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, also include their information.

ACH name:	North Central Accountable Community of Health
Primary contact name **Phone number** **E-mail address**	John Schapman, Deputy Director 509-886-6435 John.schapman@cdhd.wa.gov
Secondary contact name **Phone number** **E-mail address**	Linda Evans Parlette, Executive Director 509-886-6438 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: • 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.

    See attachment: NCACH.SAR4.Attachment A.1.31.20

10. **Budget/funds flow.** ***Not Applicable.***

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

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

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: The Colville Confederated Tribes (CCT) is the only tribal and Indian Health Care Provider in our region. During this reporting period, NCACH staff partnered with Public Safety staff from the CCT as part of the NCACH funding they received for Narcan training and distribution. In October, NCACH staff offered two train-the-trainer sessions in Nespelem in order to build the tribe's internal capacity to continuously train staff on Narcan. One session targeted law enforcement staff and the other included representatives from EMS, Public Safety, Corrections, and Peacemaker Circle staff. A total of 12 staff were trained as trainers.

During an in-person meeting with Colville Tribes Health & Human Services leadership in early August, NCACH staff began discussing a partnership to support the formation of a regional data-driven committee. Since then, NCACH helped coordinate and facilitate two in-person meetings in Nespelem (October and November). The purpose of these meetings is to explore what tribal public health/behavioral health data is tracked across the region's many partners, with a focus on overdose and suicide data. The goal is to draw on this data to inform action and improve care coordination between partners in the region. These efforts are continuing into 2020. Engaged partners include hospital, behavioral health, tribal health, public safety, and public health representatives in the region. Some of NCACH's currently-funded partners are participating, including Coulee Medical Center and Grant Integrated Services.

These and other partnerships were shared with the Tribal Council during an update by NCACH staff to the Colville Tribes Health & Human Service Committee in mid-November.

12. Design Funds.

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

Earned Design Funds	Estimated Design Fund expenditures	Remaining Design Fund balance	Percent remaining Design Fund balance
$6,000,000	**$2,730,683**	**$3,269,317**	**54%**

NCACH is utilizing the remaining Design Funds to pay for expenses that are not project specific and need to be paid through NCACH directly, instead of through Public Consulting Group (Washington State Financial Executor). This includes project management staff costs (major expense), expenses for workgroup meetings, travel, and communications/community outreach by NCACH staff. Any remaining Design Funds will be converted into contingency/reserve funding. NCACH currently anticipates spending Design Funds primarily for project management and administration over the course of the Medicaid Transformation Project.

Use Categories	Design Fund Expenditures	Expenditure details (narrative)
Administration	$1,188,270	Administrative funds are being utilized to pay for basic staffing and other expenditures that are not directly related to workgroups and their projects (Human Resources, 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.
Community Health Fund	$-	NA
Health Systems and Community Capacity Building	$224,029	These funds were utilized to pay for initial consulting for establishing the Pathways Community HUB, to assist with initial evaluation of regional data and providing infrastructure support to enhance our region's local Coalitions for Health Improvement (County-specific coalitions of stakeholders).
Integration Incentives	$10,456	These funds were utilized to bring a contracting specialist to our region to hold a full day seminar teaching NCACH behavioral health providers tips for when they start developing contracts with insurance companies.
Project Management	$1,307,929	These funds are being utilized to pay for staffing, contracted consultants unable to be paid out of the Financial Executor Portal, and general resources needed to manage project work of implementation partners throughout NCACH's 6 designated Medicaid Transformation Projects.
Provider Engagement, Participation and Implementation	$-	NA

Provider Performance and Quality Incentives	$-	NA
Reserve/Contingency Fund	$-	NA
Shared Domain 1 Incentives	$-	NA
Other (describe below):	$-	NA
Total	**$2,730,683**	

*Use Categories were developed in conjunction with the Financial Executor Portal. Categories and definitions did not exist at the time of Design Fund distribution to ACHs. It is likely that ACHs may have used similar, but not the same, Use Categories to identify Design Fund expenditures.

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

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 the second quarter of 2022. 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. **Incentives to support integrated managed care.** Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support behavioral health providers transitioning to integrated managed care.

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

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

c) Description of use should be specific but concise.

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

Use of incentives to assist Medicaid behavioral health providers		
Use of incentives (narrative)*	**Expenditures ($)**	
	Actual	**Projected**
A contract with Feldesman Tucker Leifer Fidell LLP provides technical assistance and review of contracts for behavioral healthcare providers who do not have contracting experience with Managed Care Organizations (MCOs).	**$35,275.00**	**$75,275.00**

A contract with Xpio provides IT technical support to behavioral health providers who needed assistance in making adjustments to their medical record systems to bill MCOs for services provided. Prior to integration in January 2018, approximately $200,000 was spent on behavioral healthcare providers for technical assistance support by Xpio.	**$23,146.66**	**$23,147.00**
A contract with the UW AIMS center provides assistance on how to emphasize the behavioral health component of bi-directional integration. This contract was through 2018 but could be extended in the future (and would include additional costs.)	**$41,346.00**	**$41,346.00**
Stage 1 funding through the Whole Person Care Collaborative (WPCC) helped 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 will go to behavioral healthcare providers for participating in the Whole Person Care Learning Community from 2019 - 2021 and after completing deliverables outlined for Learning Community members. This funding will support the continued progression of tactics outlined in the behavioral healthcare providers' change plans.	**$495,000.00**	**$1,897,500.00**
This allocation is for project management costs for consultants who support the WPCC, helping both behavioral healthcare providers and physical health providers move closer to bi-directional integration as well as whole person care. 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.	**$246,485.29**	**$780,000.00**
Total	**$1,398,753**	**$3,374,493**

Integrated Managed Care funding is also being utilized to support outpatient providers' clinical process improvement efforts to address whole person health as well as partnerships with community behavioral health providers to collectively achieve the goals of bi-directional integration. The above chart demonstrates the funding that behavioral health providers received or costs incurred contracting with agencies as part of the WPCC. NCACH is also working on partnerships with CCT which may include partnering with their behavioral health departments on initiatives such as bi-directional integration. As those efforts are developed, funding allocations will be reflected in the above chart.

Section 2. Project implementation status update

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

Attachments

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

14. Implementation work plan

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

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

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

   i. Work steps and their status.

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

         - Completed, Deliverable Met: The work step deliverable has been completed. The ACH is able to provide supporting documentation regarding the completion of the deliverable upon request.
         - Fulfilled for Quarter, Remains in Progress: Actions were taken toward achieving the work step deliverable, but the deliverable has a target end date in the future. The ACH is able to provide supporting documentation regarding activities fulfilled in the quarter upon request.
         - Delayed, Remains in Progress: Work step deliverable is past due. Work step was scheduled to be complete, but the ACH is still working towards completion.
         - Not Started: Work step has not been started.

      2. The ACH is to assign a status for each work step provided in the implementation plan work plan. This applies to work steps that have yet to be started.

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

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

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

See attachment: NCACH.SAR4.Attachment B.1.31.20 (excel file)

15. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.[3] To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

Instructions:

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

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

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

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

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

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

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

See attachment: NCACH.SAR4.Attachment C.1.31.20 (excel file)

Documentation

[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.

The ACH should provide documentation that addresses the following:

16. Quality improvement strategy update

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

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

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

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

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

NCACH Response: Quality improvement strategy update

As described in NCACH's Quality Improvement Strategy (QIS), NCACH structured and tailored its QIS framework differently for specific types of funded partners, given their unique contributions to our project portfolio. Our goal across the board is to promote continuous learning and improvement. There have been no modifications to our strategy. The following are quality improvement efforts and findings from this reporting period by type of funded partner.

Whole Person Care Collaborative: All 17 primary and behavioral health care providers submit quarterly narrative and measure reports, typically at the end of each quarter (note: the due date for quarter 4 reports was extended to January, given the holiday break.) NCACH's two Practice Facilitators review reports for completion, identify areas where partners may need additional support, and celebrate successes. At the July 2019 WPCC meeting, NCACH and its contracted Improvement Advisor shared an Improvement Progress Snapshot based on quarter 1 data. The presentation included quantitative and qualitative summaries of our partners' progress with testing and implementing changes across the 8 sections of their change plans. This presentation, including dashboard screenshots of run charts and key themes (both successes and challenges), can be found at (pp.24-40): http://www.mydocvault.us/uploads/7/5/8/6/7586208/7.1.19._wpcc_meeting_packet_for_website.pdf.

Summary findings include:

- Strengthened improvement processes
- More organized teams, processes, and systems
- Increased collaboration and sharing within and across sites
- Better systems for gathering and processing information and data
- Comprehensive care and services growing

Lessons learned from these reports reiterate that staffing, turnover, and electronic medical record (EMR) transitions continue to limit our providers' capacity to progress as fast as they would like. In other words, juggling competing priorities with limited resources continues to be a challenge. In addition, issues with EMR accuracy and completeness, accurate code, and the lack of health information exchange prevent partners from getting the right data and sharing the right information.

In the spirit of NCACH's own continuous improvement, NCACH also sought feedback from partnering providers about what is working well and what could work better in the monthly WPCC leadership meetings. One of the lessons learned from this feedback was that partners want more time allocated to peer sharing during these meetings. This feedback has been built into our meeting plan for 2020.

Transitional Care and Diversion Intervention Workgroup: As mentioned in our QIS, hospital and EMS partners have different QI expectations. Hospitals submit measure reporting on a quarterly basis and a narrative report semi-annually. Findings and lessons learned from the EMS and hospital reports were shared during the July workgroup meetings. For detailed summaries, reference:

> http://www.mydocvault.us/uploads/7/5/8/6/7586208/governing_board_hospital_update_final.pdf
>
> http://www.mydocvault.us/uploads/7/5/8/6/7586208/governing_board_ems_update_final.pdf

NCACH has built in shared learning and peer updates into TCDI Workgroup meetings. For example, in September, Lake Chelan Community Hospital and Coulee Medical Center shared updates about their current implementation efforts. To ensure we are providing the right support to our partners for continuous improvement, NCACH also distributed a survey to collect partner feedback regarding what activities were most beneficial and areas where they might need more support. This shaped TCDI workplans and trainings for 2020. EMS partners submit a quarterly report consisting of short narratives and measures. In the spirit of NCACH's own continuous improvement, NCACH met with a few EMS partners in July to streamline NCACH's reporting template to address concerns expressed by partners.

Opioid Workgroup: Partners receiving rapid-cycle opioid funds are required to submit a mid-point and final narrative report as well as share a verbal update to the Opioid Workgroup. Final reports from the first and second round of Rapid Cycle Opioid Funding were due January 2019 and July 2019, respectively. NCACH also signed Memorandums of Understanding (MOU) with five organizations who successfully applied for a third round of rapid cycle funding (project period July 2019-June 2020), as well as MOUs with three organizations who successfully applied for school-based prevention funding. Their mid-point reports and deliverables were due at the end of December. As part of the verbal reporting requirements for funded partners, Coulee Medical Center, Washington 2-1-1, and Three Rivers Hospital shared updates about

progress and impact at the August Opioid Workgroup meeting. For details regarding progress, findings, and lessons learned, please review the August presentation slides located at http://www.mydocvault.us/regional-opioid-stakeholders-workgroup.html. One of the school-based prevention awardees shared assessment results, as well as plans for 2020-21, at the November Opioid Workgroup meeting.

Pathways HUB: NCACH staff continue to hold bi-weekly check-ins by phone and quarterly in-person meetings with Action Health Partners (AHP), the community-based organization coordinating the implementation of the Pathways HUB across our region. AHP staff provide monthly updates to the NCACH Governing Board, including status updates and program metrics (e.g. total clients referred, assigned, enrolled, and total pathways initiated.) Based on these conversations and reports, NCACH is aware that implementation of the Pathways HUB has been slower than anticipated. In order to understand challenges and identify potential solutions, NCACH engaged the Center for Community Health and Evaluation (CCHE) to complete a formative evaluation drawing on stakeholder interviews. This report was completed at the end of November, and CCHE presented report findings to NCACH's Governing Board at their December meeting. The evaluation report, which includes a summary of successes, challenges and recommendations, can be found in the meeting packet (pp. 19-22) here: http://www.mydocvault.us/uploads/7/5/8/6/7586208/12.02.19_gb_meeting_packet.pdf. In response to the report, the HUB subcommittee of AHP staff, Board members, and NCACH staff met in mid-December to discuss potential adjustments. This will be a major focus at the NCACH Governing Board retreat in January 2020.

Coalitions for Health Improvement: During this reporting period, Coalitions for Health Improvement (CHIs) embarked on their own efforts to prioritize and allocate a total of $450,000 in NCACH funding for health-related projects through a community investment process. After a rigorous and competitive application process (sixty-three letters of intent were submitted totaling $3.75 million in requests), five of the thirty-two small project applications were funded (application requests for more than $25,000 are still under review.) Much like other funded partners, the five funded partners will be required to submit quarterly narrative reports including a mid-term and final report. Each partner was asked to outline project metrics, which will be included in the final report. Narrative reports are designed to surface lessons learned and barriers so that NCACH may support partners as needed. Given the smaller funding amounts, however, the reporting templates for small projects are concise in order to minimize any reporting burden on partners. Funded partners will also be required to provide a verbal report to one of the local CHIs and during a partner meeting of their choosing. Verbal reports are designed to increase peer sharing and strengthen relationships between our network of providers. Since funded projects are beginning in 2020, NCACH does not yet have any findings, lessons learned, or adjustments to share.

Narrative responses

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

17. General implementation update

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

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

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

   ACH Response: NCACH offers a variety of trainings and technical assistance across the different projects. These trainings may be organized by the NCACH or the NCACH will link the organization with an agency that can provide the training/technical assistance as appropriate. For example, as members of the Whole Person Care Collaborative (WPCC) address opioid use disorder (OUD), one organization requested a training for their nursing staff who work with providers who provide medication assisted therapy (MAT). The NCACH staff linked this organization with the UW AIMS center who offered a 2-hour training on the challenges and stigma of OUD and the nurse's role in MAT. This training provided a foundation for the organization to build their OUD program by defining roles and responsibilities for the team members, develop workflows, and create an environment where patients feel safe to pursue OUD treatment.

   Additionally, the WPCC organized a learning and action network (LAN) to address team-based care as organizations move away from the traditional hierarchy of medicine to a collective approach. This LAN addressed team culture, team communication, psychological safety, change fatigue and improvement, multi-generational work teams, and complex systems and teams. Over the course of 3.5 months, clinical teams met for 1.5 hours every 3-4 weeks to discuss each topic. A subject-matter expert shared evidence and models for each topic followed by conversations. Teams were then tasked with homework that addressed each topic and the application within their individual environments and the culture that the topic encompasses. For both of these examples, it requires a culture change within the environment. While some progress has been made not everyone has adopted the approach. NCACH continues to move toward Patient-Centered Medical Home (PCMH) principles and the current population health LAN will continue to promote evidenced-based guidelines for team-based care and chronic disease management.

   For Hospital partners, NCACH focused on Transitional Care Management follow-up with patients 24 – 48 hours after discharge. Initially, partners went through a 2-3-day training to educate organizations on how to develop workflows for transitional care management and train staff to provide the service. During early 2019, partners identified a need for additional technical assistance on coding and billing for these services to insurance companies. On July 30th, NCACH partnered with Confluence Health to offer a Coding and Billing webinar to all participants. This webinar was then posted on our online portal for partners to access anytime for future trainings. Additional technical assistance was provided by Confluence upon request.

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

   ACH Response: This reporting period, NCACH continued to partner with Collective Medical Technologies to build and expand the network of providers exchanging information across our region through Collective Medical. This is an important health information tool to promote coordination of care and follow-up for complex patients who are at risk for ending up in the emergency department or hospital. Training activities targeted behavioral health and primary care providers involved in the Whole Person Care Collaborative. NCACH coordinated and offered two optional webinars and engaged Collective Medical staff as faculty. These webinars focused on practical nuts and bolts (workflows and functionalities) to help those not yet up and running make a more informed decision about whether this platform is the right fit given their capacity and goals. For those currently using the platform, the webinars offered tips on how to be strategic and optimize the platform. The webinars were also designed to help providers understand the difference between EDie and the unique outpatient interface (which has been a point of confusion.) Support and ongoing training for this tool will be required over the next two years, as providers are at various stages of readiness. The webinars were recorded and made available through our portal for future viewing.

   Some of our clinical partners have also given read-only EHR access to other healthcare systems where they have shared patients. This strategy was already in place in the North Central region, but NCACH's work with partners on expanding a Transitional Care Management (TCM) model has increased this type of information access. While not a true HIE, this short-term solution to the disparate EHRs employed by various sites (hospitals, emergency departments, and outpatient clinics) increases information exchange in order to improve transitional care management (including greater coordination around follow-up calls.)

   ACH Executive Directors are collaborating to develop an ACH Health IT Strategy comprised of a vision for health IT in Washington, goals and recommendations, and near-, mid-, and long-term ACH activities. The ACHs collectively developed and agreed upon the following vision for health IT in Washington:

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

   To achieve this vision, the ACHs are working to identify a set of initial goals and recommended activities that support each goal. ACHs will discuss the goals and recommendations with stakeholders and determine how each fit with the ACHs' priorities, projects, and roadmaps, and adding relevant activities to their plans for 2020 and beyond. The ACHs are also identifying best practices to be shared and potentially scaled among ACHs and developing individual action plans for

accomplishing priority recommendations. Later in 2020, the ACHs plan to begin implementing their action plans.

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

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

   ACH Response: NCACH's Transitional Care and Diversion Intervention project created a process for each of its implementation partner's project plans for partners to coordinate services with community-based organizations and receive funding to help support project plans in 2019. This process allowed each acute care provider to identify a social determinant of health need in their community and identify the most appropriate community partner to help fulfill that need.

   Hospital partners focused on identifying patients that transitioned out of their organization (via Emergency Department or inpatient) that needed additional supports/services to ensure they received appropriate follow-up care. A specific example of this is the partnership between Columbia Basin Hospital and People for People (a local transport agency). Columbia Basin Hospital identified those patients who had follow-up and specialty appointments in neighboring communities (e.g. Moses Lake, which is 20 miles away), but lacked adequate transportation to make it to those appointments. They partnered with People for People to schedule and reimburse transportation for those patients with the goal of reducing ED utilization and readmission.

   Emergency Medical Service (EMS) organizations agencies were required to develop a treat and refer program with a community partner to identify non-emergent patients and refer them to low-acuity services. For example, Aero Methow Rescue Services instituted a treat and refer protocol that identified non-acute patients and coordinated their care with their primary care provider (PCP), behavioral health, other appropriate social service, and/or Methow Valley-specific service purveyors such as Lookout Coalition, Room One, Guardian Angels, Methow at Home, and other social and spiritual groups. Each agency (clinical and community-based) contributes to patients' care plans to ensure the patient receives the appropriate services to keep them out of the emergency department.

   In addition to the work being done with hospital and EMS partners through the Transitional Care and Diversion Interventions projects, the Pathways Community HUB provides care coordination for a select population. The selected target population for the HUB is three or more ED visits in the past 12 months. Samaritan Healthcare is a current referral partner, referring patients that qualify directly to the HUB for targeted outreach and engagement. Patients that enroll receive comprehensive community-based care coordination. The HUB has contracted with both clinical and community-based partners to provide care

coordination for both clinical and social determinant of health needs (all pathways are available).

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

   ACH Response: As mentioned in our Quality Improvement Strategy update above, NCACH engaged the Center for Community Health and Evaluation (CCHE) to complete a rapid-cycle formative evaluation to understand implementation challenges and identify potential solutions to the Pathways HUB's slower than expected expansion.

   NCACH also engaged CCHE to complete a rapid-cycle evaluation to help identify ways of strengthening the three Coalitions for Health Improvement (CHI) in the NCACH region. While CHIs have had some successes, the overall impact to-date has been limited. CCHE conducted an online survey of all CHI members first, and interviewed selected members of each CHI. The final evaluation report was shared with the CHI leadership council in December 2019 and will be shared with the Governing Board in February 2020. The goal is to draw on the results and recommendations to strengthen CHI functioning going forward, and to promote their sustainability beyond the MTP.

   In addition to the measure dashboards in the WPCC portal that monitor performance, NCACH is building quarterly improvement summaries into the WPCC meeting calendars. The goal is to share these 2 months after the end of each quarter. For a sample quality improvement presentation, see (pp.63-76): http://www.mydocvault.us/uploads/7/5/8/6/7586208/12.02.19_gb_meeting_packet.pdf. These are designed to help partners understand the collective progress and challenges across the NCACH region.

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

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

      NCACH Response: Stage 2 funding for the Whole Person Care Learning Community is divided into two parts. The first part is fixed funding intended to compensate organizations for the time, effort and resources necessary to implement their change plans, which includes bi-directional integration, participation in both monthly meetings and annual symposium, and conduct MeHAF and PCMH assessments. This fixed funding is set based on their annual number of Medicaid encounters. The second part is a variable component paid to each organization when they participate in learning activities, in which participation is voluntary. Several organizations have utilized the funding to modify their physical environment, hire staff, or purchase/upgrade EHRs to support integrated care.

   2. Project 2B: Provide information related the following:

a. Schedule of initial implementation for each Pathway.

NCACH Response: (*Note that in attachments related to project 2B, Care Coordinators and Pathways Community Specialists (PCS) are used interchangeably).* All pathways were implemented at the launch of the Pathways Community HUB on October 1,2018, as shown in the table below:

Pathway	Date of implementation (actual or anticipated)	Notes (optional)
Adult education	October 1, 2018	
Employment	October 1, 2018	
Health insurance	October 1, 2018	
Housing	October 1, 2018	
Medical home	October 1, 2018	
Medical referral	October 1, 2018	
Medication assessment	October 1, 2018	
Medication management	October 1, 2018	
Smoking cessation	October 1, 2018	
Social service referral	October 1, 2018	
Behavioral referral	October 1, 2018	
Developmental screening	October 1, 2018	
Developmental referral	October 1, 2018	
Education	October 1, 2018	
Family planning	October 1, 2018	
Immunization referral	October 1, 2018	
Lead screening	October 1, 2018	
Pregnancy	October 1, 2018	
Postpartum	October 1, 2018	

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

NCACH Response: NCACH has opted to contract out the implementation of the Pathways Community HUB rather than to implement this project itself. Since the intent is to build an independent self-sustaining HUB, NCACH distributes all Project 2B funding to the HUB lead agency, AHP, based on their progress in establishing a self-sustaining HUB. In turn, AHP contracts with care coordination agencies and referral partners to build the network of providers that make up the Pathways Community HUB. The following is a list of funded partners and their role in Project 2B.

Agency	**Role in Pathways Community HUB**
Action Health Partners	Lead Agency
Moses Lake Community Health Center	Care Coordination Agency and Referral Partner
Rural Resources	Care Coordination Agency
Grant Integrated Services	Care Coordination Agency
Samaritan Healthcare	Referral Partner

The above listed Care Coordination Agencies and Referral Partners are all located in Moses Lake. AHP is currently working to expand HUB services to

Chelan, Douglas, and Okanogan Counties, which will add additional Care Coordination Agencies and Referral Partners.

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

CCA Name	Total # of Referrals to CCA for any Pathway
Grant Integrated Services	277
Moses Lake Community Health Center	409
Rural Resources	388

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

NCACH Response: AHP is utilizing the Care Coordination Systems (CCS) platform to collect and monitor performance data. AHP monitors the following metrics monthly:

- Enrollment rates
- Pathways initiated
- Pathways closed, incomplete
- Pathways closed, complete
- Pathways 2X benchmark (pathways that have been open for more than 2 times the average length of time to complete)
- Time from initial assignment to outreach
- Compliance with a due diligence process
- Compliance with an opt-out process

AHP holds monthly meetings with the Care Coordinators and their supervisors to review these reports, make quality improvement plans, and share best practices.

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

NCACH Response: Initially, AHP experienced a high staff turnover rate due to difficulty finding qualified support staff. Barriers and gaps for AHP in hiring and retaining staff included:

- High staff turnover has resulted in the inability to maintain the preferred FTE staffing needed for the program
- Challenges finding employees with appropriate skill sets for support staff (client data management, data processing, critical thinking, etc.)
- Affordable IT expertise
- Not enough upper level management staffing, therefore many of the critical business skills have to be contracted out at higher costs

Currently, AHP's HUB program staff is stable. At this time there are zero vacant positions within AHP, increasing their capacity to work with prospective Care Coordination Agencies who will need to hire Care Coordinators as they engage with the program.

f. Describe the training plan for community health workers, and the number trained. What is the feedback loop for the identification and offering of continuing education training and development? What evaluation and assessment does the ACH conduct, if any, post-training to determine if trained individuals have increased skills, competencies, or performance? How does the ACH use such information or other feedback to determine trainings to provide either to individuals or groups, what trainings to require as mandatory versus individual goals-based, and key partners to include in offering trainings.

NCACH Response:
Training Plan and Number Trained: The following individuals have been trained:

- 10 HUB operations staff
- 3 Care Coordinator Supervisors
- 5 Care Coordinators

To date, AHP has utilized the CCS Care Coordinator and Supervisor Training. While this training meets national certification standards there are several barriers to continued use of this training platform:

1. The training is cost prohibitive for sustainability
2. In an independent evaluation, the "training was not viewed as valuable by the Care Coordinators interviewed. Particular weaknesses were in training around Community Health Worker skills and providing workflows for [care coordinator] activities."
3. The AHP Care Coordination Network Director was trained to be a CHW Medical trainer for CCS but this process has not moved forward due difficult contracting requirements causing issues and constraints.

AHP is in the process of developing their own training curriculum that can be utilized on demand and will not be as costly. To make this happen, AHP is working with a cross-ACH collaborative group consisting of other ACHs and AHP. These meetings occur twice per month to collaborate and discuss training, curriculum, quality assurance, and other challenges or processes to standardize. This has been both a significant success and a significant barrier. Collaboration and standardization led to a strong training plan, however, it has required a significant investment of AHP's time and resources to collaborate across ACHs.

Currently, AHP's plan moving forward for Care Coordinator training is:

1. All Care Coordinators and Supervisors will be required to attend and complete the DOH CHW training and online modules.
2. A two-day training will be provided by AHP staff to onboard and provide activation training.
3. Initial oversight of practice will be conducted by a Supervisor from another organization or AHP staff.

The first training under this new protocol is scheduled for February 2020 for a new Care Coordinator and Supervisor at an existing Care Coordination Agency called Rural Resources.

Continuing Education Training and Development: AHP staff provide continuing education training and development through education, information, and subject matter experts during the Care Coordinator/Supervisor monthly meetings. Topics have included successful outreach techniques and proper documentation. There is a continued need to streamline training. AHP is looking into developing and curating online/webinar trainings (e.g. CPR) for Care Coordinators and Supervisors. This could be created for either a single HUB or as a statewide resource to share across HUBs. To date, startup and onboarding training challenges have taken priority over this.

Post-Training Assessment and Evaluation: AHP currently reviews enrollment rates and performs chart audits to help guide Care Coordinators in practice. AHP is currently evaluating other ways to assess/evaluate Care Coordinators' work within the HUB and provide real time feedback. In addition, NCACH performed an independent evaluation of the HUB implementation, which included assessing the training and support Care Coordinators receive.

Utilizing Feedback to Determine Trainings: Care Coordinators and Supervisors are encouraged to give feedback regarding the HUB and the work they do during the monthly Care Coordinator/Supervisor meetings or directly to HUB staff at any time. AHP has utilized the results of the independent evaluation to inform their newly-revised training plan. With the exception of the introductory training, additional trainings are currently mandated by the Care Coordination Agency rather than the HUB. AHP is working on developing a list of additional trainings that would be helpful to both Care Coordinators and Supervisors as a starting place for in-services, webinars, and trainings. NCACH is working with AHP to explore providing Chronic Disease Self-Management trainings and train-the-trainer opportunities for Care Coordination Agencies along with our primary care and behavioral health partners.

g. Describe technology enabled care coordination tools being used, and how information being captured by care coordinators is integrated with clinical information captured through the statewide health information exchange.

NCACH Response: CCS is the platform being used to document information and collect data. Due to other regional contracts/programs within AHP, including the requirements as an HCA-contracted MCO, the AHP team is required to review all HUB referrals for potential Health Homes enrollment. This requires access to both AHP data and Provider One data.

Other care coordination technology tools are available but have not been accessible or approved for AHP use to date. For example, AHP is unable to access Provider One for Pathways HUB program purposes as a non-clinical provider, however AHP has access to Provider One for use with their Health

Homes program only. AHP has encountered barriers in executing data-sharing agreements that result in bi-directional closed-loop referral/data exchanged between SDOH and clinical partners (made possible by Application Program Interface (API) building) due to cost and contractor time constraints.

h. Include two examples of checklists or related documents developed for care coordinators.

NCACH Response: AHP has created a number of checklists and related documents for care coordinators. A non-exhaustive list is below:

- Supervisors Training – How to review Pathways/Checklist/Tools and Sign off: Document showing the Supervisors how to create a Signing Identity in the CCS system to review documents, notes, and tools completed by the Care Coordinator and sign off on work done. ***See NCACH.SAR4.Attachment D.1.31.20.***

- Pathways Pregnancy Tracking Guide – Enrollment Checklist: Checklist or Guide to help the Supervisor and Care Coordinators know what to do with a pregnant patient in the program from enrollment through delivery of the newborn and what status to assign the patient throughout the process. **See NCACH.SAR4.Attachment E.1.31.20.**

- Client Discharge: a document created to explain the process for discharge of a client with clearly-identified steps for the Care Coordinator, Supervisor, and HUB staff. See **NCACH.SAR4.Attachment F.1.31.20.**

- Education Pathway How-to Guide: A PowerPoint presentation that explains to Supervisors and Care Coordinators how to use the Education Pathway and what educational materials are appropriate to use. **See NCACH.SAR4.Attachment G.1.31.20.**

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

   Not Applicable. NCACH received approval to remove implementation of POLST forms

4. Project 3A: Provide two examples of the following:

   a. Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recover supports.

NCACH Response: The NCACH Opioid Workgroup endorsed a comprehensive 2019 Opioid Project Plan to support prevention, treatment, overdose prevention, and recovery efforts. Strategies included:

- Rapid Cycle Opioid Applications – Awards of up to $10,000 are available to organizations to implement small-scale rapid cycle projects that are shovel ready. These funds are flexible but must be used to address the core components described above. Examples of successful Rapid Cycle Opioid Applications include: Naloxone distribution from the Emergency Department for those presenting with Opioid Overdose or Opioid Use Disorder installing medication lock boxes in public housing, implementation of school-based prevention curriculum, placing a medication take back box in a community that did not have one, and supporting a syringe exchange program. In total, 28 Rapid Cycle Awards have been given to date and projects have addressed all of the core components.
- North Central Opioid Response Conference – Utilizing the Distributed Conference Model developed by Washington State University Extension, NCACH brought together 325 local leaders across 10 sites in North Central Washington (NCW) to address the opioid epidemic in their local communities, with a focus on prevention strategies. All 10 sites were connected via technology to watch two outstanding keynote presentations that kicked off the conference. Following those presentations, participants at each site took part in a facilitated discussion to identify local opioid response assets and gaps and to create a local community action plan. Thirteen Community Action Plans were developed, identifying local champions and project teams to carry the work forward. Several Community Action Plans have since secured funding for implementation.
- Dissemination of Dental Prescribing Guidelines – NCACH hosted an Evidence-based Dental Pain Care Workshop to train dental providers and staff on new opioid prescribing guidelines and rules. All participants received 4 hours of free dental continuing education. Approximately 75 local dentists and staff attended this workshop.
- Increase Awareness of Opioid Use and Addiction & Reduce Stigma – expanding on a 2018 Opioid Rapid Cycle Award, NCACH worked with a local partner to bring increased awareness to opioid use in our region.
- School-based prevention – Also expanding on a 2018 Opioid Rapid Cycle Award, NCACH worked with partners to develop a comprehensive assessment of school-based prevention activities at each of the school districts in our region. This was essential since as NCACH began to explore ways to support school-based prevention, it became apparent that there was limited understanding of what prevention activities were already happening and in which schools. Building off the assessment, the partners developed a 2020-21 School-Based Prevention Project Plan. Additional funds are being invested in 2020-21 to implement these project plans.

- Whole Person Care Collaborative Addressing the Opioid Use Crisis Change Plan Section – NCACH Primary Care and Behavioral Health providers participating in the Whole Person Care Collaborative are required to write, update, and report on a change plan that addresses all of NCACH project areas including Project 3A. Within this change plan, partners are encouraged to ensure providers are trained on evidence-based opioid prescribing guidelines as well as increase access to Medication Assisted Treatment (MAT). During this reporting period, organizations have developed new policies on Suboxone therapy and opioid prescribing. The NCACH region has increased the number of sites at which patients can receive MAT services and two organizations have reported a decrease in their overall opioid prescriptions.
- Naloxone Training and Distribution – NCACH has made funding available to partners to be able to train and distribute Narcan to individuals and organizations at risk of witnessing an overdose. This funding has been utilized by an Opioid Treatment Network (a MAT network in the NCACH region), emergency department, tribal partner, behavioral health partner, recovery advocacy group, and others.
- Recovery Initiatives and Events – This strategy was informed through conversations with the Central Washington Recovery Coalition. NCACH sponsored 17 individuals with lived experience to attend a Recovery Coach Academy training and a Recovery Coach Train-the-Trainer training in Wenatchee. In addition, NCACH supports recovery awareness events in the region and has commissioned 6 short "Stories of Recovery" videos to raise awareness about opioid use and recovery supports.

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

NCACH Response: NCACH staff monitor the 2016 Washington State Interagency Opioid Working Plan for updates. With each update, staff reconcile the updated plan with the previous version to identify any changes to the plan. If changes occur, staff ensure that current NCACH strategies remain in alignment with the State Plan. All strategies that NCACH is currently implementing are in alignment with the most current Washington State Interagency Opioid Working Plan.

NCACH staff are always monitoring for new clinical guidelines that are released. Clinical guidelines are shared with our partners through the Whole Person Care Collaborative Portal and via our monthly Opioid Workgroup Update email.

c. A description of existing local partnerships the ACH has convened or leveraged to implement strategies under this project, including a summary of the structure, frequency of meeting, and confirmation that the partnership includes all required individuals and entities (e.g., consumer representatives,

community-based service providers, and law enforcement). Describe any successes and challenges with identification of partnership leaders and champions.

NCACH Response: NCACH convenes a Regional Opioid Stakeholders Workgroup. This Workgroup formed in the fall of 2017 with the purpose of informing and monitoring Project 3A of the Medicaid Transformation Project. At the time, several local opioid stakeholder groups were meeting. NCACH was cognizant not to dampen or hinder the work of the local groups, however, it was essential to create a Regional Workgroup since there were no current groups meeting who covered all four counties that NCACH serves. Since the creation of the Regional Opioid Workgroup, some of the local stakeholder groups have joined with our Regional Opioid Workgroup (for various reasons including retirement of facilitators and lack of dedicated facilitators). NCACH works to ensure broad representation within the Workgroup as much as possible. This is difficult for some stakeholders such as consumers and the justice system who often have unavoidable conflicts during the day. Knowing these are integral partners in any opioid response plan, NCACH staff make it a priority to attend other meetings where these partners are already gathering. These include the Central Washington Recovery Coalition and the North Central Community Partnership for Transition Solutions. Through these groups, NCACH staff have been very successful at engaging community members, especially those with lived experience and those working within the justice system.

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

NCACH Response: NCACH has identified two critical gaps in recovery support services in our region: 1) Chemical Dependency Professionals (CDP) and 2) Peer Supports. To address these gaps, NCACH is doing the following:

- Chemical Dependency Professional – NCACH partnered with the Washington Association for Community Health to develop a CDP Apprenticeship Program. This statewide program will pair online learning with on-the-job training. This format has the potential to be a game changer for CDP training, especially in rural areas where it is difficult to fill a cohort of students (e.g. Okanogan County) or areas lacking a college with this field of study (e.g. Moses Lake). This approach will increase the number of trained CDPs as well increase access to services in more remote locations.
- Peer Supports – NCACH hosted a Recovery Coach Academy Training along with a Train-the-Trainer course. The course was integral to our mission of building capacity within our region. Each of the newly trained trainers has committed to providing a minimum of one training within the first year after receiving their certification. Now that there are more trained Recovery Coaches in the region, NCACH is planning to also provide a Certified Peer Counselor (CPC) Bridge training in the NCACH region to allow trained Recovery Coaches to become CPCs through an

abridged version of the CPC training. This is essential in order for our providers to be able to take advantage of the newly reimbursable Substance Use Disorder CPC services. This approach will increase the number of certified Recovery Coaches and CPCs as well as increase the number of locations offering these services.

5. Project 3C: Provide the following: ***Not Applicable. NCACH did not select this project in its Transformation Project Portfolio.***

a. A summary of mechanisms established for coordinating care with related community-based services and supports, as well as referral relationships that have been established with dentists and other specialists, such as ENTs and periodontists.

b. Two examples of workflows developed to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed.

c. A summary of methods used to engage with payers in discussion of payment approaches to support access to oral health services. If applicable, indicate payment approaches that have been agreed upon.

6. Project 3D: Provide the following:

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

NCACH Response: When the NCACH developed the framework for its change plan, chronic care management was interwoven into the drivers for chronic disease management. As the WPCC Learning Community continue to implement their change plans, several organizations have developed sophisticated programs. For example, as Catholic Charities integrated aspects of physical health within their setting it became evident that case managers were naïve about the interrelations between physical and behavioral health. In order to mitigate this gap in knowledge, Catholic Charities partnered with Action Health Partners (AHP) to educate case managers on chronic disease self-management so they had a basic understanding of the diseases and how patients are instructed to care for themselves. A Catholic Charities nurse helped them understand how these diseases can exacerbate behavioral health disorders. Additionally, the WPCC Learning Community kicked off a year-long learning activity in October 2019, focusing on both diabetes and depression. The content presented by subject matter experts follows the chronic care guidelines. Through the WPCC, NCACH is providing an environment for primary care organizations to dissolve silos and work together. To provide seamless care, several WPCC organizations have data-sharing agreements with the largest healthcare provider in the region to view patient records in their EHR.

b. Description and two examples for how the Chronic Condition/Transition Management plans align with and partner with Pathways or other

community-based care coordination strategies or programs to address social needs interventions (e.g., referrals to program/communication and data sharing for shared care planning).

ACH Response: Moses Lake Community Health Center employs a Care Coordinator supported by the Community-Based Coordination program, formerly known as Pathways HUB. They, along with Grant Integrated Services, recently became referral partners, identifying at-risk patients and referring them into the program. In addition, all 17 organizations with the WPCC are developing or improving upon their SDOH screening processes. In this reporting period, Coulee Medical Center adopted a SDOH screening form and trained their admitting staff, community health workers, and health information management staff in preparation for going live in the first quarter of 2020.

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

ACH Response: The Health Care Authority released a position statement in October 2019 to provide guidance with respect to payment and sustainability planning for the Pathways Community HUB. ACH Executive Directors, MCO representatives, and HCA leaders had been meeting monthly since August to clarify HCA's direction and vision for care coordination and to understand its impact on Pathways Community HUB implementation. This new information, along with the findings and recommendations from the formative evaluation CCHE completed for NCACH, have put the Pathways HUB model implementation at risk. A sub-committee of Board, NCACH staff, and AHP staff are having in-depth informed discussions about the future of community-based care coordination in the NCACH region.

In terms of workforce, staff turnover (including turnover of leadership and support staff) adds to the challenges of NCACH partners. At least 4 out of our 17 WPCC organizations have experienced significant leadership transitions in the past year. This exacerbates existing recruitment and retention challenges for rural areas and also demands continuous training and onboarding of staff involved in complex multi-year health system transformation efforts (as noted in a partner progress report, this "involves a steep learning curve.") As a result, workload increases for staff who are already stretched thin, can lead to further burnout. NCACH's approach is to be understanding and flexible with delays as providers face these workforce challenges.

As outlined in the Midpoint Assessment Report, HIT continues to present significant challenges across ACHs. Robust EHR systems are cost prohibitive for our small rural providers. The lack of interoperability between disparate EHRs (even within the same healthcare system) has severely limited information sharing and care coordination. In addition, many HIT platforms in use by clinical partners don't allow for user-friendly data aggregation/extraction, which negatively impacts their ability to do population health management. While NCACH is doing its part by promoting platforms that have a track record of increasing information sharing and care coordination (e.g. Collective Medical), HCA lacks a statewide vision that is relevant to ACH partners. ACH Executive Directors have collaborated to develop an ACH Health IT Strategy, which they plan on

sharing with HCA in the first quarter of 2020 (*see response to question 17.a.i.2.*) HIT is a critical challenge that is intricately tied to value-based care.

NCACH partner responses to HCA's latest VBP survey identified the lack of interoperable data systems and lack of access to comprehensive data on patient populations among the greatest barriers to participating in VBP. NCACH partners listed HIT/HIE planning, implementation, and/or reporting as the technical support that would be most helpful to their organization, followed by value-based reimbursement. NCACH has provided some support to partners by promoting quality improvement practices that do not depend on perfect systems, and by offering HIT technical assistance and coaching (through Comagine Health) for example, to build interfaces and databases that can draw from multiple systems to build a more complete picture. With limited resources, however, NCACH is not in a position to meet the scale of needs across the four-county region.

18. Pre- and post-project implementation example

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

ACH Response: From the beginning, NCACH has challenged its partners to integrate behavioral health/primary care within their organizations and clinics. The WPCC Learning Community was tasked with developing a change plan for their own collective. This was their opportunity to create a plan that would play out over the five years of the MTP. Mid-Valley Clinic had dreamed of integrating behavioral health but did not have a plan. The WPCC change plan put an item on their wish list into writing with a plan to achieve it. In Mid-Valley Clinic's words:

> *Our Psychiatric ARNP is HERE! She officially starts on 10/14/19 and we are so incredibly excited to introduce integrated BH into our organization. By putting our strategy our goal of integrated BH on paper (change plan), it made the goal seem more achievable, versus keeping it on our wish list.*

NCACH learned that helping partners develop a concrete road map via the Change Plan or practice facilitation precipitates transformation by giving the organizations a path to move forward.

19. Regional integrated managed care implementation update

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

NCACH Response: Chelan, Douglas, and Grant counties transitioned to integrated managed care on January 1, 2018. Okanogan county transitioned to integrated managed care on January 1, 2019. NCACH worked closely with the one BHO-contracted behavioral health provider in Okanogan County to ensure they were prepared for integrated managed care and to address issues after the transition. NCACH hosted monthly Early Warning System (EWS) calls with representatives from HCA, MCOs, Behavioral Health Administrative Services Organization, and behavioral health

providers. While several minor issues were identified and resolved during the EWS calls, there were no significant issues needing attention. NCACH staff worked to ensure that behavioral providers were aware NCACH staff were available to support with any issues that came up, though that support was rarely needed.

NCACH contracted with Xpio to provide technical assistance for both pre- and post-transition as needed. This resource was used minimally because it was rarely needed. NCACH continues to offer a single point of contact or liaison for our behavioral health providers if they need it. For example, recently, a provider reached out with concerns around data elements they are now asked to report on (elements that were required by the BHO, but were not required by HCA during the first year of integrated managed care). NCACH staff were able to work with HCA to understand the necessity of this request and report back to our partners. NCACH staff also share information, as necessary, with Behavioral Health Providers (e.g. updated billing guides).

Lastly, RCW 71.24.880, 2018 legislative session recommended an interlocal leadership structure to keep track of the transition to fully integrated managed care within a regional service area. NCACH Executive Director, Senator Parlette is leading these meetings, which will occur on a quarterly basis beginning in 2020.

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

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

Attestations

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

	Yes	No
20. The ACH supported Independent External Evaluator (IEE) activities to understand stakeholders' and partners' successes and challenges with Medicaid Transformation project implementation. ACH support or engagement may include, but is not limited to: • Identification of partnering provider candidates for key informant interviews. • ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary. • Directing the IEE to public-facing documents (e.g., fact sheets for providers or community members) that help the IEE understand ACH transformation projects and related activities.	x	

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

Section 3. Value-based Payment

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

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

Narrative responses

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

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

ACH Response: Partnering providers of the WPCC Learning Community submit quarterly reports that outlines successes, barriers, and next steps. NCACH reviews these reports and develops strategies, when needed, to assist organizations with identified barriers. NCACH also organizes learning activities that provide more focused technical assistance from subject matter experts. Finally, practice facilitators are assigned to each organization to ensure forward progress is made and assist with struggles as they arise. These methods are illustrated in the following detailed example.

Coulee Medical Center did not have an EMR that could collect, aggregate, and produce reports that would help staff track quality improvement changes made in the clinic. This lack of quantitative data severely impacted their movement towards population health management and thus value-based care. Having two medical records that do not communicate, including one that uses a DOS operating system, was a substantial barrier. As a mitigation strategy, NCACH contracted with Comagine Health to provide HIT support that would help overcome this hurdle. Working with Coulee Medical Center's IT point person, they were able to develop an Access Database that collected data from two different medical records and produce a report with laboratory data that could be filtered as needed. This first step allows for Coulee Medical Center to implement population health strategies to address the needs of patients who have diabetes.

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

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

ACH Response:

Low VBP Knowledge or significant barriers/challenge: Value-based care relies on every member of the team working in sync to provide the best quality care to patients. Historically, medicine has been very hierarchal, relying on the provider to deliver the care. As organizations move towards value-based care, roles and responsibilities are shared among members of the care team. NCACH hosted a team-base care learning activity to promote high-functioning teams rather than hierarchy. Attendance in the webinars and completion of the homework assignments resulted in a change amongst Lake Chelan Community Clinic staff in how they interacted with each other. The staff became closer as a team, drawing on each other's strengths as they learned to communicate effectively, recognize change fatigue, and respect the multi-generational divide. This change in environment benefitted them most as they faced the challenge of losing all of their providers. The staff of Lake Chelan Community Clinic had to work together synchronously not only to keep their doors open, but also to continue to provide care for their patients as they transitioned to all-new providers.

Small provider: In October, the WPCC kicked off a year-long Population Health Management Learning and Action Network (PH LAN). Quality measures are a large component of value-based care contracts. This PH LAN will build the Center for Alcohol and Drug Treatment's (CFADT) capacity to monitor specific measures each month as they implement quality improvement strategies. As a small substance use disorder treatment provider CFADT is challenged with a small staff who are responsible for multiple projects in addition to learning how to utilize an EHR to monitor quality metrics as they prepare for VBP. Support from PH LAN faculty, peers, and an assigned practice facilitator will boost their capacity while developing these critical skill sets.

Behavioral Health: Understanding and implementing quality improvement processes helps organizations improve the quality of health care they provide to all patients, which is at the core of Value-Based Purchasing (VBP). NCACH has organized several foundational quality improvement (QI) courses. This has been important for Grant Integrated Services (GrIS). Having no knowledge of QI, GrIS has formed a QI team that meets regularly and has begun implementing QI processes. GrIS staff also participate in the NCACH monthly QI Affinity Group, led by a subject matter expert and NCACH staff. This venue allows them to ask questions and test their assumptions to help improve their internal processes.

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

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

State provider VBP survey communication activities		
Tactic	**Incentives offered? (Yes/No)**	**New tactic? (Yes/No)**
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 HCA if needed.	No	No
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.	No	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 all but one major provider in our region complete the survey. This continues to be the theme every year due to the strong relationship NCACH has with its partners. Due to that success, NCACH has not changed its tactics each year.*

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

ACH Response: Each year, NCACH shares value-based payment survey data with providers to gather input. In response to feedback, NCACH has provided basic VBP materials on its Healthcare Communities portal and shared those materials at previous WPCC meetings. NCACH recognizes that interoperability still remains an issue with providers in our region and has been working with Collective Medical Technology on developing trainings for providers on the Collective Ambulatory System. In Spring of 2019, NCACH invited JD Fischer and Rachel Quinn from the HCA to present on the 2018 VBP survey results and HCA's plan for the Rural Multi-Payer Model. This was an opportunity to educate rural providers on the current status of both initiatives and give them an opportunity to ask questions of HCA staff. NCACH continues to work on clinical practice transformation efforts that center around PCMH and the 10 building blocks of primary care to help partners develop the clinical workflows necessary to be prepared for value-based care. However, NCACH recognizes that ACHs are not able to provide the contracting expertise to partners that may be necessary in some instances and continue to look towards the state to develop the resources necessary to support all providers in their transition to value-based care.

Section 4. Pay-for-Reporting (P4R) metrics

Documentation

24.P4R Metrics

P4R metrics provide detailed information to the IA, HCA and ACHs on partnering provider implementation progress for Projects 2A and 3A at a clinic/site level.[4] Twice per year, ACHs will request partnering providers participating in Project 2A and 3A to respond to a set of questions. Potential respondents should be consistent with the list of partnering provider sites identified in the ACH's Partnering Provider Roster affiliated with Project 2A and 3A. ACHs will gather the responses and report an aggregate summary to the state. ACHs will receive credit for timely reporting on these indicators of project implementation progress.

Related resources and guidance:

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

Instructions:

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

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

Format:

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

Submit P4R metric information. See attachment: NCACH.SAR4.Attachment H.1.31.20

[4] 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

North Central (NCACH)

July 1, 2019- December 31, 2019

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

Table 1: Incentives earned

	Q3	Q4	Total
Project 2A		$ 406,871.00	$ 406,871.00
Project 2B		$ 279,724.00	$ 279,724.00
Project 2C		$ 165,291.00	$ 165,291.00
Project 2D		$ 165,291.00	$ 165,291.00
Project 3A		$ 50,860.00	$ 50,860.00
Project 3D		$ 101,718.00	$ 101,718.00
Integration		$ -	$ -
VBP		$ -	$ -
Total	$ -	$ 1,169,755.00	$ 1,169,755.00

Table 2: Interest accrued for funds in FE portal

	Q3	Q4	Total
Interest accrued	$ 19,159	$ 24,496	$ 43,655

Table 3: distribution of funds for shared domain 1 partners

	Q3	Q4	Total
Shared domain 1	$ -	$ -	$ -

Table 4: incentive funds distributed, by use category

	Q3	Q4	Total
Adminstration	$ -	$ -	$ -
Community health fund	$ -	$ -	$ -
Health systems and community capacity building	$ 296,799.00	$ 178,308.35	$ 475,107.35
Integration incentives	$ -	$ -	$ -

Project management	$ 51,825.00	$ 115,917.65	$ 167,742.65
Provider engagement, participation, and implementation	$ 89,599.00	$ 329,850.00	$ 419,449.00
Provider performance and quality incentives	$ 449,982.00	$ 331,000.00	$ 780,982.00
reserve/contigency fund	$ -	$ -	$ -
Total	$ 888,205.00	$ 955,076.00	$ 1,843,281.00