Care Collaborative Manager	1.0 FTE	Wendy Brzezny	1.0 FTE: Lead of the Whole Person Care Collaborative which provides the primary care and behavioral health provider engagement in the Transformation Project (2A, 2B, 2C, 2D, 3A, and 3D).
Practice Facilitator	1.0 FTE	Open Mariah Brown	1.0 FTE: Support each stage of practice transformation in a clinical setting from design to implementation to spread of best practices.
Practice Facilitator	1.0 FTE	Open Heather Smith	1.0 FTE: Support each stage of practice transformation in a clinical setting from design to implementation to spread of best practices.
Director of Clinical Change Management	Hourly	Peter Morgan	Hourly: Provides additional support to the Whole Person Care Collaborative which provides the primary care and behavioral health provider engagement in the Transformation Project.



North Central Accountable Community of Health

ACH Earned Incentives and Expenditures

January 1, 2019 - June 30, 2019

Source: Financial Executor Portal

Prepared by: Health Care Authority¹

Funds Earned by ACH During Reporting Period²		
2A: Bi-directional Integration of Physical and Behavioural Health through Care Transformation	\$	1,915,443.00
2B: Community-Based Care Coordination	\$	1,316,866.00
2C: Transitional Care	\$	778,148.00
2D: Diversion Interventions	\$	778,148.00
3A: Addressing the Opioid Use Public Health Crisis	\$	239,430.00
3B: Reproductive and Maternal/Child Health	\$	-
3C: Access to Oral Health Services	\$	-
3D: Chronic Disease Prevention and Control	\$	478,861.00
Integration Incentives	\$	323,114.00
Value-Based Payment (VBP) Incentives	\$	300,000.00
IHCP-Specific Projects	\$	-
Bonus Pool/High Performance Pool	\$	-
Total Funds Earned	\$	6,130,010.00

Funds Distributed by ACH During Reporting Period, by Use Category³		
Administration	\$	-
Community Health Fund	\$	-
Health Systems and Community Capacity Building	\$	376,128.90
Integration Incentives	\$	7,850.00
Project Management	\$	193,137.06
Provider Engagement, Participation and Implementation	\$	216,881.74
Provider Performance and Quality Incentives	\$	592,500.00
Reserve / Contingency Fund	\$	-
Shared Domain 1 Incentives	\$	913,327.00
Total	\$	2,299,824.70

Funds Distributed by ACH During Reporting Period, by Provider Type³		
ACH	\$	-
Non-Traditional Provider	\$	544,731.78
Traditional Medicaid Provider	\$	841,765.92
Tribal Provider (Tribe)	\$	-
Tribal Provider (UIHP)	\$	-
Shared Domain 1 Provider	\$	913,327.00
Total Funds Distributed During Reporting Period	\$	2,299,824.70

Total Funds Earned During Reporting Period	\$	6,130,010.00
Total Funds Distributed During Reporting Period	\$	2,299,824.70

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

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

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

³ Definitions for [Use Categories and Provider Types](#)

ACH : North Central Accountable Community of Health
Contact Name/Email : John Schapman

Date of Request : 3.14.19

Transaction #	Date	Payment Amount	Provider Name	Original Use Category	Updated Use Category
838	2018/06/26 02:00 PM	4,666.00 \$	CSI Solutions LLC	Project Management	Health Systems and Community Capacity Building
1105	2018/07/24 02:01 PM	43,760.00 \$	Centre for Comprehensive Motivational Interventions Society	Project Management	Health Systems and Community Capacity Building
1178	2018/08/06 05:31 PM	4,666.00 \$	CSI Solutions LLC	Project Management	Health Systems and Community Capacity Building
1265	2018/08/21 02:00 PM	4,666.00 \$	CSI Solutions LLC	Project Management	Health Systems and Community Capacity Building
1267	2018/08/21 02:00 PM	21,880.00 \$	Centre for Comprehensive Motivational Interventions Society	Project Management	Health Systems and Community Capacity Building
1328	2018/09/17 05:00 PM	8,082.00 \$	CSI Solutions LLC	Project Management	Health Systems and Community Capacity Building
1358	2018/10/02 02:00 PM	13,782.00 \$	* University of Washington	Project Management	Health Systems and Community Capacity Building
1359	2018/10/02 02:00 PM	8,082.00 \$	CSI Solutions LLC	Project Management	Health Systems and Community Capacity Building
1493	2018/10/16 02:01 PM	4,666.00 \$	CSI Solutions LLC	Project Management	Health Systems and Community Capacity Building
1494	2018/10/16 02:01 PM	2,650.00 \$	Shift Consulting LLC	Project Management	Health Systems and Community Capacity Building
1668	2018/11/13 03:01 PM	8,591.11 \$	Shift Consulting LLC	Project Management	Health Systems and Community Capacity Building
1674	2018/11/13 03:01 PM	4,666.00 \$	CSI Solutions LLC	Project Management	Health Systems and Community Capacity Building
2388	2018/12/25 03:01 PM	121,695.00 \$	Centre for Comprehensive Motivational Interventions Society	Project Management	Health Systems and Community Capacity Building
2392	2018/12/25 03:01 PM	4,666.00 \$	CSI Solutions LLC	Project Management	Health Systems and Community Capacity Building
2397	2018/12/25 03:01 PM	2,450.00 \$	Shift Consulting LLC	Project Management	Health Systems and Community Capacity Building
2400	2018/12/25 03:01 PM	13,782.00 \$	* University of Washington	Project Management	Health Systems and Community Capacity Building

Brief description¹ (optional): After reviewing some of the payments we had made to partners providing contracted support to our outpatient behavioral health and primary care providers. We determined they were better classified as providing services that enhance health Systems and community Capacity Building vs. providing project management support since the work they did was to help partners improve the capacity in their individual clinics.

The Accountable Community of Health (ACH) understands that this workbook will be attached to the Semi Annual Report and serves as the record for use category modifications.
 The ACH certifies that this information is complete and accurate.

YES	NO
x	

ACH Signature of Authority²

Date

¹ Note: HCA and the Financial Executor reserves the right to request additional information or documentation associated with this attestation or the associated modification request

² Accountable Community of Health Signature Authority is defined as the Accountable Communities of Health Executive Director (or equivalent).

Submit completed forms to HCA's Medicaid Transformation inbox MedicaidTransformation@hca.wa.gov