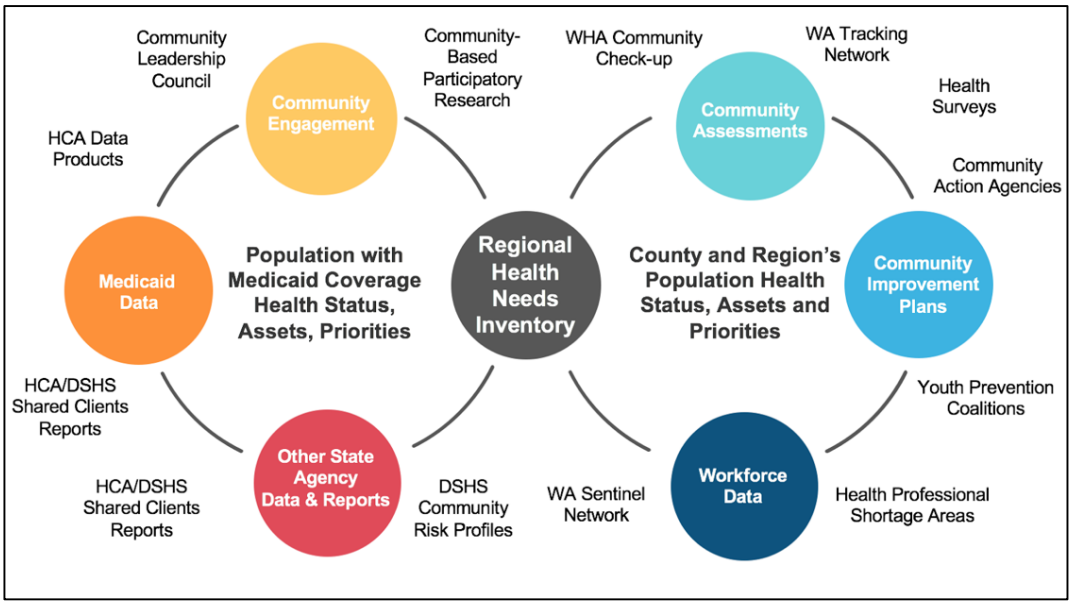
SECTION I: ACH – LEVEL

ACH	North Sound
Name	Liz Baxter, MPH
Phone	360.386.5745
Email	Liz@NorthSoundACH.org

Regional Health Needs Inventory

A Regional Health Needs Inventory (RHNI) is both a framework and resource to support investigating and synthesizing information about our region's greatest health needs, as a foundational step toward project selection and planning. (HCA, 2017). The aim of the North Sound Accountable Community of Health's (the North Sound ACH) RHNI is to be a comprehensive collection of Medicaid data, public data sources, workforce information, community assessments, and community improvement plans that support project selection, informs decision-making and project implementation (Figure 1). The data presented throughout the ACH Project Plan Template moves us closer to the goal of providing a compelling data-driven rationale for all selected projects now and into early 2018. The RHNI will be periodically updated, in collaboration with partners, throughout the planning and implementation phases of the Demonstration.

Figure 1: Regional Health Needs Inventory Framework



We have outlined RHNI findings in the ACH Project Plan Template by the categories listed below and provided a high-level snap-shot of findings that are described in greater detail throughout this section and within each toolkit project area:

1. **Data Informed Planning & Implementation:** Describes the process, tools and partners utilized throughout the North Sound ACH's data-driven decision making for project area selection.
2. **Addressing Health Equity:** Describes the North Sound ACH's methodology for selecting target populations, measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriate targeted interventions through Targeted Universalism.
3. **Regional Health Needs Inventory Summary**: Each sub-section provides a high-level summary of overall regional health needs, health needs among Medicaid enrollees, how issues are currently being addressed and highlights how future Demonstration projects in the North Sound will address needs.
    - Demographics: North Sound ACH region has the second largest total and Medicaid population in the state, nearly half individuals with Medicaid coverage are children.[1] The region is

[1] RHNI Starter Kit, HCA, released May 8, 2017.

geographically diverse, some areas are very rural or remote and pose challenges for accessing services.

- Social Determinants: Variability of socioeconomic risk factors like poverty, homelessness and unaffordable housing impact segments of the population throughout the region.[2]
- Life Expectancy & Mortality: Life expectancy varies greatly by where people live, in the North Sound the average age of life expectancy is 81 years old, though the range by census tract is 71-90 years old.[3] Deaths associated with suicide, drug overdose and chronic conditions are a growing concern among community partners, especially for the Medicaid population.
- Emergency Department Visits and Hospitalization: Behavioral health challenges (including mental health and substance use disorder) and chronic disease are a significant causes of emergency department visits and hospitalization in the region.
- Behavioral health & Substance Abuse: Medicaid enrollees with mental illnesses and chronic conditions impact over 40,000, these co-occurring illnesses are exacerbated by each other and lead to a shorter life expectancy.[4]
- Opioid Crisis: Opioid abuse and overdose involving prescription opioids and heroin are worsening rapidly and negatively impacting families throughout the region, the region lost 607 individuals from 2012-2016.[5]
- Chronic Disease: Chronic Disease diagnosis rates are low, though burden of disease and risk factors impact 10-25% of Medicaid enrollees and vary by age.[6]
- Reproductive, Maternal, Child Health: Prenatal care in the first trimester among pregnant women with Medicaid ranges from 60-70% by county.[7] The region's rate for unintended pregnancy is 37% an important measure to monitor as it aggregates a variety of social, behavioral, cultural and health factors- particularly women's access to tools for family planning.
- Oral Health: Only 34.6%of Medicaid enrollees who are eligible for dental services receive care.[8] Low utilization rates may be associated with insufficient capacity to see adult patients, transportation, location, and cost of care.
- Communicable Disease & Immunization: Immunizations rates amongst children are some of the lowest in the state, only 31% of toddlers are current on their vaccinations.[9]
- Preventive Services and Access to Care: Residents with Medicaid in the North Sound are more likely to experience worse quality of care compared to those with commercial insurance.[10]

4. **Partner Capacity**
    - Regional Health System Capacity: There are 32 community health center sites, 16 rural health clinics, 46 North Sound BHO contracted behavioral health agencies, 10 health systems and hospitals, 8 tribal health clinics, 4 mobile care services and 1 correctional complex.
    - Community-Based Organization Capacity: The region has a rich history of CBO's working together, there are 5 Transportation Services; 5 local health departments, 20 housing services; 17 schools/community colleges; 21 Local, state and federal government agencies; 19 consumer advocacy organizations; 57 social service/human service agencies; 6 local employers; 12 homeless shelters; 14 faith based organizations; 24 food banks and 3 immigrant service organizations.
5. **Data Sources:** A comprehensive list of data sources the North Sound ACH has gathered for the RHNI and to inform project area selection.

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[2] Washington State Tracking Network, WADOH, 2017.
[3] Washington State Tracking Network, WADOH, 2017.
[4] Utilization for MH Service Needs, RDA-DSHS, July 2017.
[5] Opioid-related Deaths in Washington State 2006–2016, WADOH, May 2017.
[6] Utilization for MH Service Needs, RDA-DSHS, July 2017.
[7] RHNI Starter Kit, HCA, released May 8, 2017.
[8] RHNI Starter Kit, HCA, released May 8, 2017.
[9] RHNI Starter Kit, HCA, released May 8, 2017.
[10] Community Check-Up, Washington Health Alliance, 2015.

DATA INFORMED PLANNING & IMPLEMENTATION

The North Sound ACH implemented several strategies to ensure data-driven decision making to support project area selection. Initial project planning began in February 2017 with self-formed workgroups organized around the eight toolkit project areas, comprised of diverse stakeholder participants. This approach enabled partners to share local and regional knowledge, identify opportunities for collaboration, evaluate current data, and explore potential strategies to consider projects. Simultaneously, the North Sound ACH Program Council (standing committee of the North Sound ACH Board) made a recommendation to screen potential project areas based on three criteria: whether the data demonstrated a regional need, whether partners existed to meet the metrics, and how projects align with the toolkit models.

In June 2017, the North Sound ACH's data analyst began preparing to update the RHNI by reviewing and analyzing public data sources and the Health Care Authority's (HCA) Medicaid data products to identify needs and facilitate selection of possible target populations for project areas. During this same period, the North Sound ACH staff created a crosswalk of the pay-for-performance metrics, creating a visual of what data elements will be tracked to earn incentive dollars, and used the tool with workgroups to drive project selection. The tool (Figure 2) included the most current local, regional, and state metric data, as well as historic trend data when available. This tool became a valuable resource for workgroups and the Program Council to discuss the feasibility of proposed projects meeting the required metrics. An estimated predictive gap analysis was later added to the tool upon the HCA release of metric target selection methodology.

Figure 2: Example of Metrics Crosswalk for Active Care Coordination Metrics

Medicaid Transformation Project Metrics June 2017	2A: Bi-directional Integration	2B: Care Coordination	2C: Transitional Care	2D: Diversion Interventions	3A: Opioids	3B: Repro/MCH	3C: Oral Health	3D: Chronic Disease	North Sound ACH Numerator	North Sound ACH Denominator	North Sound ACH Rate	North Sound ACH 3-Year Trend (HCA Data Product)	Method for Assessment for ACH Performance	National Benchmark (King County Analysis)	Gap to Goal-Initial Target	Gap to Goal-Additional Number Needed to Treat	Improvement Over Self- Initial Target (2% Improvement)	Improvement Over Self- Additional Needed to Treat or Reduction	Revised Numerator
Follow-up After Discharge from ED for Alcohol or Other Drug Dependence within 7 days*	X	X	X						417	2,068	20%	Decreasing	Gap to Goal	n/a	n/a	n/a	n/a	n/a	n/a
Follow-up After Discharge from ED for Alcohol or Other Drug Dependence within 30 days*	X	X	X						602	2,068	29%	Decreasing	Gap to Goal	n/a	n/a	n/a	n/a	n/a	n/a
Follow-up After Discharge from ED for Mental Illness within 7 days*	X	X	X						715	1,212	59%	Decreasing	Gap to Goal	n/a	n/a	n/a	n/a	n/a	n/a
Follow-up After Discharge from ED for Mental Illness within 30 days*	X	X	X						841	1,212	69%	Decreasing	Gap to Goal	n/a	n/a	n/a	n/a	n/a	n/a
Follow-up After Hospitalization for Mental Illness within 7 days*	X	X	X						N/A	N/A	N/A	n/a	Gap to Goal	n/a	n/a	n/a	n/a	n/a	n/a
Follow-up After Hospitalization for Mental Illness within 30 days*	X	X	X						N/A	N/A	N/A	n/a	Gap to Goal	n/a	n/a	n/a	n/a	n/a	n/a
Inpatient Hospital Utilization per 1,000*	X	X	X		X			X	13,945	1,377,688	10.1	Decrease	Improvement over self	n/a	n/a	n/a	9.90	-309	13,636
Mental Health Treatment Penetration (18-64 years Broad Version)	X	X							20,394	47,751	43%	Decrease	Improvement over self	n/a	n/a	n/a	43.6%	403	20,797
Mental Health Treatment Penetration (12-17 years Broad Version)	X	X							N/A	N/A	N/A	n/a	Improvement over self	n/a	n/a	n/a	n/a	n/a	n/a
Outpatient Emergency Department Visits per 1000 Member Months	X	X	X	X	X	X	X	X	104,659	2,391,069	44	n/a	Improvement over self	n/a	n/a	n/a	43.12	-1,556	103,103
Percent Homeless (18-64 years) *		X	X	X					5,847	121,494	5%	Increasing	Improvement over self	n/a	n/a	n/a	4.7%	-132	5,715
Plan All-Cause Readmission Rate (30 Days)		X	X						907	5,952	15%	n/a	Gap to Goal	n/a	n/a	n/a	n/a	n/a	n/a
Substance Use Disorder Treatment Penetration*		X							6,640	20,940	32%	Unchanged	Improvement over self	n/a	n/a	n/a	32.3%	131	6,771

Between July and October 2017, data were shared periodically with workgroups and the Program Council, though challenges persisted in providing timely and reliable data that met the planning needs of each workgroup. One

major issue was the varying methods of identifying total Medicaid population for the region. In general, regional counts differed due to selected month and/or year of data and the reporting agency's definition of Medicaid population. For example, majority of behavioral health and substance abuse data products from the Department of Social & Health Services' Research & Data Analysis (DSHS-RDA) included Medicaid only and dual-eligibles. These issues have been raised to HCA and a remedy is currently pending.

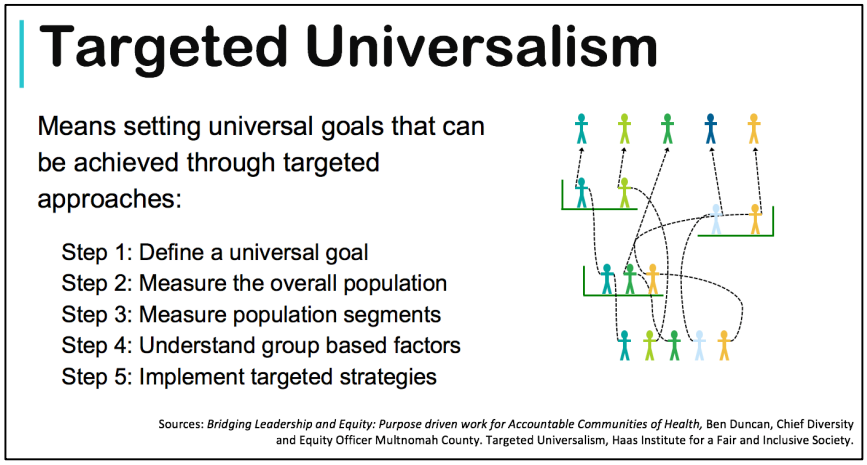
Despite these challenges, North Sound ACH staff actively participated in bi-weekly ACH-HCA statewide data lead calls and networked with other ACHs to identify useful project area data and utilize existing public data sources from the Washington State Department of Health, Washington Health Alliance and the Washington State Department of Social and Health Services. Pairing the HCA's Medicaid data products with these additional data sources has created a wide spectrum of information of regional needs and assets used to support project selection, identify possible target populations and most importantly, prepare the North Sound ACH for project implementation in 2018.

While data sources for the RHNI and project area selection are primarily HCA data products and publically available data, improved data sharing agreements and interoperability between the ACH and partnering providers is a priority for improving access to high-quality and timely data. The region's data sharing capacity has increased with the Snohomish Health District's award of the WADOH Chief Health Strategist funding, which requires the development of collaborative data sharing agreements among the five local health jurisdictions and the North Sound ACH. As project planning begins in 2018, the North Sound ACH will work closely with HCA to establish data sharing agreements with partnering providers as needed.

ADDRESSING HEALTH EQUITY

While committed to delivery system reform, the North Sound ACH believes in order to achieve improvements in health equity we must continually look downstream, midstream, and upstream, and lean into uncomfortable dialogue about class, privilege, and race. To support this commitment, the North Sound ACH will use Targeted Universalism (Figure 3) for selecting target populations, measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriate targeted interventions. Targeted universalism defines universal goals for all, then identifies obstacles faced by specific groups, and tailors strategies to address the barriers in those specific situations; it is a different way- a powerful way- to make the transformational changes we need. Ultimately, this approach shows how a universal project area goal can improve health for an entire population, while at the same time it can target approaches to address disparities within groups. The North Sound ACH is also committed to knowledge sharing with partners and has provided trainings for workgroups related to health equity, including one on Targeted Universalism, with Ben Duncan, Multnomah County's Chief Diversity and Equity Officer.

Figure 3: Targeted Universalism, Haas Institute

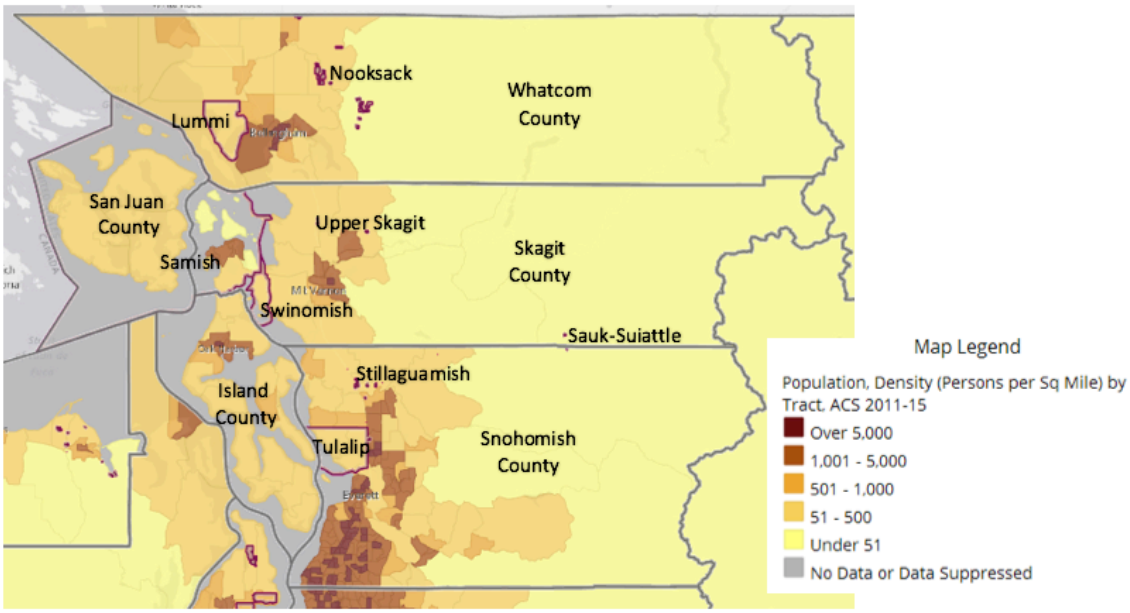


REGIONAL HEALTH NEEDS INVENTORY SUMMARY

Demographics

Comprised of five counties (Island, San Juan, Skagit, Snohomish, Whatcom) and eight tribal nations (Figure 4), the North Sound ACH region is geographically large with diverse populations. North Sound is the second largest populated ACH in Washington with 1,184,790 residents, the majority (63%) of whom live in Snohomish County. The majority (63%) of the region's residents are working-age adults (18-64), while 15% are older adults (65+) and 22% are children (<18).[11] The five counties range from urban to rural settings and are connected by highways, majority of the region's health services are located in the largest cities of Everett (109,000), Bellingham (88,000) and Mount Vernon (33,000), the further away individual lives from these urban areas creates limited access to vital healthcare services in rural and remote areas.[12] San Juan County is only accessible via ferry, and by ferry from island to island within the county.

Figure 4: County Boundaries and Tribal Lands, North Sound Region, Community Commons, 2015



As reported by WADOH's Office of Community Health Systems Series on Rural-Urban Disparities, rural populations of Island, Skagit, Snohomish and Whatcom counties have become more urban, while San Juan County's rural population (100%) has remained unchanged (Table 1).

Table 1: Change of Population Distribution & Percent Population Rural, North Sound

Geography	2000 Population % Rural	2010 Population % Rural	Population Change Direction
Island	48%	47%	More Urban
San Juan	100%	100%	Same
Skagit	33%	29%	More Urban
Snohomish	11%	11%	More Urban
Whatcom	32%	26%	More Urban
Washington	18%	16%	More Urban

Data Source: Community Health Systems Series on Rural-Urban Disparities, WADOH, 2017.

[11] RHNI Starter Kit, HCA, released May 8, 2017.
[12] Census Reporter, U.S. Census Bureau, 2017.

In 2016, 286,760 North Sound residents had Medicaid coverage—accounting for 24% of the region's total population and making it the second largest Medicaid-populated ACH region. Snohomish County is home to the largest concentration of Medicaid enrollees (172,000), while Skagit County has the highest percent of Medicaid enrollees at 31% (37,318), followed by Whatcom with 27% (57,368), San Juan 24% (3,917), Snohomish 22% (172,919) and Island 18% (15,238).[13] Regionally, more females (53%) and adults (55%) have Medicaid coverage.[14] While the North Sound ACH region has the second largest population in the state, many areas in our region are very rural or remote (such as San Juan and Island Counties, and east Whatcom, Skagit, and Snohomish counties), with significantly less population density and challenges accessing services located in urban centers. North Sound ACH project planning will consider the diversity of our region across the five counties and ensure that project strategies are flexible enough to adapt to rural and remote as well as urban areas (employing adaptations such as telehealth, mobile services, and more).

The average number of months of continuous Medicaid coverage for individuals (including dual eligible) in the North Sound ACH region is 3.3 years, compared to the state average of 3.5 years. Rates of continuous coverage vary across Medicaid population segments such as person with disabilities (6.3 years), elders (5.6 years), non-disabled children (4 years), non-disabled adults (2 years), and newly eligible adults (2 years).[15] The North Sound ACH will continue to advocate for ongoing enrollment access to Medicaid and the organization responsible for Medicaid enrollment activities in the region (Washington Alliance for Health Advancement) is engaged in activities through the ACH, with a presence on the Program Council and among the workgroups.

Within the region's Medicaid beneficiary population there is greater diversity compared to the general population (Table 2). For example, while 83% of the total population is white, only 61% of Medicaid enrollees are white. Snohomish county has the largest population for all race/ethnic population segments, while Skagit County has the highest percent of Hispanic (19%) population. Over 10,000 American Indian/Alaskan Native individuals with Medicaid coverage reside in the North Sound, which is the largest ACH population in the state, underscoring the North Sound ACH's commitment to support and collaborate with the eight tribal nations in the North Sound ACH region on Medicaid and other health transformation efforts. Further research will be required with nearly 24% of North Sound Medicaid enrollees reporting their race as Other or Unknown in order to better identify health disparities by race and ethnicity. As we move from planning to implementation, current demographic data for Medicaid enrollees will be necessary for all project areas when selecting targeted interventions.

[13] Healthier Washington Dashboards, retrieved October 2017.
[14] RHNI Starter Kit, HCA, released May 8, 2017.
[15] Measure Decomposition Data, RDA/DSHS, released July 7, 2017.

Table 2: Medicaid Population Demographics, North Sound Region & Washington				
Measures	North Sound		Washington	
	Count	%	Count	%
Overall	286,760	-	1,916,391	-
Gender				
Male	134,436	47%	910,688	48%
Female	152,324	53%	1,005,702	52%
Race/Ethnicity				
American Indian/Alaska Native	10,550	4%	59,484	3%
Asian	13,812	5%	87,458	5%
Black	12,058	4%	139,303	7%
Native Hawaiian/ Pacific Islander	6,751	2%	56,668	3%
White	174,613	61%	1,089,197	57%
Multiracial	3,949	1%	27,704	1%
Other	37,323	13%	277,704	15%
Unknown	27,704	10%	178,940	10%
Ethnicity				
Hispanic	53,808	19%	412,132	22%
Not Hispanic	179,184	62%	1,166,900	61%
Unknown	53,768	19%	337,359	18%
Age				
Adult (19+)	158,779	55%	1,057,442	55%
Child (<19)	127,981	45%	858,949	45%
Language				
English	256,268	89%	1,588,222	88%
Spanish	21,487	7%	172,807	9%
Other	5,707	2%	51,135	2%
Unknown	1,326	.005%	11,746	1%
Data Source: Healthier Washington Dashboards, retrieved October 2017.				

Social Determinants

Throughout the project area selection process, staff and workgroups recognized the importance of social determinants of health (SDOH) and the impact these conditions have on an individual's health. As we move from planning into implementation with both clinical and community-based partners we must ensure social determinants of health are considered when selecting targeted inventions.

In the North Sound, there is wide variability in health status and socioeconomic risk factors in key areas throughout the region. Using the Washington Tracking Network, the North Sound ACH identified differences in key SDOH indicators across the counties and within communities (Table 3). The number of residents living in poverty by county ranges from 9% (Island County) to 15% (Whatcom County), while nearly 40% of the total population in each county is impacted by unaffordable housing.[16] This disparity is likely contributing to increasing rates and total number of homelessness among non-elderly adults with Medicaid coverage (from 3.7% (3,816) to 4.8% (5,847))[17] throughout the North Sound region. The lack of access to affordable housing, often a complicating factor to achieving better health outcomes, needs to be addressed as part of any strategy to meaningfully approve population health and chronic disease. Homelessness and the lack of safe, affordable housing has been identified as a barrier to achieving health outcomes and a risk factor for negative health outcomes in all eight project areas. Care Coordination, Transitional Care, and Diversion Interventions specifically address homelessness in their project strategies, as Percent Homeless is a performance metric in those three areas, and the North Sound ACH

[16] Information by Location, Washington Tracking Network, WADOH, 2017.
[17] ACH Toolkit Historical Data, HCA, released August 17, 2017.

plans to implement strategies that will support community efforts to reduce homelessness. Homelessness greatly limits a person's ability to address chronic illness, their ability to fully recover after release from the hospital, exacerbates behavioral health challenges (mental health challenges and substance use disorder), greatly increases their interaction with law enforcement, and for children experiencing homelessness, constitutes a significant adverse childhood experience and significantly limits their ability to succeed in school. Many partners in our region are working to address this issue, including housing providers (emergency shelters, transitional and long-term housing), case management support and outreach, community paramedics, and advocates working to increase the amount of affordable housing in our communities.

Table 3: Social & Economic Determinants of Health, North Sound & Washington

Geography	Limited Access to Vehicle	Limited English Speaking	No HS Diploma	65+ Living Alone	Living with a Disability	Un-affordable Housing	Total Livin g in Poverty	Adults with no Insurance
Island	4%	2%	5%	12%	15%	37%	9%	11%
San Juan	4%	2%	5%	14%	13%	39%	11%	18%
Skagit	5%	7%	12%	11%	14%	38%	12%	17%
Snohomish	5%	8%	8%	8%	12%	40%	10%	12%
Whatcom	7%	5%	9%	11%	13%	39%	15%	14%
Washington	7%	8%	10%	10%	10%	37%	13%	16%

Data Source: Information by Location, Washington Tracking Network, WADOH, 2017.

DSHS's Community Risk Profiles indicate differences between overall state and county rates of social and economic risk factors associated with youth well-being and substance abuse. In the North Sound region, early criminal justice involvement among adolescents vary by county, some county rates significantly higher than the state average:[18]

- Arrest rate (per 1,000) of adolescents (age 10-17) by county and state:
  - WA-28.00, Island-14.26, San Juan-8.89, Skagit-43.84, Snohomish-25.74, Whatcom-33.21
- Arrest rate (per 1,000) of younger adolescents (age 10-14) by county and state:
  - WA-12.49, Island- 4.69, San Juan- 0.84, Skagit-21.42, Snohomish-10.74, Whatcom-14.84
- Arrest rate (per 1,000) of younger adolescents (age 10-14) for alcohol and drug law violations by county and state: WA-1.96, Island-0.61, San Juan-0.28, Skagit-5.56, Snohomish-1.51, Whatcom-3.10

In 2016, 6.5% (7,938) of Medicaid non-elderly adults were arrested at least once during the year, slightly below state averages (6.6%).[19] North Sound ACH work in the Diversion Interventions and Transitional Care project areas in particular address criminal justice involvement and how it overlaps with community health. In the Diversion Interventions project area, coordinated cross-sector care collaboratives will be scaled up across the region to provide support for "high utilizer" community members, who are high utilizers of emergency medical services, jails, and social services, to provide coordinated care and alternatives to these systems. Several of these care collaboratives have proven to be successful in our region, and the North Sound ACH will build on this work. In the Transitional Care project area, strategies will be implemented to support successful transitions from incarceration, including supporting community members with finding access to housing, physical and mental health services, and other resources, to reduce the likelihood of recidivism. Many partners are eager to engage in this work, including county jail services, emergency medical services, housing providers, behavioral health providers, and more. The North Sound ACH is confident that through a collaborative approach, arrest rates can be reduced and health outcomes for this population can be improved.

County level rates of victims of child abuse and neglect in accepted referrals exceeds state average (33 per 1,000) in Island (39 per 1,000), San Juan (39 per 1,000), Skagit (41 per 1,000) and Whatcom (45 per 1,000) counties, while Snohomish county has the lowest rate in the North Sound ACH region (33 per 1,000). Early criminal justice involvement and violence against children contribute to damaging adverse childhood experiences (ACEs) that

[18] Community Risk Profiles, RDA/DSHS, July 2017.

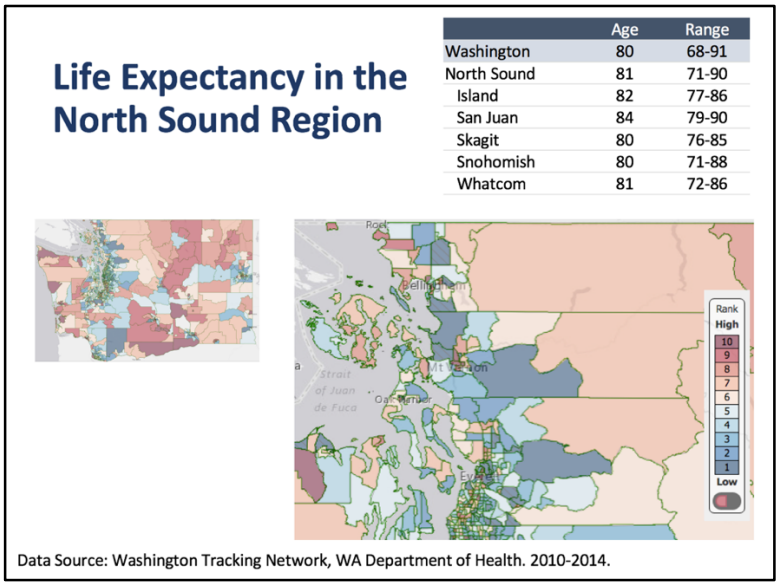
[19] ACH Toolkit Historical Data, HCA, released August 17, 2017.

have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity, including poor mental and physical health outcomes and success in education and employment (CDC, 2017). In 2013, between 25% to 36% of adults in the North Sound self-reported three or more adverse childhood experiences.[20] Community partners, especially early child advocates in the Reproductive, Maternal and Child Health (RMCH) project area, have reinforced the importance of preventing ACEs and educating providers about trauma-informed care in all project areas. Strategies in all project areas will be addressing the needs of adults who are experiencing the consequences of ACEs (such as addiction, poor physical health outcomes, incarceration, mental health challenges, etc.), so a key focus of the RMCH area is integrating a life course perspective into all project area strategies. Work in the RMCH area will specifically work to prevent ACEs through supporting planned, safe pregnancies and reducing unintended pregnancies, improving infant and child access to primary care, and collaborating with partners across the region to address social determinants of health.

Life Expectancy & Mortality

While the most recent county health rankings indicate the five counties within North Sound are ranked in the top 10 (of 39) of the healthiest counties in the state, data indicates quality of life varies throughout the region. Life expectancy for all residents in the North Sound region is estimated to be 81 years, though varies by census tract from 71 to 90 years (Figure 5). Life expectancy depends on a range of individual and community influences - such as disease, lifestyle, socioeconomic factors- and represents an inclusive, high-level measure for health. Life expectancy data will continue to assist the project planning process by identifying health disparities among population segments in the region.

Figure 5: Life Expectancy in North Sound & Washington



	Age	Range
Washington	80	68-91
North Sound	81	71-90
Island	82	77-86
San Juan	84	79-90
Skagit	80	76-85
Snohomish	80	71-88
Whatcom	81	72-86

Data Source: Washington Tracking Network, WA Department of Health. 2010-2014.

Mortality rates allows us to assess underlying diseases, injuries or circumstances that lead to deaths, and assess linkages between social determinants of health and outcomes. Among Medicaid enrollees in North Sound, the leading causes of death (accounting for 70% of all deaths) are 1) cancer 2) unintentional injury, 3) major cardiovascular disease, 4) chronic liver disease and cirrhosis, and 5) intentional self-harm (suicide).[21]

The overall rate of suicide in the North Sound is 14.6 per 100,000 and varies considerably by county: Skagit (14.1), Snohomish (15.2) and Whatcom (15.8) county's rates are lower than the Washington State rates, while

[20] Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016.
[21] RHNI Starter Kit, HCA, released May 8, 2017.

Island (19.9) and San Juan (18.5) are the highest in the region.[22] Between 2012 and 2016, 607 individuals died from an opioid related overdose (intentional, unintentional and undetermined) in the North Sound.[23]

Suicide and overdose deaths are particularly important to monitor as project planning and implementation begins for Bi-Directional Integration of Physical and Behavioral Health Services and Addressing the Opioid Use Public Health Crisis. Both project areas include target populations at increased risk for suicide and overdose and seek to reform delivery systems to better identify and treat these populations. By comparing the mortality rates with prevalence of certain illnesses and/or risk factors, causal relationships may emerge, allowing a better understanding of how certain community health needs may be addressed.[24]

Emergency Department Visits & Hospitalization

Reducing outpatient Emergency Department visits is a priority across all North Sound ACH project areas, and will be addressed through a variety of strategies, including upstream prevention, increasing access to primary care, and providing diversion programs to promote an alternative to the ED when appropriate. In 2016, the leading diagnostic reasons for emergency department visits among Medicaid enrollees residing in the North Sound region were:

- Symptoms, signs and abnormal clinical and laboratory findings- 31946 visits
- Injury, poisoning and certain other consequences of external causes- 30945 visits
- Diseases of the respiratory system- 16362 visits
- Diseases of the digestive system- 9553 visits
- Mental and behavioral disorders- 9062 visits
- Diseases of the musculoskeletal system and connective tissues- 8568 visits
- Diseases of the skin and subcutaneous tissue- 8221 visits
- Diseases of the genitourinary system- 7190 visits
- Pregnancy, childbirth and the puerperium- 5601 visits
- Diseases of the nervous system- 4059 visits

In the North Sound region, behavioral health challenges (including mental health and substance use disorder) and chronic disease are a significant cause of hospitalization among Medicaid enrollees (Table 4). Bidirectional integration of physical and behavioral health, Opioids, and Chronic Disease project areas will be implementing strategies to address these causes. Diversion Interventions will be implementing strategies to connect community members to non-ED services to address the conditions listed in Table 4, as well as providing care coordination to connect ED "high utilizers" to appropriate community services such as primary care, behavioral health care, and community wellness programs. Transitional Care will be implementing strategies to reduce hospital readmissions by supporting patients transitioning out of inpatient hospital and behavioral health settings. These approaches together should reduce hospitalization rates for the North Sound region and promote better health outcomes for community members.

[22] RHNI Starter Kit, HCA, released May 8, 2017.
[23] Opioid-related Deaths in Washington State 2006–2016, WADOH, May 2017.
[24] Community Commons: Community Health Needs Assessment, September 2017.

Table 4: Leading Causes of Hospitalization among Medicaid Beneficiaries, North Sound		
Hospitalization Cause	**Count**	**%**
Mental and Behavioral Disorders	1426	14.5%
Injury and Poisoning	926	9.4%
Septicemia	723	7.3%
Diseases of Heart	552	5.6%
Diseases of the musculoskeletal system and connect	509	5.2%
Substance Use Disorder	484	4.9%
Cancer/Malignancies	432	4.4%
Skin and Subcutaneous Tissue Infections	422	4.3%
Respiratory Failure/Pulmonary Collapse	368	3.7%
Diseases of Liver, Biliary Tract, and Pancreas	363	3.7%
All Other Causes	5069	51.5%
Total	9848	100%
Data Source: RHNI Starter Kit, HCA, released May 8, 2017.		

Behavioral Health & Substance Abuse

The prevalence of mental illness and addiction is a complex challenge for the health systems, communities, and families in the North Sound. As reported by WADOH's Chronic Disease Profiles, 21% of 10th graders in the region reported that they have seriously considered committing suicide and 35% reported feeling sad or hopeless. Overall, 17% of adults reported their general health as fair or poor and 12% experienced severe mental stress. Over 10% of Medicaid enrollees were diagnosed with a mental illness, with the highest rates of depression reported for whites (12.3%), American Indian/Alaskan Natives (10.7%), and Non-Hispanic (11.8%) individuals. Asian (4.1%) and Native Hawaiian/Pacific Islander (4.8%) reported the lowest rates.[25]

Rates of substance abuse, including use of nicotine, alcohol, opioids and other drugs is prevalent in the North Sound among residents with and without Medicaid coverage. County rates of smoking among adults ranges from 13% to 17%. Similarly, rates of binge drinking range from 13% to 19%.[26] This type of information has driven collective community health improvement efforts throughout the North Sound to address mental illness and substance abuse disorders as a priority for the last five years. The opioid crisis in particular has been a strong focus of regional partners in recent years, as opioid use and opioid overdose rates have increased. The North Sound BHO created the North Sound BHO Opioid Reduction Plan in 2017, which proposed multiple strategies to promote opioid use prevention, access to treatment, overdose prevention, and long-term recovery options. This plan has formed the basis for North Sound ACH strategies in the Opioids project area, and will be carried out by many diverse partners, including clinical partners, community-based partners, school-based partners, and more. In addition to opioids, many strong community programs in our region focus on reducing nicotine and alcohol use and reducing chronic disease, such as programs through the YMCA, local Community Action agencies, local health jurisdictions, and more.

Mental illness, substance abuse and chronic conditions exacerbate one another, which is why it is a fundamental priority to identify co-occurring illnesses as we further define target populations for project areas and select project interventions. The importance of this data cannot be overstated, the scale of impact these conditions have among Medicaid enrollees in the North Sound are tremendous and evident in the various data provided by the HCA:

- Mental and behavioral disorders (14.5%) are the leading cause of hospitalizations for Medicaid enrollees.[27]
- 83,176 (33%) of jointly served (HCA/DSHS) Medicaid individuals have mental health needs.
- 30,350 (12%) of jointly served (HCA/DSHS) Medicaid individuals have substance abuse disorder treatment needs

[25] RHNI Starter Kit, HCA, released May 8, 2017.
[26] Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2015.
[27] RHNI Starter Kit, HCA, released May 8, 2017.

- 21,000 (8%) of jointly served (HCA/DSHS) Medicaid individuals were diagnosed with co-occurring disorders.
- 40,626 of Medicaid enrollees were diagnosed with a Mental Illness and one or more chronic condition
- 20,135 of Medicaid enrollees were diagnosed with a Substance Use Disorder and one or more chronic condition
- Adult Medicaid enrollees who were arrested in the last year are nearly five times as likely to need substance abuse treatment compared to those not arrested.[28]
- Adults with Medicaid and behavioral health needs were two times as likely to utilize the emergency department three or more times per year, those with co-occurring disorders were over four times as likely to visit the emergency department.[29]

Several North Sound ACH project areas will be implementing strategies designed to address the relationship between mental illness, substance use disorder, and chronic disease, including Bidirectional Integration of Physical Health and Behavioral Health, Diversion Interventions, Transitional Care, Addressing the Opioids Crisis, Chronic Disease, and Care Coordination. Integrating primary care and behavioral health care and promoting a "whole person" approach to will be essential to meeting the health needs of high risk community members with co-occurring behavioral health and chronic disease diagnoses. Diversion Interventions and Transitional Care will support Medicaid enrollees in the community to ensure they have access to appropriate, sustainable care options where they live, and reduce the need to visit the Emergency Department. Care Coordination, through implementation of the Pathways Community HUB model, will support high-risk community members and their families in accessing the clinical care and community-based services they need and navigate a complex system. Finally, Chronic Disease and Opioids project areas will implement strategies designed to prevent and appropriately treat (or manage) chronic disease and opioid use disorder.

Opioid Crisis

Communities across Washington, including the North Sound region, are currently experiencing an opioid abuse and overdose crisis involving prescription opioids and heroin (Table 5). Approximately 600 individuals die each year in Washington from opioid overdose with an increasing proportion of those deaths involving heroin.[30] Between 2012 and 2016, 607 individuals died from an opioid related overdose (intentional, unintentional and undetermined) in the North Sound (Snohomish-488, Whatcom-69, Skagit-66, Island-38, San Juan-9).[31] In 2016, there were 38,546 Medicaid enrollees with at least one opioid prescription in the last year, and over 10,000 had a diagnosis history of opioid abuse and/or dependence.[32]

Table 5: Opioid Trends, North Sound

Geography	Increases in Annual Rate (per 100,000): 2002-2004 to 2011-2013			Opioid Overdose Death Rate (2012-2016)
	Publicly-funded treatment admissions for any opiate	Deaths attributed to any opiate	Crime Lab cases involving any opiate	
Island County	525%	77%	239%	10.9
San Juan County	368%	N/A	N/A	N/A
Skagit County	367%	42%	182%	11.2
Snohomish County	321%	69%	-11%	12.4
Whatcom County	309%	23%	122%	7
WA State	197%	31%	86%	9.6

Data Source: Opioid Trends Across WA State (ADAI Info Brief). Caleb Banta-Green, April 2015.

The North Sound ACH will implement a four-pronged approach to addressing the opioid crisis, which includes prevention efforts (improving prescribing practices, medication safety, and education), increasing access to treatment (including Medication Assisted Treatment), overdose prevention through access to Naloxone, and

[28] Utilization for MH Service Needs, RDA-DSHS, July 2017.
[29] ACH Profiles: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017.
[30] Opioid-related Deaths in Washington State 2006–2016, WADOH, May 2017.
[31] Opioid-related Deaths in Washington State 2006–2016, WADOH, May 2017.
[32] RHNI Starter Kit, HCA, released May 8, 2017.

increasing access to long-term recovery. The North Sound ACH strategies are based in the North Sound BHO's Opioid Reduction Plan, released in 2017 with strong community partner participation.

Chronic Disease & Risk Factors

The WADOH Chronic Disease Profiles indicated variability of chronic disease burden and risk for local populations in the North Sound region. Overall, health disparities within chronic disease risk factors and burden were present in population segments by gender, race/ethnicity, age, education and income (Table 6).

Table 6: Chronic Disease Risk Factors, Burden, Health Disparities in North Sound

Measure	WA	North Sound	Health Disparities by Population Segments				
			Gender	Race & Ethnicity	Age	Education	Income
Poor Mental Health Status- Adults	11%	10%	Female	AI/AN Hispanic White	18-24 25-34	HS or Less Some College	Less Than $25,000 $25,000 to $49.999
Asthma- Adults	10%	9%	Female	AI/AN White	18-24 45-54 55-64	HS or Less Some College	Less Than $25,000 $25,000 to $49.999
Diabetes- Adults	8%	8%	Male	Hispanic Asian	45-54 55-64 65+	HS or Less	Less than $25,000
Personal Health Care Provider- Adults	74%	75%	Male	AI/AN Native* Black* Hispanic	18-24 25-34 35-44	HS or Less	Less Than $25,000 $25,000 to $49.999
Obesity- Adults	27%	26%	Female	AI/AN Black* Hispanic White*	35+	HS or Less Some College	Less Than $25,000 $25,000 to $49.999
Smoking- Adults	16%	16%	Male	AI/AN White	18-24 25-34 35-44 45-54	HS or Less Some College	Less than $25,000 $25,000-$49,000

Data Source: Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016.

Actual chronic disease diagnosis rates among Medicaid enrollees are relatively low as reflected in claims data, with 3% showing billing codes for with diabetes diagnosis, 3% with billing for asthma diagnosis and 10% with billing for major depression diagnosis.[33] However, diagnosis rates may not be the strongest measure to indicate the disease burden of chronic conditions, including behavioral health and substance abuse. Analyzing claims data through the lens of the Chronic Illness & Disability Payment System[34], burden of chronic illness and/or disease can be seen in the association of claims and disease categories (Table 7). The top five chronic illness diagnoses in North Sound were;[35]

1. Depression
2. Pulmonary conditions like asthma, COPD
3. Hypertension
4. Gastro conditions like intestinal infections, ulcers and hernias.
5. Osteoporosis, musculoskeletal anomalies

[33] RHNI Starter Kit, HCA, released May 8, 2017.

[34] Improving Health-Based Payment for Medicaid Enrollees: Chronic Illness & Disability Payment System, University of California- San Diego, 2000.

[35] ACH Profiles Future, DSHS/RDA, released April 11, 2017.

Table 7: Leading Chronic Illnesses by Medicaid Client Groups						
Disease Group	Disease Group Description	North Sound Total	North Sound %	Non-Disabled Adults %	Newly Eligible Adults %	Non-Disabled Children %
Psychiatric, medium low	Major recurrent depression	46,893	18.3%	25.0%	20.2%	10.5%
Pulmonary, low	Viral pneumonias, chronic bronchitis, asthma, COPD	37,279	14.6%	14.9%	12.5%	11.8%
Cardiovascular, extra low	Hypertension	32,100	12.6%	11.9%	16.0%	<1%
Gastro, low	Ulcer, hernia, GI hemorrhage, intestinal infectious disease	31,072	12.2%	15.8%	13.3%	5.2%
Skeletal, very low	Osteoporosis, musculoskeletal anomalies	29,268	11.4%	11.9%	12.3%	6.8%
Skin, very low	Cellulitis, burn, lupus erythematosus	24,742	9.7%	10.8%	10.5%	6.1%
Psychiatric, low	Other depression, panic disorder, phobic disorder	23,858	9.3%	12.6%	9.8%	4.3%
Skeletal, low	Rheumatoid arthritis, osteomyelitis, systemic lupus	23,301	9.1%	9.4%	9.5%	4.2%
Cardiovascular, low	Endocardial disease, myocardial infarction, angina	19,177	7.5%	6.2%	7.5%	1.6%
Central Nervous System, low	Epilepsy, Parkinson's disease, cerebral palsy, migraine	17,355	6.8%	5.5%	5.7%	1.9%
Data Source: ACH Profiles Future, DSHS/RDA, released April 11, 2017.						

Through implementation of the Pathways HUB for community-based Care Coordination and the Chronic Care Model, including Healthy Homes, Million Hearts and the Chronic Disease Self-Management Program in the project area for Chronic Disease, the North Sound ACH will work in both community based and clinical setting to improve our regions ability to address chronic disease and focus on the populations suffering the greatest disparities.

Reproductive, Maternal and Child Health

A mother's experience even prior to conception can alter the development of the fetus and child. Lack of prenatal care, unintended pregnancy, teen births, smoking during pregnancy, and breastfeeding for less than two months increases the likelihood of maternal and infant health risks. These risk factors and birth outcomes vary throughout the North Sound ACH region by county (Table 8) and may highlight a lack of access to preventive care, insufficient provider outreach, and/or social barriers preventing utilization of services. In 2016, there were 5,981 births to women with Medicaid coverage and 62% received prenatal care in their first trimester. Among pregnant women with Medicaid, Island county had the highest rates of prenatal care with 70% (185) followed by 69% (34) in San Juan, 63% (544) in Skagit, 62% (731) in Whatcom and 61% (2217) in Snohomish.[36]

Partners in the North Sound region are working together to further improve access to prenatal care through home visiting programs like Nurse Family Partnership and Early Head Start. Additionally, the North Sound ACH will implement strategies designed to promote healthy, intended pregnancies, such as One Key Question (designed to identify a patient's pregnancy intentions in the following year, which can connect them with appropriate contraception or prenatal care) and HealthySteps, which embeds a HealthySteps child development specialist in a

[36] RHNI Starter Kit, HCA, released May 8, 2017.

primary care practice who is skilled in supporting families identify, understand and manage parenting challenges (including family planning and pregnancy spacing), which can reduce Adverse Childhood Experiences.

Unintended pregnancy is an important measure to monitor as it aggregates a variety of social, behavioral, cultural and health factors- particularly women's access to tools for family planning. Overall, unintended pregnancies accounted for 37% of North Sound births. Utilization rates of most or moderately effective contraceptive care among Women (15-44) with Medicaid is 31% and Long-Action Reversible Contraception is only 8% as shown in Table 8.

The North Sound ACH plans to implement family planning-based strategies to reduce unintended pregnancies. These strategies include increasing access to and utilization of LARC through provider training and community education, which will be implemented together with primary care providers, family planning providers, and Obstetrician/Gynecological providers (including those providing care to postpartum women). The ACH will build on the success of our SIM "Early Win" Project focused on LARC access, in which providers were trained on LARC counseling and insertion, and educational materials on LARC for providers and patients were developed. This project continues to be supported by community resources from Kaiser Permanente. Another strategy is pregnancy intention counseling through the One Key Question method, which asks patients (or clients in community-based settings) "do you intend to get pregnant in the following year" and supports patients in accessing appropriate, effective contraceptive methods or preparing for healthy pregnancy. This pregnancy intention counseling can happen in any setting, not just primary care or family planning settings, including social service providers, behavioral health providers, and more. The North Sound ACH plans to work with strong partners and advocates in our region including Planned Parenthood, local health jurisdictions, Community Action agencies, primary care providers, and more.

Table 8: Birth Health Risk Factors and Contraceptive Care, North Sound

Measure	North Sound	Island	San Juan	Skagit	Snohomish	Whatcom	Washington
Total Population							
Unintended pregnancy	37%	37%	37%	37%	37%	41%	38%
No first trimester prenatal care	19%	20%	20%	20%	20%	20%	20%
Smoking during third trimester	9%	16%	16%	16%	6%	16%	9%
Adolescent mother	9%	1%	1%	2%	1%	2%	2%
Premature Births	5%	7%	6%	9%	9%	9%	10%
Low Birth Weight	1%	4%	4%	6%	6%	5%	6%
Medicaid Women (15-44)							
Most or Moderately Effective Contraception	31 %	32%	27%	32%	31%	33%	31%
Long-Acting Reversible Contraception	8%	8%	6%	8%	8%	10%	8%
Medicaid Post-Partum Women (15-44)							
Most or Moderately Effective Contraception	37%	42%	30%	40%	37%	40%	41%
Long-Acting Reversible Contraception	14%	21%	5%	13%	14%	15%	16%
Prenatal Care Entry by Women with Medicaid-Paid Births in First Trimester	62.0%	70.3%	69.4%	62.7%	61.2%	62.0%	65.2%

Data Source: Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016. RHNI Starter Kit, HCA, released May 8, 2017

Oral Health

The highest priority in the region for oral health is expanding access to and utilization of dental services by Medicaid enrolled adults. In the North Sound, 32% of adults reported that they had not been to a dentist in the last year and 35% reported not having a dentist.[37] Despite being eligible for dental services, North Sound residents with Medicaid coverage have lower rates (34.6%) of receiving dental services compared to the state average (38.2%).[38] These rates vary by county from 22.5% to 35.6% (Table 9). Only 19.7% of eligible adults (21+) received dental services, while 51.7% of children (20 and under) did receive care.[39] Among the 9 ACH regions NSACH overall ranks third best in access, but 9th for adults and 5 of 9 for children. Island and San Juan counties are in the lowest quartile statewide for the "all ages" population.

Table 9: Medicaid Dental Services Utilization, North Sound

Geographic Area	All Ages	Under 20 yrs	Ages 21+ yrs
Island County	29.3%	46.0%	17.0%
San Juan County	22.5%	45.7%	6.7%
Skagit County	35.6%	54.6%	16.5%
Snohomish County	35.6%	51.1%	21.7%
Whatcom County	33.2%	53.3%	17.6%
North Sound	35.0%	52.0%	20.0%
Washington	38.2%	56.3%	22.1%

Data Source: Preliminary Medicaid Provider Files Dental Tables, HCA released June 27, 2017.

Federally Qualified Health Centers accounted for approximately 40% of the Medicaid beneficiary claims for dental care in 2016, with 60% provided by private practice or other dental services[40] (Table 10)**.** Barriers to accessing care include insufficient capacity to see adult patients, transportation, location, and cost of care. Residents living in poverty in all five counties stated, “not enough preventative dental care” as a barrier to accessing care. According to the 2015 Snohomish County Low Income Needs Assessment, 11% of low income households stated the location of dental services as prohibitive to oral health. North Sound ACH oral health strategies aim to expand access to and utilization of dental care by addressing these barriers. These strategies include expansion of existing clinic capacity, implementation of new provider models, integration of dental screening and referral into primary care practices, and mobile dental services in community settings.

[37] Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016.
[38] RHNI Starter Kit, HCA, released May 8, 2017.
[39] RHNI Starter Kit, HCA, released May 8, 2017.
[40] Preliminary Medicaid Provider Files Dental Tables, HCA released June 27, 2017.

Table 10: Dental Services Capacity of Community Health Centers & Federally Qualified Health Centers, North Sound					
County	CHC/FQHC	Total Dental Chairs	Dentist FTE	Hygienist FTE	CHC/FQHC Dentists & Medicaid Population Ratio
Island	Sea Mar	2	1	0	1:14,942
San Juan	NA	NA	NA	NA	NA
Skagit	Sea Mar	10	1	3	1: 36,739
Snohomish	CHC- Snohomish Sea Mar	70	10	33.75	1: 16,679
Whatcom	Sea Mar Unity Care NW	39	6	17	1: 9308
North Sound	TOTAL	121	18	53.75	1: 15,431
Data Source: Preliminary Medicaid Provider Files Dental Tables, HCA released June 27, 2017. RHNI Starter Kit, HCA, released May 8, 2017.					

Immunizations & Communicable Disease

Immunization rates in the North Sound are consistently lower than the state averages (Table 11). Only 31% of toddlers were up-to-date with their vaccinations.[41] Vulnerable populations like young children, immunocompromised adults and elderly are more likely to contract life-threatening vaccine preventable diseases. In 2015, there were 327 Pertussis cases in the North Sound, which accounted for 24% of the statewide total.[42] These low rates may be due to a variety of factors, including parents' opposition to vaccinations, low rates of well-child visits, limited access to primary care, and more. The North Sound ACH plans to implement strategies to improve immunization rates such as HealthySteps, where a HealthySteps child development specialist is embedded in pediatric practices to support families in effective parenting and child development, and can help educate parents on the importance of immunizations and identify and strategize around barriers to receiving immunizations. Additionally, the North Sound ACH plans to collaborate with area partners on immunization education in our region.

Table 11: Overall Immunization Rates, North Sound		
Measure	North Sound	WA
Adolescent (age 13) TdaP & MCV1 immunization rate	45%	60%
Adolescent (age 13) HPV immunization rate	16%	19%
Child (Age 2) Combo 10 HEDIS immunization rate	31%	33%
Adult Influenza Immunization Rate	39%	42%
Data Source: RHNI Starter Kit, HCA, released May 8, 2017.		

Sexually transmitted infections (STIs) have been steadily increasing throughout the North Sound ACH region and typically impacting young adults. The most common reportable STI in the North Sound is chlamydia. In 2015, there were 3,694 cases of chlamydia in the North Sound, with 60% (2,203) of those cases in Snohomish county, followed by Whatcom 21% (765), Skagit 11% (399) 8% (307) and San Juan .5% (20) counties.[43] The percentage of female Medicaid enrollees 16–24 years of age in the North Sound who were identified as sexually active and who had at least one test for chlamydia during the measurement year differs from the state average of 51% and varies by county; Island with 39%, San Juan 40%, Skagit 48%, Snohomish 45% and Whatcom 56%. In the

[41] RHNI Starter Kit, HCA, released May 8, 2017.
[42] Washington Tracking Network, WADOH, 2017.
[43] RHNI Starter Kit, HCA, released May 8, 2017.

Reproductive, Maternal and Child Health Project area strategies will work to increase screening for chlamydia through provider training, as well as embedding a reproductive, maternal and child health perspective in all project areas. Additionally, the Care Coordination project area can increase access to STI screening by connecting community members to the appropriate screening pathway. The ACH can also work to include STI screening as part of a "whole person care" approach to ensure that it is offered as part of regular primary care visits, so that the ACH's work to increase access to primary care can increase chlamydia screenings.

Tribal Community Health Assessments

Assessing the overall health needs and assets of tribal nations residing in the North Sound ACH region is important when implementing Targeted Universalism in region-wide project planning and provide ongoing technical assistance for any data needs. As stated by Victoria Warren-Mears, Direction of the Northwest Tribal Epidemiology Center, "American Indian and Alaskan Natives in the Pacific Northwest are a small but diverse population. Northwest Tribes have demonstrated their resilience and leadership in facing multiple historical, social, economic and health challenges. Tribal leaders recognize that valid and reliable health statistics are the foundation of a strong public health system. However, AI/AN are not well-represented in local, state, and national health status reports. Without reliable health information, tribes remain limited in their ability to identify priorities and actions that will improve the health of their communities." The WA State American Indian/Alaska Native Community Health Profiles produced by Northwest Tribal Epidemiology Center Washington and Northwest Portland Area Indian Health Board measures the health status of American Indian and Alaskan Natives residing in Washington is a comprehensive assessment resource. The report identifies similar risk factors and burden of disease among AI/AN, as well as health disparities including;[44]

1. Disparities in maternal and child health indicators (teen pregnancy, smoking during pregnancy adequate prenatal care infant mortality)
2. Mortality rates (heart disease, cancer, diabetes, unintentional injuries/violence & stroke)
3. Access to care (primary care-annual screenings and exams, dental care & immunizations)
4. Communicable disease (sexually transmitted diseases)
5. Healthy lifestyles and environments (obesity, access to safe, healthy and nutritious foods, smoking/tobacco cessation, asthma & prevalence air quality

Preventive Services and Access to Care

Preventive services can minimize poor health outcomes through early identification of health problems. In the North Sound, there is variation in individual's access to care, disease management and health screenings among the counties, as well as differences among those with Medicaid or commercial insurance coverage (Table 12).[45]

[44] Washington State American Indian/Alaska Native Community Health Profiles, Northwest Tribal Epidemiology Center Washington & Northwest Portland Area Indian Health Board, 2014.

[45] Community Check-Up, Washington Health Alliance, 2015.

Table 12: Medicaid & Commercial Insurance Outcomes, North Sound and WA					
	Medicaid %		Commercial %		North Sound Medicaid Vs. Commercial
Measure	WA	North Sound	WA	North Sound	
Access to primary care (ages 12–19 years)	86%	87%	90%	89%	Worse
Access to primary care (ages 12–24 months)	89%	87%	98%	98%	Worse
Access to primary care (ages 2–6 years)	75%	75%	89%	89%	Worse
Access to primary care (ages 20–44)	71%	72%	92%	92%	Worse
Access to primary care (ages 45–64)	75%	76%	96%	96%	Worse
Access to primary care (ages 65+)	84%	84%	98%	98%	Worse
Access to primary care (ages 7–11 years)	86%	87%	90%	90%	Worse
Managing medications for people with asthma	60%	58%	67%	65%	Worse
Mental health services for adults	46%	47%	29%	28%	Better
Mental health services for children	63%	61%	35%	33%	Better
Statin therapy for patients with cardiovascular disease	20%	20%	82%	83%	Worse
Spirometry testing to assess and diagnose COPD	22%	25%	40%	42%	Worse
Staying on antidepressant medication (12 weeks)	58%	57%	72%	71%	Worse
Staying on antidepressant medication (6 months)	42%	42%	56%	54%	Worse
Blood sugar (HbA1c) testing for people with diabetes	63%	65%	90%	91%	Worse
Eye exam for people with diabetes	63%	64%	75%	75%	Worse
Kidney disease screening for people with diabetes	71%	75%	86%	87%	Worse
Adolescent well-care visits	41%	40%	44%	41%	Same
Breast cancer screening	27%	26%	75%	73%	Worse
Cervical cancer screening	55%	53%	75%	72%	Worse
Chlamydia screening	51%	48%	39%	36%	Better
Colon cancer screening	43%	46%	63%	63%	Worse
Well-child visits (ages 3-6 years)	58%	60%	73%	71%	Worse
Taking cholesterol-lowering medications as directed	57%	62%	76%	75%	Worse
Taking diabetes medications as directed	45%	45%	65%	64%	Worse
Taking hypertension medications as directed	59%	62%	79%	78%	Worse
Potentially avoidable ER visits	19%	18%	10%	10%	Better
Data Source: Community Check-Up, Washington Health Alliance, 2015.					

While it is too early to determine the causes as to why North Sound's Medicaid enrollees experience worse or better outcomes of listed health care measures compared to those with commercial insurance, the Washington Health Alliance's (WHA) Community Check-up also provides sub-systems for hospital, health systems, and clinic level data. In December 2017, the Community Check-up will provide three years of trend data allowing for historical analysis of the Common Measure Set for Health Care Quality and Cost listed above. In addition to the community assessment work spearheaded by the region's community-based organizations, data related to access, scheduling and wait times will be collected in the 2018 North Sound Current State Assessment. Linking these types of data with social determinants data will become invaluable as we continue to advocate for culturally appropriate and trauma-informed care with clinical and community-based organizations in Bi-Directional Integration, Reproductive Maternal Child Health, Care Coordination, Opioids, and Chronic Disease project areas.

PARTNER CAPACITY

Regional Health System Capacity

The North Sound ACH considers ongoing partner engagement key to project implementation success and necessary for leveraging community resources. In the North Sound, there are 32 community health center sites,

16 rural health clinics, 46 North Sound Behavioral Health Organizations (BHOs) contracted behavioral health agencies, eight tribal health clinics, four mobile care services and one correctional complex. We have 10 health systems and hospitals, three of which are critical access hospitals (Table 13). Physical health and primary care providers are uniformly engaged as a sector through the formation of the Health Systems Advisory Council, an ad hoc gathering of health system leaders advising North Sound ACH staff and self-reporting coverage of over 75% of Medicaid Managed Care assignees in the region.

Table 13: Hospitals and Bed Counts, North Sound Region

Hospital	County	Bed Count
Whidbey General Hospital*	Island	25
PeaceHealth Peace Island Medical Center*	San Juan	10
Island Hospital	Skagit	43
PeaceHealth United General Medical Center*	Skagit	97
Skagit Valley Hospital	Skagit	137
Cascade Valley Hospital	Snohomish	48
Providence Regional Medical Center Everett	Snohomish	372
Swedish Medical Center- Edmonds	Snohomish	217
Valley General Hospital	Snohomish	112
PeaceHealth St. Joseph Hospital Bellingham	Whatcom	252

*Indicates Critical Access Hospital. Data Source: Hospital by Location, Washington State Hospital Association, 2017.

In the realm of Behavioral Health, the North Sound BHO is a close partner and takes a leadership role in assuring involvement from the region's BHA's, particularly for project planning and implementation such as in the area of Bi-Directional Integration of Physical and Behavioral Health services. Both groups will be integral to success in overall project planning and implementation by assuring engagement from our regional health systems.

Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P) help us identify geographic areas, population groups, and facilities with too few primary care, dental, and mental health providers. Within the counties of the North Sound, there are 70 HPSA's and 10 MUA/P.[46] HPSAs are used by several state and federal programs to determine eligibility for payment enhancements and workforce programs, this type of information will be vital to workforce planning activities and enhancing recruitment strategies. The Department of Health (DOH) conducts the Primary Care and Dental Care Provider Survey to determine HPSA status, and the surveys provide county-level information of the rate of dental and primary providers serving Medicaid patients, the proportion of Medicaid patient in practice, and those accepting new patients (Table 14).

[46] Health Professional Shortage Areas (HPSA), Medically Underserved Areas/Populations (MUA/P), Data by Geography, FQHC/CHC, HRSA Data Warehouse, 2017.

Table 14: Primary Care and Dental Care Provider Survey, North Sound Counties			
Provider/County	% of providers who treat Medicaid patients	% of providers accepting new Medicaid patients	Average practice % of Medicaid patients
Dental Care			
Island	28.6%	17.9%	10.4%
San Juan	28.6%	28.6%	6.0%
Skagit	49.1%	11.3%	23.6%
Snohomish	37%	21%	25%
Whatcom	43.8%	19.2%	27%
Primary Care			
Island	72.7%	40.9%	26.2%
San Juan	93.8%	68.8%	8.1%
Skagit	79.7%	73.4%	9.9%
Snohomish	89%	54%	17%
Whatcom	43.8%	19.2%	27.0%
Data Source: Primary Care and Dental Care Provider Survey, WADOH, 2009-2014			

Recent findings from the Washington State Health Workforce Sentinel Network survey data[47] indicates there are changes in workforce needs and demands that must be taken into consideration as project planning continues and implementation begins. According to the most recent data (April-May 2017), the North Sound ACH region is experiencing exceptionally long vacancies for registered nurses, mental health counselors, licensed practical nurses, nursing assistants and physicians, while simultaneously experiencing increasing demand for medical assistants, nursing assistants, mental health counselors, nurse practitioners and registered nurse. This type of information from the Sentinel Network is essential to building a baseline workforce analysis to be folded into broader assessment processes in 2018, when surveying a cross-section of clinical and community-based partnering providers in conjunction with the Practice Transformation Support HUB for all areas of focus in Domain 1. This analysis will identify gaps at the local, regional and statewide level and seek ways for the North Sound ACH to work with partners to address them.

In early 2018, North Sound ACH staff will work with implementation partners and technical assistance contractors to further assess how regional providers are currently serving the Medicaid population. The aim of such assessments would be to answer the following questions:

- How many Medicaid enrollees are assigned and/or being currently cared for by partnering providers?
- How many providers are currently implementing selected evidence-based approach(es) included in the North Sound project portfolio?
- Where relevant, how are partnering providers currently engaged in selected pay for reporting activities?
- Who is and is not currently accepting Medicaid patients? If not, why?

Community-Based Organization Capacity

Regional community-based organizations (CBO's) exist throughout the North Sound. These community care providers will be critical for successful project implementation. In addition to robust representation at all levels of governance, Community Based Organizations are also filling important roles in the planning process for project implementation. Particularly in the project areas of Chronic Disease with use of a fruit and vegetable prescription program and community based lifestyle classes and Care Coordination with the establishment of the Pathways HUB, Community Based Organizations are poised to take a prominent role in all ACH activities in the region. In the North Sound, we have identified:

- 5 transportation services

[47] Facilities Survey, Washington State Health Workforce Sentinel Network, 2017.

- 5 local health departments
- 20 housing services
- 17 schools/community colleges
- 21 local, state and federal government agencies
- 19 consumer advocacy organizations
- 57 social service/human service agencies
- 12 homeless shelters
- 14 faith based organizations
- 24 food banks
- 3 immigrant service organizations

Local health departments and community action agencies routinely assess the needs of their constituents through community surveys and/or community events. These community engagement activities are crucial to planning supportive services that meet individual needs and address barriers to care. In the Island County 2015 Community Health Assessment low-income respondents reported their greatest health priorities and barriers. Around 18% of respondents ranked mental health care as a priority, yet the limited availability of mental health providers-those that accept publicly funded insurance and/or able to prescribe medications—and the lack of community services for clients experiencing mental illness were noted as barriers to care. In Island County 13% of respondents said substance abuse treatment was "extremely important" to their household while 20% said these services were "very hard to get."

In the 2015 Snohomish County Health Service District Community Needs Report over 25% of respondents reported using public transportation every day, yet the lack of transportation was reported by at least 25% of all people interviewed as a barrier to: going to medical appointment, to dental appointments and getting alcohol/drug treatment. From their 2015 Community Health Assessment Skagit County noted the four biggest barriers/challenges to health were 1) stress, 2) time, 3) income, and 4) physical activity and access to healthy foods. In 2015, the Opportunity Council, a community action agency for Whatcom, Island & San Juan Counties, reported that region-wide the most common reasons for not receiving any of four types of health care (medical, dental, mental health, or medications) are the high-cost and not having insurance.[48] In Whatcom county, there is a high level of unmet need for behavioral health care services and an estimated 70.5% of adults eligible for treatment for substance abuse do not receive care.

The North Sound ACH staff will continue to work with community-based organizations, the Community Health Leadership Council and other implementation partners to further identify what community resources are currently available to the Medicaid eligible population and/or proposed target populations. This will be accomplished by:

- Work with partners to review existing resources maintained by the three community action agencies in the North Sound in order to identify services being provided, populations served and service eligibility.
- Identifying how many Medicaid eligible lives are touched by community-based organizations and which organizations serve as coordinated systems that act as a one stop shop for services.
- Ensure community-based organizations are invited to participate in the North Sound ACH's Data Learning Team, where suppressed client intake, risk assessments and referral data/information will be reviewed when appropriate.

DATA SOURCES

Below is a comprehensive list of data sources the North Sound ACH has gathered for the RHNI and to inform project area selection. Sources are referenced throughout the ACH Project Plan Template and within each of the eight project areas.

- 10 Priority Areas to Improve the Health & Wellness of Skagit County Residents, Skagit County Population Health Trust, Skagit County Public Health and Community Services, September 2017. *

[48] Prosperity Project: Experiences of Poverty in Whatcom, Island and San Juan County, Opportunity Council, 2015.

- 2015 Annual Report for the Community Health Improvement Plan, Whatcom County Health Department, 2015. *
- ACH Profiles Future, DSHS/RDA, released April 11, 2017.
- ACH Toolkit Historical Data, HCA, released August 17, 2017.
- An Assessment of Primary Care Capacity in Washington State, Washington Healthcare Access Alliance, 2015.
- BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017.
- Census Reporter, U.S. Census Bureau, 2017.
- Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015.
- Chronic Disease Profiles (North Sound) WADOH, April 2016.
- Community Check-Up, Washington Health Alliance, 2015.
- Community Commons: Community Health Needs Assessment, September 2017.
- Community Health Assessment, Island County Public Health, 2015.*
- Community Health Assessment, Skagit County Population Health Trust, Skagit County Public Health and Community Services, 2015.*
- Community Health Assessment, Snohomish Health District, 2017.*
- Community Health Assessment, Whatcom County Health Department, 2011.*
- Community Health Improvement Plan, Snohomish County Health District, 2014.*
- Community Health Needs Assessment 2017-2019, Providence Regional Medical Center Everett, 2017.*
- Community Health Needs Assessment Report-Island Hospital, Skagit County Public Hospital District No. 2, Anacortes, Washington, December 31, 2016.*
- Community Health Status Report, San Juan County Health & Community Services, 2016.*
- Community Health Systems Series on Rural-Urban Disparities, WADOH, 2017.
- Community Risk Profiles, RDA/DSHS, July 2017.
- County Health Rankings: Annual County Rankings, September 2017.
- Eligibility Overview Washington Apple Health (Medicaid) Programs, HCA, April 2017.
- Facilities Survey, Washington State Health Workforce Sentinel Network, 2017.
- HCA Health Home Contract Manager by email, October 2017.
- Health Professional Shortage Areas (HPSA) Designations, WADOH, 2017.
- Health Professional Shortage Areas (HPSA), Medically Underserved Areas/Populations (MUA/P), Data by Geography, FQHC/CHC, HRSA Data Warehouse, 2017.
- Healthier Washington Dental Reports, Washington Dental Services, released April 5, 2017.
- Healthier Washington Dashboards, retrieved October 2017.
- Healthy Youth Survey, WADOH, 2016.
- Hospital by Location, Washington State Hospital Association, 2017.
- HPSA Primary Care and Dental Care Provider Survey (Island, San Juan, Skagit, Snohomish, Whatcom), WADOH, 2009-2014.
- Improving Health-Based Payment for Medicaid Enrollees: Chronic Illness & Disability Payment System, University of California- San Diego, 2000.
- Information by Location, Washington Tracking Network, WADOH, 2017.
- Measure Decomposition Data, RDA/DSHS, released July 7, 2017.
- Multi Agency Unintended Pregnancy Prevention, WADOH, March 1, 2017.
- National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: Parks, J., et al. Retrieved January 16, 2015.
- Washington State American Indian/Alaska Native Community Health Profiles, Northwest Tribal Epidemiology Center Washington & Northwest Portland Area Indian Health Board, 2014
- Opioid Trends Across WA State (ADAI Info Brief). Caleb Banta-Green, April 2015.
- Opioid-related Deaths in Washington State 2006–2016, WADOH, May 2017.
- PeaceHealth-Peace Island: 2016-2019 Community Health Needs Assessment and Implementation Plan, PeaceHealth, 2016.*

- PeaceHealth-St. Joseph: 2016-2019 Community Health Needs Assessment and Implementation Plan, 2016.*
- PeaceHealth-United General: 2016-2019 Community Health Needs Assessment and Implementation Plan, 2016.*
- John A. Powell, Haas Institute. Targeted Universalism. 2017. Retrieved from http://haasinstitute.berkeley.edu/targeteduniversalism
- Prosperity Project: Experiences of Poverty in Whatcom, Island and San Juan County, Opportunity Council, 2015.*
- Provider Report Files-AIM Data Product, HCA, released September 1, 2017.
- Public Water Systems that Deliver Fluoridated Water, WADOH, 2017.
- RHNI Starter Kit, HCA, released May 8, 2017.
- Sartorious, P.J. Pathways Model Aligns Care, Population Health. Health Progress: Journal of the Catholic Health Association of the United States. May-June 2015.
- Skagit Prosperity Report: A Community Needs Assessment, Community Action of Skagit County, 2013.*
- Snohomish County Low Income Community Needs Assessment, Snohomish County Human Services, 2015.*
- Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs, T. Bodenheimer MD, University of California, San Francisco, October 2013.
- Swedish Edmonds Community Health Needs Assessment 2016, Swedish Medical, 2016.*
- The Role of Medicaid for People with Behavioral Health Conditions, The Kaiser Commission on Medicaid and Uninsured, November 2009.
- Unintended Pregnancy Report, WADOH, January 17, 2014.
- Utilization for MH Service Needs, RDA-DSHS, July 2017.

** Indicates data and information from partnering organizations and providers*.

ACH Theory of Action and Alignment Strategy

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

The term "health equity," as used in this Project Plan Template, means reducing and ultimately eliminating disparities in health and their determinants that adversely affect excluded or marginalized groups.[49]

The vision of the North Sound ACH is to improve the health of people living in Snohomish, Skagit, Island, San Juan and Whatcom counties. The Board reaffirmed this vision in July 2017, with the objective of acting as a regional collaborative to strategically leverage investments and improve health across and in five counties, including the people served by eight tribal nations. The North Sound ACH region will:

- Build on the region's strong history of collaboration
- Change the frame from health care to health
- Leverage Medicaid Transformation dollars but not be held captive to it
- Invest strategically to remove/decrease infrastructure barriers
- Learn how to talk about and address equity and disparities

The values that the North Sound ACH leadership have adopted include:

- Acknowledge conflict between our desire to work upstream, and the Medicaid Transformation's focus on clinical outcomes
- Acknowledge and respect the sovereignty of our Tribal partners
- Focus on communities most impacted by disparities/inequities
- Leverage evidence and emerging data
- Be innovative, nimble and flexible
- Avoid duplication/reduce waste
- Create system-level, sustainable changes
- Agree to first seek understanding, then seek agreement

The North Sound ACH believes that its people are its greatest asset; therefore, our theory of action and alignment strategies revolve around leadership development, building capacity to meet the region's needs, and building the workforce of the future. In the required attachments, there are visuals that outline how partners connect to projects, how projects connect to varied outcomes, the critical premises that will guide the North Sound ACH's planning phase, and the toolkit project areas overlap and intersect as we move toward specific approaches and strategies to positively impact the health of Medicaid enrollees in the North Sound ACH region.

The Project Plan Template lays out our best thinking in relation to the eight toolkit project areas with what we know about regional data, assets and potential partners. Total possible DSRIP funding is unknown, the future of Medicaid expansion is unknown, and we still have significant planning to do in the coming year to explicitly lay out implementation of our projects. The people and partners who live in this region, and the ability of providers to care for the people who live in the North Sound ACH region remains our primary focus, and we will work to foster the leadership our region needs.

The ACH continues to develop and leverage partnerships to address challenges impacting population health, such as access to care, network capacity, workforce, and existing resources. Improving population health requires incorporating strategies beyond the health care delivery system, including social determinants of health, primarily led by non-health care focused entities. The ACH understands that doing things *differently,* may be more critical and difficult than doing *more* of the same. We're continually looking for opportunities for counties, hospitals, CBOs and foundations to invest together on upstream strategies.

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[49] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017. Accessible at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393.

The North Sound ACH region is geographically large with diverse populations, including eight tribal nations. One of our counties is **only** accessible via ferry, and by ferry from island to island within the county. Being 15 miles from a service is vastly different when those miles are along a major highway, as opposed to across the Salish Sea. While 27% of Washington residents are on Medicaid, 31% of Skagit County's residents and 60% of tribal members are Medicaid enrollees. The need to embed creativity and flexibility in our project planning, design, and implementation is critical to engaging partners.

Using data from the Washington Tracking Network, we found wide variability in social risk factors in key areas. In 2015, data from the region's county and hospital community health assessments identified three priority areas for our region: care coordination, behavioral health, and addressing health equity. As updated CHAs/CHNAs become available in 2018, we will refine our understanding of the region's health needs and priorities.

We are exploring partnerships with our region's five counties to form and support a Data Learning Collaborative, a regional Epidemiologist, and Public Health Chief Health Strategist. We see the five public health departments as key partners to engage and support with our team, including possible financial support.

Indicate projects the ACH will implement (a minimum of four).

Project Plan Portfolio	
Domain 2: Care Delivery Redesign	
☒	2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation
☒	2B: Community-Based Care Coordination
☒	2C: Transitional Care
☒	2D: Diversions Interventions
Domain 3: Prevention and Health Promotion	
☒	3A: Addressing the Opioid Use Public Health Crisis
☒	3B: Reproductive and Maternal and Child Health
☒	3C: Access to Oral Health Services
☒	3D: Chronic Disease Prevention and Control

[1] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017. Accessible at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393

Project Selection: Program Council Charge

The minutes of the January 2017 the Board charged the Program Council (formerly the Program Committee) with responsibility to understand details of the Medicaid Transformation Project, expectations of the Medicaid Transformation Toolkit, the Special Terms and Conditions, and utilize that knowledge to discuss and recommend toolkit project areas. The Jan 20, 2017 Board minutes state: *"Based on trust, the Board will accept the strong recommendation of the Program Committee."*

In January 2017, the Program Council's charter outlined laid out several responsibilities, including *"recommend to the Board programs and projects that facilitate accessible, affordable, quality services that improve the health of people in the North Sound ACH region; provide guidance and consultation to the Board in setting priorities for programs and services, including but not limited to, the required projects that ACHs are required to implement by agreement with HCA."*

The Program Council charter allows the Program Council to form ad-hoc workgroups to further its work. To date, eight workgroups have been meeting in relation to each of the eight Toolkit project areas.

The Board's approach to the Medicaid Transformation Project has been grounded in several assumptions:

1. The total funds that the North Sound ACH region could earn would not be sufficient to pay for the broad scope of meeting the region's needs. We would use the DSRIP earnings to leverage partnerships and other sources of revenue.

2. Deciding how many Toolkit project areas we would write to, would not be the same as agreeing to implement that same number of distinct projects.
3. North Sound ACH distinguishes the eight *project areas* from specific *projects,* which are understood to be tailored interventions or approaches that are intended to impact metrics. For example, the Reproductive and Maternal Child Health toolkit project area does not not necessarily correspond to a single project. Rather, it may encompass multiple discrete undertakings, defined as "projects". In selecting Project 3B (a project area), the North Sound ACH could carry out four specific "projects" - for instance, regionwide LARC training, a campaign to improve well child visits, collaboration with dental clinics to enhance well child checks, and implementation of One Key Question in primary care settings. Partners may overlap across projects.
4. After the workgroups explored the toolkit project areas, the next step would be to examine and identify the overlaps, intersections and possible synergies among the eight toolkit project areas, resulting in a portfolio of specific strategies and approaches (what we would then call 'projects') that cross the eight toolkit areas.

The North Sound ACH Board and staff understand that partners may have different expectations, and we continue to work to bring partners in alignment with our vision and approach. Since announcement of the Year 1 reduction, we have engaged partner leaders, workgroup leaders and our governance structure into candid conversations allowing them to challenge our decision. To date, most are in agreement that we write to all eight toolkit areas and reaffirm or refine that direction before January 2018.

Staff and Work Group Process

The workgroups have been staffed by ACH team members, but chaired by community and clinical leaders. Staff have called upon those Workgroup Leads to:

- Help craft and synthesize the approach toward selection and refinement of the toolkit requirements;
- Shape the recommendation of either including or not including a toolkit area in our final recommendation;
- Identify overlaps, synergies and intersections among the toolkit project areas; and
- Challenge assumptions about availability and capacity of partners to engage in the work needed to positively influence the required metrics.

Workgroups have included perspectives and leadership from clinicians (physical, behavioral and substance use), community based organizations, county services, MCOs, tribal partners, and some unaffiliated community members.

Brief Description of Process: How

Workgroups have been meeting since mid-spring 2017. Workgroups were first tasked with providing feedback to staff about participant recruitment, with attention to ensuring populating the work group itself – who was missing, how we could assure additional perspectives and voices were included, and assist with making those invitations to join. The workgroups were also charged with becoming familiar with the Toolkit, and providing insight into how the North Sound ACH region could approach the evidence-based models as laid out in the Toolkit, asking if we have willing partners, regional needs related to the Toolkit areas, and strategies to positively impact the identified metrics.

The Board's vision is to address health in the North Sound ACH region including Medicaid but not limited to Medicaid. Our partners see community members on Medicaid, Medicare, commercial coverage and those without coverage. Workgroup participants understand that the DSRIP efforts allow the North Sound region to transform the delivery of care and services, and that transformation will have an impact broader than Medicaid.

The North Sound ACH developed a framework for selection of project areas (Figure 6), which identified and differentiated required and desired project factors.

For example, improving region-wide health outcomes, as indicated in the toolkit metrics was one of the required criteria, and each approach has to demonstrate how it will improve health in specific metrics, which we consider

to be a proxy for improving region-wide health outcomes. In walking through each toolkit project area with its respective workgroup the staff and work group leads assigned a measure of how well their discussions and partners had addressed each item in the framework, acknowledging that more detailed information would occur while discussing detailed approaches in the planning phase.

The framework was crafted considering priorities of the Board and partners, evaluating the toolkit measures and metrics and translating those into a set of criteria that would allow us to distinguish the toolkit project areas, if such distinctions appeared.

The Program Council approved use of this framework to guide selection of the Medicaid Transformation project areas. This framework (Figure 6) was used by workgroups, and the Program Council, in discussing the toolkit area selection decisions. Each toolkit project area was assessed a value to determine current strengths and areas for improvement. Project areas were rated from needing additional work (1), somewhat strong (2), to strong (3). This analysis was used to inform the project selection process and identify project areas that were more likely to be successful than others. This process resulted in a decision to move forward with writing to all eight project areas.

Figure 6. North Sound ACH Project Framework

General

- The project is transformational and aims to accomplish something new, different, better, or more expansive than current efforts
- The project is not duplicative of other work in the North Sound ACH region (prefer complementary, additive, or expand on other work)
- The project has engaged multiple provider partners

Evidence

- The project uses an evidence-based model recommended in the Toolkit

Data

- The project addresses the metrics required by the Toolkit
- The project addresses a regional health need, as supported by data

Population

- The project is relevant to Medicaid, with potential to improve health outcomes for Medicaid enrollees
- The project targets the population required by the Medicaid Transformation Project Toolkit

Impact

- The project has potential to increase access to health care and other services
- The project considers social determinants of health
- The project does not protect obsolete models, but does not break models that are working without an adequate improved model
- The project improves population health through clinical management and addressing underlying determinants of health status
- The project has the potential to significantly impact health outcomes and/or reduce inequities

Infrastructure

- The project uses a workforce that is currently available and/or increases capacity of available workforce
- The project builds on, or leverages existing infrastructure and supports local efforts for transformation

Project Planning

- The project has a plan for sustainability beyond the Medicaid Transformation project years
- The project has the potential to be scaled up and expanded
- The project has incorporated stakeholder and public input, and has a plan for continued engagement
- The project is feasible to implement, including potential cost impacts
- The project can be flexible, and may be implemented in diverse areas, or with diverse populations
- The project has the potential to address an area of critical need in the region, or an area with high acuity

This framework guided the project plan writing process where in-depth considerations for evidence-based interventions, available resources and existing infrastructure were discussed and determined by Workgroup leads, subject-matter experts and staff over a two-month period. Project plan updates were routinely shared with the Program Council. Project area specifics for these considerations are captured in each Project Plan within Section 2 of this document.

In addition, data was analyzed for each of the eight toolkit project areas and for each workgroup to provide a preliminary analysis of level of need in the North Sound region so that workgroups would only commit to a project area if there was compelling evidence that need was document. For example, data was shared for Project 2D indicating the number of Medicaid enrollees that appear at the Emergency department for non-acute conditions. This was shared with the workgroups and with the Program Council during its project selection deliberation.

Figure 7: Example of Data Shared with Workgroups and Program Council prior to Project Selection

Project Area 2D: Diversion Interventions

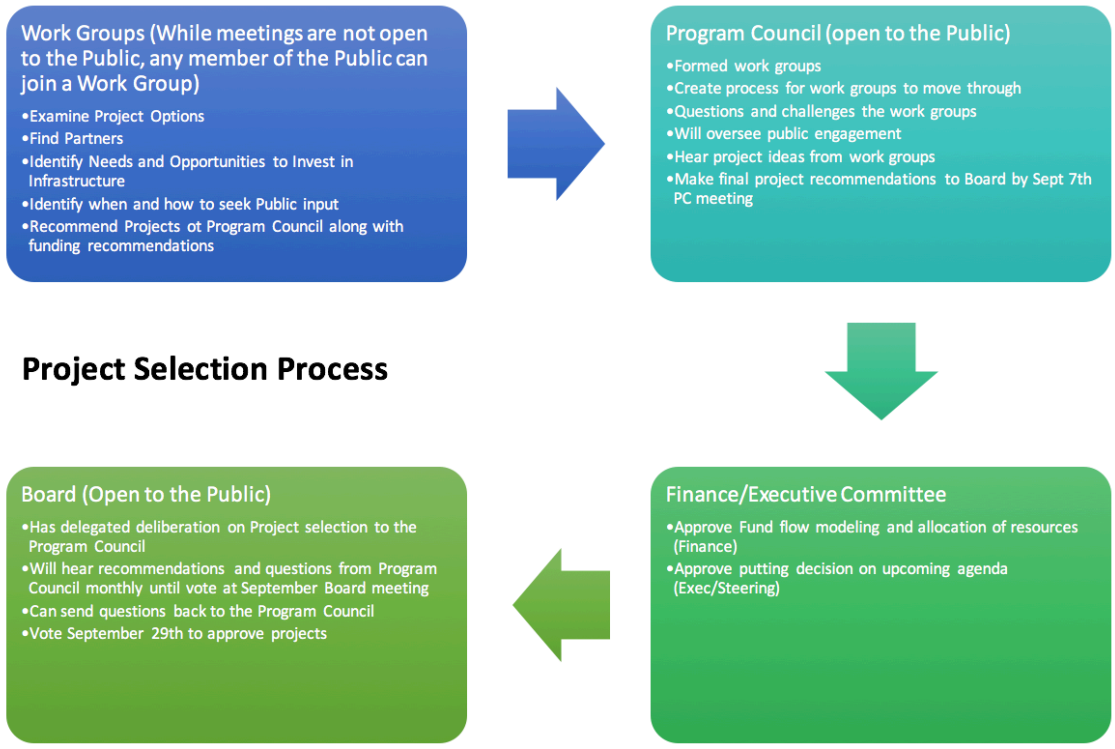
Toolkit Target Population: Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Medicaid Transformation Project Area Metrics June 2017	North Sound Numerator	North Sound Denominator	North Sound Rate	Island Rate	San Juan Rate	Skagit Rate	Snohomish Rate	Whatcom Rate	Statewide Rate	Highest Performing ACH	Lowest Performing ACH
Outpatient Emergency Department Visits per 1000 Member Months	104,659	2,391,069	44	59	27	46	44	39	51	40	72
Percent Arrested (18-64 years) *	7,938	121,494	7%	N/A	N/A	N/A	N/A	N/A	7%	N/A	N/A
Percent Homeless (18-64 years) *	5,847	121,494	5%	N/A	N/A	N/A	N/A	N/A	5%	N/A	N/A

Data Source: HCA Medicaid enrollment and claims data for 2015-2016, WA Healthcare Authority.
* Indicates data includes Medicaid and dual-eligible enrollees.

The North Sound ACH laid out its expected timeline for decision related to project selection during late Spring 2017, and was able to stay on target for the timeline, setting a target date of September 7 for the Program Council decision, and September 29 for Board decision. (Figure 8)

Figure 8: North Sound ACH Project Selection Decision Timing/Timeline



How the ACH plans to improve the region-wide quality, efficiency, and effectiveness of care processes:

Selection of toolkit project areas was driven by looking for alignment with known needs in the North Sound ACH region (tied to the RHNI); clinical and community partners with interest, capacity and influence on large numbers of Medicaid enrollees; and engagement of the five counties and eight tribal nations in the North Sound region. Workgroup leaders reached out to potential partner organizations and learned about regional needs identified through available data, recommending toolkit project areas that would improve health across the North Sound ACH region.

One of the North Sound ACH goals is to advance the adoption of VBP, which is closely tied to outcomes that DSRIP is measuring during the P4P phase. Providers who are better prepared and moving toward VBP adoption will be more efficient, and have higher quality measures than those that stay with the status quo of today's patterns of practice.

The North Sound ACH will work directly with community-based and clinical providers, including MCOs, health system, physical and behavioral health clinicians, counties, tribal partners, first responders, and community based organizations that provide supportive services such as care coordination, housing, transportation, and nutrition, to build bridges across traditional silos, forging and fostering new partnerships to improve health through actions that occur within clinical settings, enhancing them with supportive activities that occur in the community/non-clinical settings.

For example, improving the P4P metric of Hemoglobin A1Cs requires improved screening in physical and behavioral health settings, greater communication and integrated medical planning, and it requires community partners who can help with medication access, appropriate nutrition, affordable food, cooking facilities and physical activity options that will enhance health. Community Health Workers that emerge due to implementation

of the Pathways HUB, can provide linkage among and between supportive services that enhance physical health outcomes.

In order to earn DSRIP dollars, the North Sound ACH plans to financially support partnering providers who take part in training on selected practice models, professional development, assessment and evaluation strategies that will improve the care processes and care delivery system. As an independent entity, the North Sound ACH is poised to coordinate and identify opportunities to leverage efforts across the region, provide high-level strategic insight and support to better align transformation activities, and seek out new revenue and partner opportunities. The North Sound ACH is helping to coordinate system wide efficiencies that are challenging from the perspective of any one sector perspective. With a region-wide perspective, that can expand as needs are identified, the North Sound ACH has the ability to leverage resources in ways that are unique.

For example, as we focus on workforce strategies, the near term needs are aimed at current workforce, and those near to completion of current educational programs. Thinking longer term, the North Sound ACH could engage school districts so that we can entice middle and high school students to see career paths that meet the delivery system needs of the future. That would bring new partners to the North Sound ACH table.

The North Sound ACH is drafting a set of requirements for partnering providers that, in addition to their current capacity to participate in the Medicaid Transformation's project activities, will improve quality of care throughout the region, including:

- Commitment to workforce assessment
- Participate in North Sound ACH trainings and learning collaboratives
- Enroll in WAIIS and PMP
- Agree to data sharing with ACH and Local Health Jurisdictions
- Partnership between clinical and community- based organizations
- Identify leadership staff for planning teams during ACH Planning Phase
- Incorporate One Key Question into internal patient/client assessment process
- Identify providers to take part in LARC training
- Participate in solicitation of other fund/revenue sources for regional health activities
- Attest that there will be no duplication of funds from other DSRIP initiatives

The North Sound ACH is setting these expectations in order to sustain effectiveness, efficiency and quality for the longer term. Without embedding these commitments to change, the partners may see the Medicaid Transformation as a short term effort that will earn them defined funds, rather than as systemic and fundamental change. The North Sound ACH will use DSRIP funds to bring partners to the region who can provide training, technical assistance, some of which will be through the North Sound ACH's administrative percentage, but mostly through funds that are tied to specific projects. For example, using funds earned for Reproductive Maternal Child Health to support the cost of provider teams being trained on Long Acting Reversible Contraceptives or One Key Question. Whenever possible we will use local and regional resources to provide training and technical assistance to continue building capacity within the North Sound ACH region.

The North Sound ACH believes in ensuring that resource allocation is not duplicated nor redundant across project areas. To this end, coordination, collaboration, and sharing of resources will be encouraged and optimized where possible. This will include sharing of resources within the ACH region (with partners) and across ACHs.
Examples of internal ACH sharing include:

- Organization of initiatives planning into consolidated processes where possible. This will include the development of initiative planning teams across multiple project area driven by setting of care, patient population, and shared goal. The framework for this process is currently in development between the North Sound ACH and partners.
- Use of shared HIT/HIE resources such as PreManage, where contracts and purchasing of software may allow multiple partners to reduce costs and coordinate trainings for software use across multiple parties.

- Shared training resources across all relevant parties, such as SBIRT (Screening, Brief Intervention, and Referral to Treatment) or OKQ (One Key Question).

Examples of sharing across ACHs includes:

- Collaboration and coordination technology purchases, such as of care coordination or health information technology infrastructure that can be shared among ACHs.
- Sharing of Pathways Community HUB resources and trainings across multiple ACHs implementing this model is one example.

How the ACH plans to advance health equity in its community:

The ACH project area is expected to identify target populations (and/or our 'starting' place) for the project-focused work. The North Sound has expectation that communities impacted by disparities will be a key driver in selecting those initial target populations, and will be engaged in refining specific projects. To accomplish this, the North Sound ACH will have laid out three strategies so far:

- Incorporate the North Sound ACH Community Leadership Council (CLC) into the governance structure by end of 2017, adding a representative from the CLC to the Board. The CLC will add perspective and voice of those served by Medicaid. It currently has 22 members, of which more than 50% are people on Medicaid or a family member/caregiver of someone on Medicaid. When the Board adopts the charter, a member of the Council will formally join the Board.
- Provide 3-4 learning opportunities each year on health equity and reducing disparities to participating partners, Board and Committee members. Several ACH regions have expressed interest in partnering on these opportunities, including Olympic Community of Health, Better Health Together, CPAA, and North Central ACH. The North Sound ACH launched an Equity Learning Cohort on October 6th, with a training provided by Ben Duncan, Chief Diversity and Equity Officer of Multnomah County, the largest county in Oregon. The North Sound ACH will bring local, regional and national experts on equity to Washington to enhance knowledge in best practices on embedding equity into practice settings.

The overarching goal for the North Sound ACH is to advance leadership in health equity by providing development and capacity building opportunities that share best practices and project implementation around health equity. Each participating provider within the project areas will be expected to have leadership that takes part in the Equity Learning Cohort and to demonstrate how they are embedding and operationalizing equity in their project area.

How the ACH plans to demonstrate a role and business model as an integral, sustainable part of the regional health system:

The North Sound ACH is poised to play a leadership role in planning, assessment and convening/facilitation of tough discussions across the region, acting as an incubator for cross sector/multi-sector projects. With a governance structure that includes appointees from each of five counties, up to eight tribal nations, health systems, physical and behavioral health, long term care, public health, education, first responders and community members, the opportunity to discuss challenges that cross traditional divides in immense.

The DSRIP projects offer an opportunity for the North Sound ACH to demonstrate value to the region. There is a strong history of collaboration in the North Sound ACH region, but the shared ownership and decision making about services that impact multiple systems and such a large number of Medicaid lives has never been tried before. Both addressing the opioid crisis and jail diversion serve as examples where the problem touches police, EMS, county jails, courts, behavioral health, physical health, housing, and many more systems. The North Sound ACH does not aim to replace local decision making, but rather to offer an opportunity to have local decisions and authorities have a place to discuss and align strategies. Tribal partners describe the services that they provide, but their clinics also serve non-tribal members, and tribal members seek services from non-tribal settings. The North Sound ACH provides a unique opportunity to discuss and strategically plan for those overlaps and intersections, resulting in better health across the region.

One key measure of success for the ACH structure will be the continued commitment of partners, including Board leadership, to see and act on strategies that leverage the ACH decision making table to move their respective agendas. The ACH structure is only sustainable to the extent that partners find value in its existence.

One example of looking to a new source of revenue lies in the decision to have the North Sound ACH play the role of the Pathways HUB. We will continue to look for opportunities where a small and nimble organization, with an efficient and lean administrative structure can lean into other efforts in the region. The North Sound ACH is prepared to evaluate its role and appropriate size to meet the needs of the region once the Medicaid Transformation Project is coming to completion, and our success in soliciting other funds and supporting partners to continue to play a regional role.

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

There were no gaps and/or areas of improvement noted in the Phase II certification

Governance

North Sound ACH incorporated as a nonprofit corporation with the State of Washington with a Board of Directors responsible for the corporate entity.

The North Sound ACH Board of Directors has the following standing committees who provide oversight or advisor roles in the following:

- *Executive Committee:* The officers and at least one additional Board member serve as the Executive Committee. Except for the power to amend the articles of incorporation and bylaws, the Executive Committee has all the powers and authority of the Board of Directors in the intervals between meetings of the Board of Directors, and is subject to the direction and control of the full Board.
- *Finance Committee:* The Treasurer chairs the Finance Committee, which includes at least two other Board members, and can include non-Board members at the discretion of the Committee Chair. The Finance Committee is responsible for developing and reviewing fiscal procedures, fundraising and fund allocation plans, and an annual budget. The financial records of the organization shall be made available to Board members and the public.
- *Governance Committee*: The Board Chair appoints a Board member to serve as Chair of the Governance Committee, which can include Board and non-Board members. The Governance Committee is responsible for the Board's effectiveness and continuing development, including recommending nominees for Board membership, setting an annual board calendar, Board self-evaluation, and annual review of the bylaws.
- *Tribal Alignment Committee*: The Committee is responsible for examining all board decisions related to impact on our region's tribal nations. The committee includes representatives from tribal members who sit on the Board of Directors, plus at least one additional Board member who is not a tribal member.
- *Program Council*: The Board Chair appoints a Board member to serve as Chair of the Program Council, which will include Board and non-Board members. The Program Council is an advisory body to the Board and is responsible for making program and project priority recommendations to the Board for consideration, recommending policies and guidelines to the Board.
- *Community Leadership Council (tent.)*: Once the charter is approved by the Board (anticipated December 2017) the Chair of the Community Leadership Council (CLC) will be appointed by the Board Chair. The CLC is framed as an advisory body to the Board and is responsible for bringing forward perspectives of people served by the Medicaid program so that those perspectives are embedding in the North Sound ACH planning, process, decision making and evaluation.

Financial oversight: The Board's Finance Committee has oversight responsibility to review and approve monthly financials, review draft budgets and recommend approval to the full Board, approve financial policies and procedures (including banking and investment strategies) and securing independent firms to complete periodic audits of all financials. The Finance Committee also carries responsibility for recommending strategies to the Board regarding administrative/infrastructure cost and rates; sustainability and business plan development and how Medicaid Transformation funds will be shared with partners.

Clinical oversight: The North Sound ACH Program Council has key health system and clinical leadership as participants. The Program Council will hear quarterly reports on regional needs and data reports and make recommendations to the Board about possible policy or program directions, including solicitation of additional

partners. Representatives from each of the North Sound ACH region's five counties sit on the Program Council, including physical and behavioral health, housing, maternal child health, counties, tribal partners and community members. Clinical representation is primarily from medium to large systems; outreach to smaller and more rural practices is an explicit goal.

In addition, an advisory group has been formed with leadership from Providence and PeaceHealth, the region's largest FQHCs, and independent clinical practices. The BHO's leadership (BHO Executive Board, BHO Advisory Board and Interlocal Leadership Group) serve as subject matter experts and advisors in relationship to BH and SUD. The newly formed Tribal Alignment Committee will also provide clinical oversight and perspective, including how decisions affect tribal members and practices.

Community: In the fall of 2017, the North Sound ACH established the Community Leadership Council (CLC), of which over half of the participants are Medicaid enrollees, or family members/caregivers of people on Medicaid. This CLC will provide feedback and input into North Sound's decision-making and advise on community engagement efforts. The North Sound ACH is committed to meaningful engagement with community members and other stakeholders, and continues to design opportunities for engagement in project planning and implementation. In addition to the CLC the North Sound ACH Board meetings are open to the public, and each meeting has multiple opportunities for public input.

The North Sound ACH has a separate email address that is publicly used for community members to advise the North Sound ACH (voices@NorthSoundACH.org); there is also an email address to communicate with the Board (Board@NorthSoundACH.org).

Beginning in 2018 Board meetings will rotate across the region, including to tribal locations, fostering greater access for community members to learn about and provide feedback on the North Sound direction and decisions.

Data: The North Sound ACH Program Council is responsible for identifying, assessing, analyzing, and translating available data to inform decision-making and other project processes. The North Sound ACH Data and Research Manager will provide quarterly updates on RHNI changes and available data allowing the Program Council to recommend changes or updates to project approaches for the Medicaid Transformation project.

Program management and strategy development: The Board of Directors, in approving the North Sound ACH Program Council's charter, delegated responsibility for setting program and project recommendations to the Program Council.

The Finance Committee is responsible for ensuring that the organization's capacity is reflected in the budget and budget assumptions, and all Finance Committee information and recommendations are heard at the Board meeting in public sessions. The Board has delegated to the Executive Director, through an approved Board resolution, responsibility for ensuring staff capacity to lead and manage the projects that we undertake, including development of strategies to meet the agreed upon goals. The Executive Director provides an Operations Update monthly to the Board of Directors, or more frequently as urgent needs arise. The Operations Updates summarize progress toward goals, administrative and staffing changes, and statewide Healthier Washington updates.

The Board, by its composition, includes sector representatives and regional/county representatives, to ensure that we have broad reach across our five counties.

As of November 2017, the North Sound ACH has 8 full time staff:

Liz Baxter, Exec. Director	Ross Howell, Project Manager
Kyle Davidson, Deputy Director	Heather McGuinness, Project Manager
Nicole Willis, Data and Analysis	Leah Wainman, Community Engagement
Tiffany Edlin, Exec. and Gov. Coordinator	Hillary Thomsen, Admin. and Project Coordinator

The North Sound ACH is currently recruiting for three additional positions: A third Project Manager, a Tribal and Community Liaison, and the Pathways HUB Director. The Executive Director is responsible for all final communications efforts on behalf of the North Sound ACH.

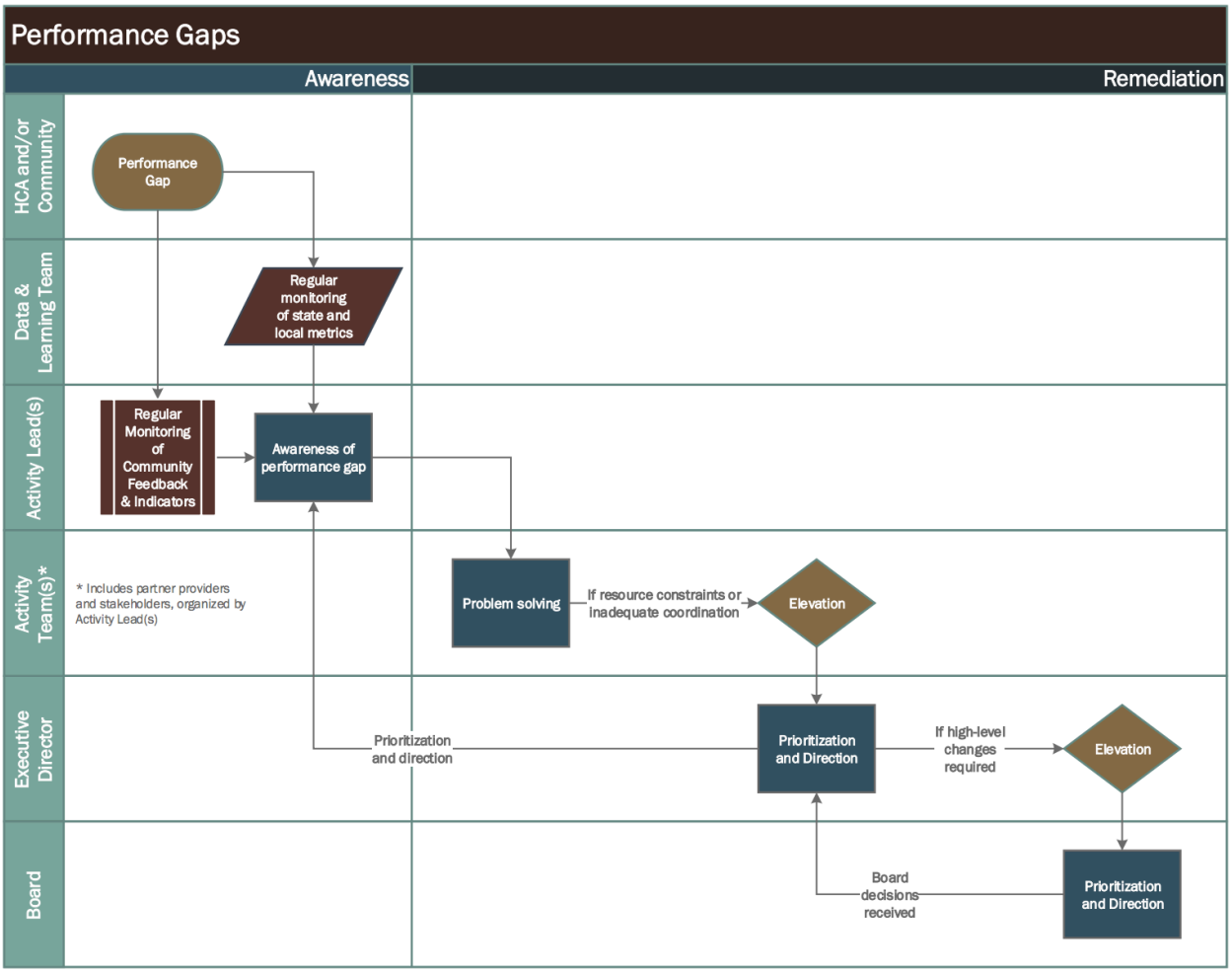
Overall monitoring infrastructure will be led by Project Managers, who will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or

collected on a monthly or quarterly basis for review by the data and learning team. They will also lead Activity Teams that include partner providers, community representatives, and other stakeholders.

As illustrated in Figure 9, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

Figure 9: Performance Gaps Process Map



Significant changes or developments related to the governance structure since Phase II Certification:

The Community Leadership Council (with a majority composition that are people on Medicaid or family/caregivers of people on Medicaid) launched in September 2017, and has been working to draft its charter. The Council will provide perspectives of people being served by Medicaid and advise on community engagement strategies and policy decisions impacting people on Medicaid. The Chair of the Council will also be a Board member, ensuring two-way communication between the Board and Council.

Areas of improvement identified in Phase II Certification related to its governance structure and decision-making processes:

None were noted in Phase II application.

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

The North Sound ACH anticipates partnering providers that will receive payment and some that will not. For example, a local foundation may want to partner, but not be able to receive payment or not desire payment even though they are a key partner for a specific project. The North Sound ACH currently has each project area assigned to a Project Manager, and MOUs/Contracts will lay out the requirements that partners must agree to in order to participate and earn funds. As we begin the planning phase, we are building reporting measures that will allow partnering providers to report on their progress toward pay-for-reporting measures and eventually pay-for-performance metrics. We will build into all MOUs/Contracts expectations of performance levels with adjusted levels of payment that align with the varied levels of performance. We do not yet have final versions of MOU/partner agreements, as they are currently under review by our legal counsel.

The North Sound ACH is drafting the approach to partner agreements in three phases following with different methods/approaches to payment: 1) the Planning phase which will pay for time and activities; 2) implementation during P4R will pay for time, activities, project participation and implementation; 3) implementation during P4P will pay incentive payments based on performance levels.

If partners do not meet expectations during any of the three phases, the draft plan is that there will be a period of negotiation with the specific partner to better understand the reason for low performance and determine if there is a mitigation strategy before considering terminating the provider from participating, regardless of whether they are being paid or not. Terminating participation from receiving payment would be distinct from determining a partner is not participating in a project area altogether.

We will require documentation along with numbers, for example, in reporting how many people took part in a training for P4R. Partnering providers may also be asked to provide a list of staff by name, or other unique identifier, so that we can be assured that there is no duplication in reporting from time period to time period.

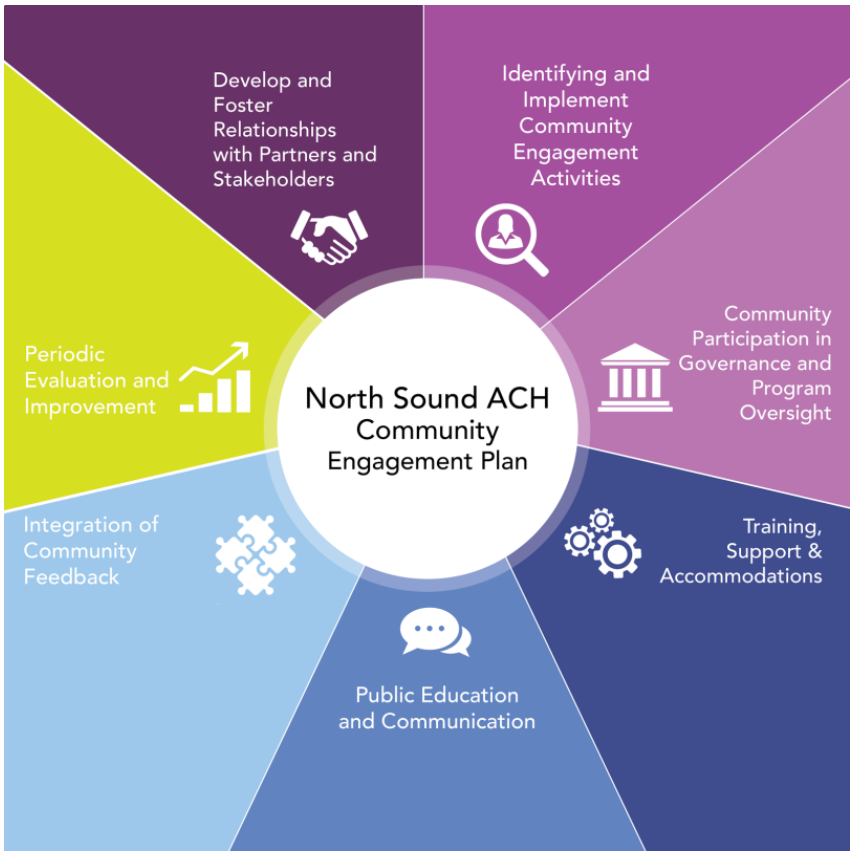
The North Sound ACH, working with ACH partners in other regions are developing a common monitoring and reporting framework, and exploring potential partnerships with several consultants, including Providence's Center for Outcomes Research and Evaluation (CORE) and King County's data and analytics section to support reporting during P4R period of the Medicaid Transformation project. This process will include specific steps to take action with providers who are either low- or non-performers. Project Managers will be assigned specific projects and groups of providers to monitor. Activities by Project Managers will include site visits, meetings with providers to identify successes and challenges, periodic surveys to measure progress toward contractual goals. One strategy under discussion to incentivize providers to remain engaged, is to have financial disincentive for participating providers who cease to participate in the North Sound ACH project(s); for example, they may risk losing any access to incentive dollars under P4P. These decisions will be further fleshed out during the first quarter of 2018.

Community and Stakeholder Engagement and Input

Healthcare transformation through Accountable Communities of Health offers a unique opportunity to include those communities facing the greatest health disparities, who have traditionally been underrepresented in the decision-making process. In order to ensure the success of transformation projects, and as a reflection of our commitment to equity, the North Sound ACH Board of Directors approved the development of a plan to actively involve those with Medicaid health coverage in the work of the North Sound ACH.

The community engagement process (Figure 9) reflects the guidelines put forth by the Northwest Health Law Advocates and the WA Community Action Networks advising ACH's on their community engagement activities. From these guidelines, the North Sound ACH created a multifaceted community engagement plan with equity as the guiding force. The engagement plan is a circular model, acknowledging that community engagement is a continuous, rather than finite process. As a part of the ACH commitment to grassroots-level engagement in the North Sound, the organization hired a Community Engagement Coordinator with experience working with Medicaid eligible populations for a local Community Action Agency.

Figure 10: North Sound ACH Community Engagement Plan Framework



Examples of executed actions from the plan include:

Community Participation in Governance and Program Oversight

- The formation of a Community Leadership Council (CLC) to join the North Sound ACH's governance structure. The CLC contains nineteen community members and represents all five counties. The CLC's membership is comprised of people who are or have received services paid for by Medicaid (51% of participants), and individuals who provide direct services to people with Medicaid health coverage (49% of participants). The CLC will play a key role in tailoring future engagement activities to the specific needs of the communities they represent.

- Many CLC members have participated in workgroups and project planning activities.

Public Education & Integration of Community Feedback

- Updates to the North Sound ACH Facebook page, with locations and times where the public can meet and speak with staff during all public and partner events, including Board and Program Council meetings.
- Hosted public forums and community conversations on Opioid Use and Dependency issues in rural eastern Whatcom County
- In collaboration with a local Community Action Agency: planned two focus groups comprised of graduates of a Financial Literacy and Renter's Education workshop, including residents of public housing programs, participants in Work First and Temporary Assistance for Needy Families (TANF).

Develop & Foster relationships with Partners & Stakeholders

- Formed partnerships with Community Action Agencies in all five counties, a primary source of direct services for individuals who live at or up to 125% of the Federal Poverty Level.
- Provided education for Whatcom, San Juan, & Island Counties Community Resource Networks on the work of the ACH and invited participation of providers and their engaged clients.
- Education for Community Health Workers from Snohomish County Community Health Center on the work of the North Sound ACH, including invitations to both CHWs and engaged patients to participate in the CLC and project area workgroups.

In September 2017, the Community Engagement Coordinator spent 16 of 20 days in the community engaging stakeholders including community members receiving services paid for by Medicaid and direct service providers. The Board and Program Council will continue to seek public input at each meeting to support decision-making processes. In addition, the Community Leadership Council has reserved time during the monthly meetings for additional public input and/or comment. The ACH prompts and solicits community feedback on the North Sound ACH Facebook page on a weekly basis. At every community/partner event the coordinator will deploy a survey for community members with Medicaid health coverage.

North Sound ACH newsletters go out at least once monthly before public meetings of the Board and Program Council, with a mailing list of more than 500 recipients. Events posted on the FB page are also posted with sufficient lead time to allow for planning and transportation in advance of attendance. In addition, we have remote access to meetings.

Transparency and public input:

While the North Sound ACH utilizes digital means to disseminate information, including event dates and times to the public in the form of: 1) the North Sound ACH website, 2) the North Sound ACH Facebook page, and 3) the monthly community newsletter. We also call on our diverse and extensive regional partner network to disseminate information to potential partners and other stakeholders, and in the future, we will work with the Community Leadership Council to disseminate ACH meeting and event information on the grassroots level.

All ACH meetings are open to the public with time reserved within every meeting for public input. Since its formation in August, all 2017 dates, times and locations for the CLC meetings have been posted on the North Sound ACH website and Facebook page. Within two weeks of each CLC meeting, minutes are made available to the public and posted to the North Sound ACH website. The North Sound ACH Community Engagement Coordinator has shared CLC dates, time and location at community meetings and partner events 29 times since September 2017.

All ACH Board and Program Council meetings are posted on the North Sound ACH public-facing website. At least a week before each North Sound ACH Board and Program Council meeting, the meeting agenda and materials are made available to the public. Within two weeks following the meeting, recordings and meeting minutes are made available on the North Sound ACH website. Staff provides remote access opportunities for all North Sound ACH public meetings.

The Program Council and Workgroups include broad cross-sections of stakeholders. Stakeholders on the Program Council voiced concerns regarding available information within which to make project selection recommendations during the July and August meetings. The concerns and responses are recorded in meeting minutes. Staff reviewed questions and concerns, then presented data and evidence in response during the August and September scheduled meetings. At any point in between meetings, stakeholders have the ability to reach out to staff including the Executive Director to voice concerns or questions. Responses are provided directly, included as an agenda item for the next regularly scheduled meeting or information/feedback responses are provided in the monthly newsletter.

Community input from all five counties helped shape elements of the Project Plan. Throughout the project selection phase, the North Sound ACH incorporated community responses and feedback found in partner community needs assessments, including the Prosperity Report for Whatcom, Island & San Juan counties, the 2015 Skagit County Population Health Trust Advisory Committee Report: Community Health Priorities, and the 2015 Snohomish County Low-Income Community Needs Report from Community Action Agency of Snohomish County. Examples of how this feedback was incorporated into project selection and planning include:

1. In Washington state, only 22% of eligible Medicaid recipients receive preventative oral health services.[50] As part of the community needs assessment process, when asked, residents living in poverty in all five counties stated "not enough preventative dental care" as a barrier to accessing healthcare. According to the 2015 Snohomish County Low Income Needs Assessment, 11% of low income households stated the location of dental services as prohibitive to oral health. In response to the community needs assessments and stakeholder input, including those with Medicaid health coverage, the North Sound ACH included Oral Health as part of our project plan template and plan to address the issue of access through the project.
2. A tribal member, the mother of a child with Substance Use Disorder and a sitting member of the North Sound ACH Community Leadership Council provided project selection input on both the Diversions and Opioid project areas. During the ACH presentation for the North Sound Behavioral Health Advisory Board and in several CLC meetings she voiced her frustration with silos that exists between behavioral health, the courts and the juvenile justice system. In response to CLC member and other community members interviewed as part of the 2015 Snohomish County Needs Assessment, the Program Council approved the Diversions project area and plans to address the issue of breaking down system silos.
3. In Snohomish County, community members living in poverty reported "social and human services are difficult and confusing to navigate," "inaccurate and conflicting information," and fear of judgment from direct service providers. During the October CLC meeting, a member reported that health systems are difficult to navigate for a parent of disabled children. She described her efforts as a mother of a child on Medicaid and navigating the different physical and behavioral health systems. In response, the North Sound ACH embraced the Pathways Care Coordination model and its use of Community Health Workers (CHWs) as a means to address these commonly voiced barriers to care. The use of the Pathways model through data connections with the Hub functions as a way to reduce duplicative and inaccurate referrals and information to Medicaid recipients and their caregivers navigating the healthcare system.

Embedded in the Community Leadership Council draft charter is an ongoing commitment to community engagement on the part of each Council member and the Council as a whole. The diversity among council members includes: socioeconomic, professional, geographic, language, and life experiences which will help tailor the community engagement plan to better reach those populations suffering from health inequities, and who we hope to target for population health improvement. Each CLC Council member will serve a two-year term and the coordinator will recruit new members annually. The CLCs engagement plan will encompass the five-plus years of the Medicaid Transformation period, but will also function beyond the Medicaid Transformation period as a Community Advisory Council for all future work of the North Sound ACH.

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[50] Washington State Department of Health. (2016, March 29). Adults with Unmet Medical Needs. Data obtained from the . *Washington Tracking Network, Washington Department of Health*.

Engaging local county government(s):

There are several ways that North Sound ACH has approached engaging county governments in the work of the Medicaid Transformation.

- During 2017, County Councils/Commissions from each of the region's five counties were asked to nominate someone to the North Sound ACH Board to foster two-way communication and collaboration between the work of the ACH and the counties. All five counties have nominated a member, with three of those nominations consisting of county elected officials.
- An Interlocal decision making body was formed in the North Sound ACH region to foster discussion on the mid-adopter process and resulting transition decisions for the BHO. Both the North Sound ACH Executive Director and an ACH Board member sit on the Interlocal decision making body.
- Leadership from each of the five counties (public health and human services) have been engaged in both workgroup discussions and on the Program Council.
- The North Sound ACH Data and Analysis Manager is developing a Data Learning Team, which will include participation from the Health Departments and community assessment capacity in all five counties.

Areas of improvement, as identified in its Phase II Certification, related to community engagement, partnering provider engagement, or transparency and communications:

Challenges/strategies included:

1) Translation of HCA/ACH-speak into plain language to address literacy and health system literacy, as this will enhance understanding of our approaches. This strategy was executed with the guidance of a public health communication consultant who developed audience specific PowerPoint and presentation materials tailored to 1) professionals; 2) community leaders (i.e. community council's or advisory councils; and 3) general public and other non-healthcare professional community members including those receiving services paid for by Medicaid.
2) Providing financial resources to address barriers such as limited transportation and child care. For our CLC council and guests, childcare and a transportation stipend are provided.

3) Alternate locations/times for engagement opportunities, including scheduled forums and public engagement events throughout the day and on weekends. Public forums have been scheduled in the evenings to be mindful of families including working families. Throughout the engagement process, plans include a focus on community engagement activities in rural or geographically isolated areas including Eastern Whatcom county, Eastern Skagit county, Eastern Snohomish county and the islands of San Juan county. CLC council members from these regions will play a role in planning our engagement activities in these regions.

Tribal Engagement and Collaboration

The North Sound ACH is honored to have success in engaging most of the eight tribes in the region, including having 5 tribal representatives appointed to sit on the ACH Board of Directors (we have Board seats open for each of the eight tribes). Currently, five tribes (Upper Skagit Tribe, Lummi Nation, Swinomish Tribe, Stillaguamish Tribe and the Tulalip Tribes) have appointed members to the Board, and the Director of the Northwest Indian Health Board serves on the Program Council.

Tribal partners in the North Sound ACH region have been engaged in the region's ACH since 2014, even prior to submitting the application to become a regional ACH. Tribal partners offer examples of creative strategies to approach care of vulnerable populations that all partners in the North Sound ACH region can learn from. Tribal partners held voting seats on the Governing Body, and each tribe has a full voting seat open to their tribe on the Board.

The North Sound ACH has recognized as a nonprofit corporation we are not in a peer relationship with tribal governments, and have therefore made space for tribal partners to define their role with the Medicaid Transformation Project in their own way and at their own speed. Some of this is developing organically as relationships are built, rather than following a linear timeline. The value of these relationships and potential partnerships is greater than the timeline of the Medicaid Transformation project.

This has been strengthened by the experience and strength of the North Sound Board leadership, which recognizes the value of strong relationships with tribal partners, and created space for flexibility and humility in response to tribal leaders describing their frustration with the HCA and North Sound ACH approaches.

For example, we know that Lummi Nation has communicated with the Health Care Authority, indicating its desire to act as its own ACH. Having participation of tribal partners who are working on tribal-specific DSRIP projects, a statewide tribal ACH strategy while continuing to sit at the North Sound ACH table has enriched our region's work, while we recognize that our tribal partners are challenged to stay engaged because of competing time and tribal government commitments. Sixty percent of Lummi Nation members are on Medicaid, and Lummi is where we see creativity in meeting the needs of their people. There is need, strength and leadership that other partners around the North Sound region can learn from, and this is true of each of the region's eight tribes.

During the last round of election for officers, Councilman Nickolas Lewis, from Lummi Nation, was nominated and elected as vice-chair of the North Sound ACH Board of Directors. Councilman Lewis presented an introductory training to the Board of Directors on tribal sovereignty, and introduced the idea of having North Sound ACH Board meetings occur at tribal nations throughout the coming year, which the full Board endorsed.

The North Sound ACH has used information and insights shared by the tribal representatives to shape our project selection decision and the work group discussions, and this data has been used to influence partner and project area selection.

The ACH's tribal partners have demonstrated innovative approaches to housing and its relationship to physical and behavioral health care, building supportive housing units that wrap recovery, addiction, employment and family support services, bringing services to the individual/family rather than requiring that families navigate complex systems when they are in crisis. Several counties in the North Sound region have expressed desire to learn more about these approaches, recognizing that tribal members with physical and behavioral health needs use tribal and non tribal service settings. They recognize the connectedness of the needs and the opportunities that exist to work in partnership.

As an example, selection of the oral health toolkit project area was influenced by the opportunity to work with and learn from the Swinomish Tribe and their plan to train and utilize Dental Health Aide Therapists (DHATs). This led to an opportunity to work with multiple ACHs (Olympic Community of Health and North Central and ACH) and the Arcora Foundation, which is also interested in supporting development of this workforce capacity, inside of and outside of tribal clinic settings. This led to interest in the North Sound ACH region to support training of DHATs for broader populations, and the experiences of tribal partners will enhance the ACH's ability to strategically grow this workforce.

Areas of improvement identified in its Phase II Certification related to tribal engagement and collaboration:

In July 2017, following the Phase I application, Councilman Nickolaus Lewis (Lummi Nation) provided a training on tribal Sovereignty to the Board of Directors. The materials from the training are being made available to Board members to facilitate continuous learning. This training is part of a series of planned trainings, with Board members requesting follow-up to learn about tribal nations, assets and project focus areas, and population health statistics.

The Board has expressed interest in learning more about the disparities faced by tribal members across the region, and the ACH will support this request by providing data, particularly for specific project areas, when available.

In addition to trainings and tribe-specific data, the Board is exploring opportunities to rotate meeting locations to be onsite at tribal locations. This would provide an opportunity to increase tribal engagement, continue to build meaningful relationships, and offer Board members an opportunity to learn more about specific tribes and the impact of ACH decisions and actions. The Board has also added the Tribal Alignment Committee to the governance structure, to ensure Board decisions are evaluated by tribal partners.

Funds Allocation

Funds Flow Oversight

For the North Sound ACH, budgets are developed by the Executive Director and the CFO, who provides accounting and CPA support for budget development and revisions. The Board's Finance Committee has responsibility of reviewing draft budget versions, providing insight to the Executive Director, and approving the final budget, which is submitted to the full Board of Directors for approval. The North Sound ACH is on a calendar fiscal year, so the 2018 budget will be put forward at the December 2017 Board of Directors meeting.

Both the Executive Director and the CFO are authorized to release funds through the Financial Executor's portal. The administrative fee that will come to the North Sound ACH has been set at 10%, which will support administrative and project management.

The North Sound ACH will adhere to the requirements laid out for/by the portal for the Financial Executor. We will have MOUs in place for all partnering providers who will be registered in the Portal who can earn DSRIP funds during the 2018 planning year, clearly articulating what is expected in order to earn DSRIP funds, and what (if any) restrictions may be placed on the DSRIP earnings. The North Sound ACH will have project management oversight around deliverables, and CFO oversight to ensure that distribution of funds earned are carried out correctly.

Powell Business Solutions is our outsourced financial and CFO services provider. During our process of recruitment and interviewing for a CFO, this firm was recommended and interviewed by the Finance Committee and external partners. The firm produces monthly financials for the Finance Committee and Board of Directors; oversee banking transactions and monitoring of bank accounts; develop oversight of budgets; and oversee payroll process -- essentially performing the functions of a CFO but at a lower cost to the ACH. Powell Business Solutions reports to the Executive Director. Powell Business Solutions, together with the Finance Committee and the Executive Director, will oversee stewardship of DSRIP Funds, and assure transparency of how funds are allocated to partners, reporting on a quarterly basis to the Board of Directors in a public meeting. We will publish in early winter 2018, narrative and visual information to explain how partners can apply to be become funded partners and how funds will flow to participating partners. The North Sound ACH’s Board is responsible for ensuring that we have a robust understanding of the funds flow process. Most of that process is within operations delegated to the Executive Director’s oversight.

The Board itself is not directly a part of managing the funds flow process, but will be updated by the Executive Director and CFO on a quarterly basis as to how funds are flowing to the ACH and participating partners. This could evolve, but at this time we are not anticipating a step for the Board in directing or managing the process. The North Sound ACH is a nonprofit corporation, with an application into the IRS to achieve tax-exempt status. As such, the Board of Directors has fiduciary (financial and legal) responsibility for the corporation. This has added complexity because the ACHs are required to have specific stakeholders and partners on the Governing Body.

To separate operational decisions from Board decisions, the Board has fiduciary responsibility for funds that come to the ACH but is not involved in day-to-day management of funds that go through the Financial Executor's portal to other partnering providers. The Board has responsibility for the ACH's final decision on project selection and will recommend guiding principles for contractor selection. The North Sound ACH defines "managing the funds flow process" in literal terms: responsibility for all operational aspects related to the flow of funds. In North Sound ACH, that is the Executive Director and CFO, guided by the Board. The Executive Director will provide periodic reports (minimum quarterly) to the Board outlining which funds have been released and for which activities. Our understanding is that the Financial Executor's portal will allow for reporting but that this is still in development.

While we have strong tracking mechanisms in place to track funds that flow through the ACH, we are still developing tracking systems for those funds that will flow between the Financial Executor and participating partners. We have questions about how those funds are attributed to the individual ACH (e.g., are we taxed on them, reportable on a 990, reportable on our financials, as sample questions that we still need clarity on as we move into the planning phase).

The North Sound ACH budget is developed in Excel, with FTE projections and expenses allocated for unique cost centers (e.g. SIM, Demonstration Admin, and Demonstration Projects), then rolled up into an overall budget for the Board of Directors. The North Sound ACH uses three tools to track expenditures:

1) Harvest App for time tracking: staff track their time in real time against budget line items and within cost centers, allowing time reporting to payroll that aligns with financial reports for monthly Board summaries,

2) APLOS: Online financial accounting software that allows for check register transactions that align with cost centers and line items in real time.

3) Contract with Powell Business Solutions: Meghan Vaughn, CPA oversees development of the budget details, develops the monthly financial reports, and trains staff who enter details in APLOS and Harvest. In concert with Cami Powell, principal at Powell Business Solutions, Vaughn reconciles transactions between bank statements, APLOS, Harvest, and Paychex (payroll reporting).

Project Design Funds

To date, Design Funds have been used primarily to support staffing up the organization, and setting up core infrastructure that is critical to our success in the Medicaid Transformation and long-term sustainability. We have recently secured a lease for the base of our operations in Bellingham, WA that will support our growing team (we currently have eight of our anticipated 12-person staff) and provide a conference room that is accessible for our team, partners, and community organizations.

Through October 31, 2017, which has been a building phase (hiring core staff, securing space, equipment and furnishings) the North Sound ACH has spent $343,725 (unaudited) from DSRIP funds:

The North Sound ACH received $6M in Design funds, and as reported in WB1 through October 31, 2017, and has spent $343,725 (unaudited) from DSRIP funds, leaving $5,656,275 unspent (unaudited) as of Nov 1, 2017:

- administration and project management, $292,062
- providers who traditionally receive Medicaid reimbursement (0)
- providers who don't traditionally receive Medicaid reimbursement (0)
- tribes (0)
- other, $51,663 subcontractors to support core infrastructure and development of Project Plan Template.

North Sound ACH projects to use the remaining Design Funds over DY 2-5 in the categories:

- administration and project management, $5,000,000
- providers who traditionally receive Medicaid reimbursement (0)
- providers who don't traditionally receive Medicaid reimbursement (0)
- tribes (0)
- other, $656,275 subcontractors to support core infrastructure and services including strategic and sustainability planning, data support, writing, and analysis.

In 2018, we plan to partner in Skagit County to create a community meeting space that is usable by the ACH, our partners from all five counties, and community organizations. We intend for this space to have audio/video conference capability, allowing remote access to learning collaboratives, shared tools, and trainers.

For the remainder of the Medicaid Transformation, we anticipate using the Design Funds to support core infrastructure (staffing, facilities, operating expenses) that will help launch the ACH as a resource and asset to the North Sound ACH region beyond the Medicaid Transformation. As part of our infrastructure, we are exploring contracts with:

- Center for Outcomes Research and Evaluation (CORE)
- Center for Evidence-based Policy
- Qualis
- Independent contractors who will provide assistance with data analysis, writing and dissemination of results, communication strategies, cloud based platforms such as the Pathways Hub.

We also plan to support a region wide Data Collaborative, providing financial support for counties and community based providers who want to build capacity in learning about available data, and how to visualize and use data effectively.

In early 2018, the Board will approve a strategic plan that outlines intentional approaches to use of the remaining Design Funds, and the percentage of DSRIP earnings that will come to the ACH for administrative management, building a resilience fund, to support non-clinical community based partners who are looking at upstream social determinants of health, and to support advocacy for other investments in the North Sound ACH region through other initiatives, both government and philanthropic.

Funds Flow Distribution

In keeping with the values that the North Sound ACH Board has laid out and agreed to, shown in

In keeping with the values that the North Sound ACH Board has laid out and agreed to, Project Incentive dollars will be prioritized toward sustainability of partnerships, relationships, workforce capacity, capacity building and specific projects that will be finalized during the 2018 planning phase. During the August and October Board of Director meetings, funds flow options were presented to the Board, and in November to the Program Council. There was consensus in several areas, knowing that this is not binding, and will vary in percentage allocations from year to year:

- To keep administrative and project management expenses lean and efficient, aiming for less than 10% of all DSRIP funds;
- To allocate a percentage of DSRIP funds to support upstream, longer term efforts that align with the Medicaid Transformation projects, including housing, food security, transportation, employment, advocacy, medication costs, and other efforts that can either inhibit or prevent community members from achieving positive health outcomes.
- The majority of funds would be set for projects and the supportive areas that enhance the viability of projects being successful, including capacity building, and Domain 1 activities of workforce strategies and population health management. Within this large investment, Board and Program Council discussed having 50% of funds steered toward project planning and implementation (shared between clinical and community providers) and the balance (approx. 30%) supporting Domain 1 activities.

Discussion about how to allocate by organization type is in its very early stages, and is leading to formation of a Fund Allocation Committee, which will make recommendations to the Board of Directors in early 2018. This represents very preliminary thinking; we anticipate having this refined during early 2018, but early discussions by the Finance Committee supports a high level allocation strategy that looks something like this:

Twenty percent to the North Sound ACH:

- 10% to the North Sound ACH as a fee for project management and administration;

- Approximately 5% to the North Sound ACH to use as a Regional Resiliency Fund to leverage upstream investments

- Approximately 5% to the North Sound ACH for external technical and subject matter consultants and contractors

Project Planning and Implementation, including support in areas of workforce strategies, population health management and capacity building

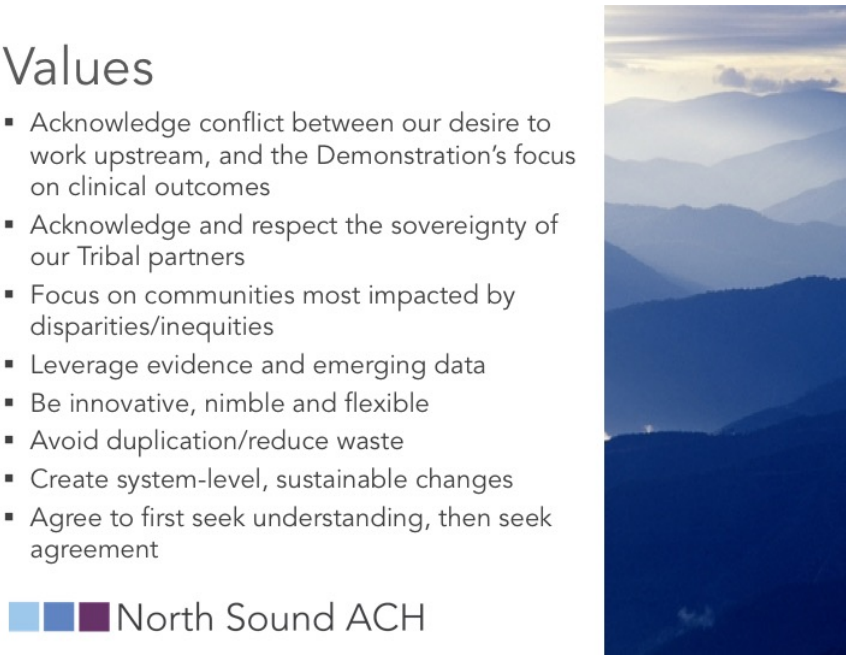
- Approximately 40% to providers traditionally reimbursed by Medicaid, including primary care providers, oral health providers, mental health providers, oral health providers, hospitals and health systems, as examples.

- Approximately 25% to community-based and social organizations, corrections facilities,counties, care coordinating agencies.

- Approximately 10% to tribal partners in the North Sound ACH region

- Approximately 5% to other organizations, including outsourced project management for specific projects, data collection

Figure 11: North Sound ACH Values



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

- **Attest to whether all counties in the corresponding Regional Service Areas (RSAs) have submitted a binding letter of intent (LOI) to integrate physical and behavioral health managed care.**

YES	NO
XX	

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

YES	NO
	XX

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

DATE (month, year)	

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

DATE (month, year)	1/1/2020

The North Sound region's five counties each voted to support moving to fully integrated managed care as a transitional mid-adopter. The North Sound BHO's Executive Board submitted a binding letter to the Health Care Authority on October 6, 2017. Part of the success in moving this work forward has come because of formation of an Interlocal Leadership Structure, even though the enabling legislation to do so did not pass in the 2017 Washington Legislature. The Interlocal Leadership Structure, which included the North Sound ACH Executive Director, a North Sound ACH Board member, tribal representative, all five MCOs and county leadership, focused on a collaborative approach to learning about the current BHO structure and funding, before asking the individual counties to vote to support mid-adopter status.

At the October 20th Interlocal Leadership meeting, the North Sound ACH Executive Director proposed having the Interlocal Leadership group make recommendations on how the mid-adopter incentive payments would be allocated. This was well received, and allows the Interlocal Leadership group shape where the incentive payments could best be invested across the region.

This proposal was presented to the North Sound ACH Finance Committee and Executive Committee on October 20th and was approved in concept. The Board approved this approach at its October Board meeting. We have not yet outlined anticipated use of mid-adopter incentive funds distinguished from our total allocation plan. Having the Interlocal Leadership group identify those strategies is advantageous as a key partner strategy, as members of the Interlocal Group will know best how those funds will support workforce challenges, health information systems, or changes to MCO required processes, as examples.

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

Domain 1 Strategies

Capacity building begins with a regional assessment of current state in each of the three Domain One areas and a dialogue with partnering community-based and clinical/behavioral health providers regarding their priorities. North Sound ACH staff have used data from available sources (e.g., MCO and HCA provider surveys) and external technical assistance to collect the information necessary for a current state/gap analysis. Once the ACH has a sense of the current state, expectations will be set with partnering providers, and investments will be targeted toward meeting milestones as planning and implementation begins.

The North Sound ACH is reorganizing the eight toolkit project areas (which were discussed in separate workgroups) to identify overlaps among target populations, sectors or potential partners, settings in the continuum of care and community, and performance or reporting metrics. This will lead to formation of planning teams. Each planning team will be charged with identifying specific needs to be addressed, and incorporating strategies that will support all project areas. Increasing value-based payment (VBP) adoption is a goal for clinical and behavioral health providers already engaged in contracting for their business models, as well as Managed Care Organizations. Workforce deficits in multiple areas will be assessed, including clinical and behavioral health settings,

community-based organizations, and care coordination, specifically including community health workers. Innovations and strategies for population health management will be gleaned from Local Health Jurisdictions, clinical and behavioral health providers, aiming toward increasing interoperability and HIT capacity in the region.

The North Sound ACH has received technical assistance from the Healthier Washington Practice Transformation Support Hub (via Qualis), Providence CORE and the Center for Evidence-based Policy and plans to deepen these relationships during the planning phase of the Medicaid Transformation in order to successfully address Domain 1 focus areas necessary to carry out projects in Domains 2 and 3. The initial work plan with Qualis centers around a regional assessment of provider capacity, including establishing an analysis in the areas of workforce needs, population health management strategies, current interoperability and Health Information Exchange and Health Information Technology efforts already underway among partnering providers in the region. Providence CORE will work closely with North Sound ACH staff to further leverage data resources and systems with implications in the area of population health management.

For VBP strategies, the North Sound ACH utilizes statewide and regional provider VBP survey results as the basis for dialogue with partnering providers, including behavioral health providers and health systems and to encourage further adoption of VBP models and address identified barriers. A separate strategy for VBP adoption will be employed for smaller and rural practices and providers, including efforts to assist with establishing quality improvement/population health management systems that can facilitate greater adoption of VBP payment models in smaller or rural practices. Finally, these activities are vetted and discussed with Managed Care Organization partners to assure their engagement, particularly in the area of encouraging further VBP adoption.

Domain 1 issues were discussed within all eight workgroups, indicating the level of need to address these domain 1 challenges in order to enhance effectiveness ad viability of Domain 2 and Domain 3 project efforts.

We believe that the North Sound ACH has identified significant potential investments in population health management infrastructure and workforce development in the response to Section I, Sub-section 7, Required Health Systems and Community Capacity (Domain 1) Focus Areas for All ACHs. These include clinical staff training in evidence-based models of integrated care and health information exchange to support population health management, as described under the headings of Workforce Development and Population Health Management Systems. These investments are foundational for all efforts within Domains 2 and 3. During the implementation planning phase in 2018, we will make final decisions on specific evidence-based models and investments and on the adoption of HIT and HIE systems. Final decisions on which specific investments will be made in which evidence-based models and which HIT and HIE systems will be made during the implementation planning phase of 2018. To promote efficiency and reduce costs, To the maximum extent possible, the North Sound ACH will seek to collaborate with statewide entities, including state government, and statewide entities and to support partnerships between ACHs, providers, and payers on common topics for all Domain 1 strategies. in order to promote efficiencies and reduce costs.

Value-based Payment Strategies

The North Sound ACH supported and promoted the distribution of the 2017 Provider VBP Survey during meetings with a self-formed Health System Advisory Coalition, a group made up of healthcare and health system partners from across the region. Aspects of the survey and the importance of its completion were presented at two different in-person meetings with the survey subsequently distributed via email with accompanying rationale. The North Sound ACH stressed the importance of survey completion to ensure our region was reflected in the statewide results and that region-specific data would later be provided to the ACH and form the baseline of a conversation to increase levels of adoption. The North Sound ACH also signaled to these partnering providers it intends to take a leadership role relative to increasing VBP adoption in the North Sound ACH region by identifying and addressing barriers, disseminating content for capacity building where possible and serving as a resource to identify best practice partners. The North Sound ACH will continue to play a role in this area in broader presentations to the community, thereby establishing and clarifying our intent to impact this important area of system transformation.

Thirteen North Sound entities responded to the VBP Provider Survey distributed by HCA. They included Behavioral Health providers (5), outpatient clinics or facilities (8), inpatient clinics or facilities (3), critical access

hospital (1), hospitals (2), Federally Qualified Health Centers (3), Multi-specialty practices (3) and an Independent, multi-provider single specialty practice (1). Of the 12 respondents reporting any revenue in categories 2C-4B of the Health Care Payment Learning and Action Network (HCP-LAN) payment framework, a majority reported some level of Medicaid revenue in these categories (7), the same number for some level of Medicare and Commercial revenue in these categories (5 each), and a lower number reported some level of other government revenue in these categories (4).

These results indicate there are levels of VBP adoption to build from and leverage in the North Sound region that can continue to foster progress. As such, the North Sound ACH will continue to seek additional information beyond the HCA survey, including data from MCOs, and other provider groups.

In a recent meeting of the self-formed Health System Advisory Coalition North Sound ACH staff sought input from participants about the current state of VBP. Those in attendance (from PeaceHealth, Providence, Swedish, Island Hospital, Snohomish CHC and Skagit Pediatrics) related VBP issues are on their radar, particularly for those health systems maintaining operations across multiple ACH areas and other states, as well as smaller providers glimpsing the approaching changes from volume to value in the wider health care finance space.

According to reported regional results from the VBP survey, of the 13 total North Sound partnering providers completing this section of the survey, one expected the current state to remain the same, four expected adoption to increase by up to 10%, five expected adoption to increase by 10%-24%, two expected change by 25%-50% and one expected an increase by greater than 50%. These results indicate a continued role for the North Sound ACH to encourage continued adoption, given a majority of providers expect change in the next 12 months.

According to reported regional results from the VBP Survey, the top barriers to further VBP adoption include lack of interoperable data systems and lack of access to comprehensive data on patient populations (e.g., demographics and morbidity data, listed by 9 providers). Next were misaligned quality measures and definitions (8 providers), followed by a lack of availability of timely patient/population cost data to assist with financial management and/or misaligned incentives and/or contract requirements (7 providers,) reported insufficient patient volume by payer to take on clinical risk and regulations or policies (federal, state or others) (5 providers,) insufficient patient volume by payer to take on risk and/or differing clinical protocols and/or guidelines associated with trainings for providers, and lack of trusted partnerships and/or collaboration with payers (4 providers,) inability to adequately understand and analyze payment models, lack of or difficulty developing medical home culture with providers, lack of trusted partnerships and/or collaboration with providers outside your organization (3 providers,) implementation of state-based initiatives e.g., State Innovation Model grant, Healthier Washington; Medicaid Transformation Demonstration (1 provider.)

In addition to these results, providers related the following barriers during in-person meetings:

- Difficulties given the lag time associated with claims data
- Interpretation and relevance in the clinical setting and the challenge of incorporating claims based results into EHRs
- Perceived lack of autonomy and difficulty to validate results from five different MCO partners, particularly for smaller practices
- Confusion over the definitions and specifications of individual measures

The North Sound ACH recognizes its role to advocate for increased levels of VBP adoption in the North Sound ACH region and pursues a strategy to communicate, educate and build capacity where possible. The North Sound ACH will engage partnering providers on these barriers and work with them to increase VBP adoption across the region. The North Sound ACH Deputy Director is a member of the MVP Action Team and works to bring information and the statewide perspective back to the region. With final results from the VBP Provider Survey, the North Sound ACH will disseminate the results of that survey and be sure to include VBP as a central topic in conversations with partnering providers. This initiative will extend across all efforts from within the North Sound ACH to effectively message its role to the community and assure continued relevance and traction on this issue.

Workforce Strategies

Successfully identifying and addressing regional workforce needs requires a baseline analysis for the North Sound ACH region and leveraging data to drive strategic improvements in targeted areas. Such an analysis of workforce capacity will be folded into broader assessment processes when surveying a cross-section of clinical and community-based partnering providers in conjunction with the Practice Transformation Support HUB for all areas of focus in Domain 1. Additional questions specific to workforce needs will be added to assessment tools to ensure sufficient partner input in this area and inform project planning and subsequent implementation across all project areas. Other data sources will be leveraged as available.

Broader efforts to identify and prioritize innovations will occur at the local, regional and statewide level. Preliminary planning in workgroups for each of the areas of the Project Toolkit identified anecdotal reports of workforce capacity gaps, such as Chemical Dependency Professionals in the area of Bi-Directional Integration and Opioids or Community Health Workers in the area of Care Coordination. Local conversations have also identified potential linkages with educational institutions including the Area Health Education Center (AHEC) at Whatcom Community College. Local connections are also established with leadership at the two local workforce development councils, including Workforce Snohomish and Northwest Workforce Council, responsible for governance and oversight of the workforce development system in the other four counties of our region. A regional approach includes leveraging data to inform the project planning process and provide a background to a current state analysis with partners. These data will be generated by the North Sound Data team and shared out to assure a data driven approach.

Contacts have been established and dialogue is ongoing with representatives from the Health Care Authority, the Health Workforce Council, the Health Workforce Industry Sentinel Network, including review of the 2015 Annual Report from the Health Workforce Council with an eye towards generating regional data. HRSA and DOH reports on Provider Shortage Areas will also inform the regional lens, as will dialogue and support from the University of Washington's Center for Health Workforce Studies. At the statewide level, the North Sound ACH will participate alongside other ACHs in the development of a statewide strategy in the area of workforce issues specific to ACH Medicaid Transformation priorities. Working together for statewide efforts will be necessary to mitigate impacts on the Medicaid population accessing services in multiple ACHs and the partners whose service areas likewise extends beyond ACH borders.

Finally, planning in multiple project areas includes preparation for implementation of models with trainings to support existing workforce and strategies to support team-based care, such as Healthy Steps, the Oral Health Delivery Framework, the Coleman Care Transitions Model, the Collaborative Care Model and the Chronic Care Model. These models will be strengthened by providing opportunities to improve partner knowledge in the areas of cultural competency and health literacy. These initiatives and projects may also require expansion of existing workforce capacity and the North Sound ACH will seek to support these efforts through training and identification of these new workforce models. Ongoing targeted conversations with partnering providers will yield dialogue on their priorities, such as questions of scope for RN's, LPN's and MA's, or a need for Certified Substance Abuse Counselors in Bi-directionally integrated settings of physical and behavioral health.

Population Health Management Systems

The first step in a region-wide approach to Population Health Management systems will be the completion of a clinical practice assessment with our partnering providers in concert with Qualis and the Practice Transformation Hub. The Patient Centered Medical Home Assessment (PCMH-A) is a widely tested and vetted tool for gauging individual practice readiness for practice transformation. Although additional questions can be added to the assessment as needed, the baseline query provides significant insight into identifying Population Health Management capacity. Engaging partnering providers to complete the assessment and reporting out aggregated results will provide the baseline for current Population Health Management systems capability, including capacity and gaps in the North Sound region.

Once this foundational assessment of clinical providers is completed, the aggregated data will be shared with the various project planning teams with the stated expectation to incorporate/align Population Health Management strategies into their process and subsequent implementation. The planning teams will include representatives from

partnering providers, Managed Care Organizations and other North Sound ACH stakeholders and can focus on expanding, using, supporting and maintaining Population Health Management systems across all projects. Many of the larger health systems using EHRs such as Epic, NextGen, AthenaHealth, and Meditech 6.1 have built-in Population Health Management tools and registries such as HealthyPlanet in Epic or HQM in NextGen. The activities of the planning teams will seek to leverage these existing capabilities wherever possible.

North Sound ACH is open to consider engagement and training for Population Health Management systems as needs are identified by individual providers and the planning teams, but will also work to identify a best practice regional engagement and training strategy, as well as options for interoperability. For example, the North Sound ACH is examining possible options for regional interoperability and communication across EHRs and HIT platforms, including EDIE/PreManage for Care Management, ImageTrend for EMS and Community Paramedicine, and CCS for Care Coordination agencies. Where EHRs used by providers do not support functional Population Health Management capabilities, the ACH will assist partners in exploring options from compatible third-party tools.

At the level of statewide and regional innovations, the North Sound ACH will partner with other ACH, MCO and statewide partners to identify shared HIT needs and opportunities and partner where possible for expanded purchasing power. Opportunities may include coordination with state-level partners to expand and enhance use of existing statewide systems such as the Immunization registry, the Prescription Monitoring Program (PMP), the Clinical Data Repository and the Emergency Department Information Exchange (EDIE.) Given that Medicaid enrollees access services across multiple ACH regions and providers likewise have operations across these same borders, maintaining a statewide approach will be both expedient and necessary.

SUPPLEMENTARY MATERIALS CHECKLIST

SECTION I: ACH-LEVEL	
Regional Health Needs Inventory	
None	
ACH Theory of Action and Alignment Strategy	
☒	Attachment(s): Logic model(s), driver diagrams, tables, and/or theory of action illustrations that visually communicate the region-wide strategy and the relationships, linkages and interdependencies between priorities, key partners, populations, regional activities (including workforce and population health management systems), projects,
Governance	
☒	Attachment(s): Visual/chart of the governance structure
Community and Stakeholder Engagement and Input	
☒	Attachment(s): Evidence of how the ACH solicited robust public input into project selection and
Tribal Engagement and Collaboration	
☐	Optional Attachment(s): Statements of support for the ACH from ITUs in the ACH region
Funds Allocation	
☒	Supplemental Data Workbook: Funds Distribution Tabs
Required Health Systems and Community Capacity (Domain I) Focus Areas for all	
None	
SECTION II: PROJECT-LEVEL	
Project Selection & Expected Outcomes	
None	
Implementation Approach and Timing	
☒	Supplemental Data Workbook: Implementation Approach Tabs
Partnering Providers	
☒	Supplemental Data Workbook: Partnering Providers Tabs
Regional Assets, Anticipated Challenges and Proposed Solutions	
None	
Monitoring and Continuous Improvement	
None	
Project Metrics and Reporting Requirements	
None	
Relationships with Other Initiatives	
None	
Project Sustainability	
None	

2A: Transformation Project Description: Bi-Directional Integration of Physical and Behavioral Health Through Care Transformation

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

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

2A: Project Selection & Expected Outcomes

Why the Project is Needed

Addressing behavioral and physical health needs is a complex challenge for the health systems, communities, and families in the North Sound. Regionally, 33% of Medicaid enrollees in the North Sound were identified as having mental health illness needs, 21% were diagnosed with a serious mental illness and 12% were identified as having substance use disorder treatment needs.[1] Only 41.5% of those patients with mental health treatment needs, 29% of those with substance use treatment needs and 11% of serious mental illness received needed treatment in 2015.[2,3] For patients with co-morbidities of behavioral health needs and chronic disease, there are disparities in access to and utilization of significant preventative care; for example, Medicaid enrollees with diabetes and substance use disorder were 65% more likely to have not received recommended A1c checks for blood glucose control.[4]

There are several reasons populations with co-occurring mental health illness, substance use disorder, or chronic disease fail to get adequate care in the existing health system. The delivery system's separation of behavioral and physical health services creates coordination and referral complexity with over half of referrals failing. Navigating this bifurcated system is daunting for trained health professionals and next to impossible for the lay public seeking help and struggling with physical and behavioral health conditions. This contributes to poorly coordinated and delivered care, increased burden of chronic disease, substance abuse disorder, and early death in vulnerable populations.

Separation of the two delivery systems creates difficulty organizing and coordinating care at multiple levels. Regulations are separated with different administrative frameworks and clinical expectations coded into state law. Licensing, oversight, contracting and payment of services are currently held separate. This creates

[1] ACH Profiles Future, DSHS/RDA, released April 11, 2017.
[2] Measure Decomposition Data, RDA/DSHS, released July 7, 2017.
[3] ACH Profiles Future, DSHS/RDA, released April 11, 2017.
[4] Measure Decomposition Data, RDA/DSHS, released July 7, 2017.

situations where an otherwise fully licensed medical (physical health) organization is unable to contract to provide behavioral health or substance abuse services. Facilities and managed care entities do not routinely or easily share health information about people utilizing care and remain highly separated into siloes. Program investments in behavioral health care that decrease the overall cost of care for the SMI population are not as effective as they could be if funding mechanisms were integrated.

Despite the system siloes, there are several promising developments toward integrating care between behavioral and physical health services in the North Sound ACH region. PeaceHealth Pediatrics and PeaceIsland Medical Center have reported to the North Sound ACH that they have, physical health settings have integrated psychiatric providers into the care team through co-located and tele-psychiatry consultations. Lake Whatcom Center, a residential behavioral health facility in Whatcom county, has integrated an Advanced Registered Nurse Practitioner (ARNP) to provide physical health services to their patients. With the support for bi-directional integration through the Practice Transformation Support Hub, dozens of physical health care and behavioral health practices across the North Sound ACH region have engaged Hub support and begun the process of bi-directional integration. In October 2017, the Interlocal Leadership Group of county governments across the North Sound ACH region committed to moving the delivery of behavioral health services to Fully Integrated Managed Care by January 1, 2020.

Through a whole-person approach, bi-directional integration of care has the potential to impact all Medicaid enrollees in the North Sound ACH by targeting the expansion of health services to two key demographics--enrollees with behavioral health needs currently using the primary care system, and people with serious mental illness (SMI) currently using the North Sound Behavioral Health Organization (BHO) system of behavioral health care. Key ACH partners in this project area are the Health Systems Advisory Coalition (HSAC) and the North Sound BHO. The HSAC has participated in the North Sound ACH's planning for integration efforts and will be involved in implementation, including its more than 205,000 self-reported, attributed Medicaid enrollees. The North Sound Behavioral Health Organization network serves 37,202 Medicaid enrollees and are critical partners in integrating care for the North Sound ACH region, providing workgroup leadership for this project area and support for implementation activities. Both directions of integration will use the main elements of the Collaborative Care model to transform clinical practice to team-based medicine that serves the whole-person in either practice setting.

Target Population

The target population for bi-directional integration strategies are all Medicaid enrollees (children and adults), particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD). Among the region's 286,760 enrollees, 83,176 identified with mental illness needs, 52,634 diagnosed with Serious Mental Illness (SMI) and 30,540 identified with substance use disorder treatment needs.

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

Targeted Universalism[5] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

<table>
<tr><th colspan="2">North Sound Project Area Reach & Impact
Project Area 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation</th></tr>
<tr><td colspan="2">Potential Target Population Reach:
• 83,176 identified with mental illness needs
  ○ 13,677 Disabled, 10,130 Non-Disabled Adults, 35,974 Newly Eligible Adults, 18,600 Non-Disabled Children, 4,795 Elders
• 52,634 diagnosed with Serious Mental Illness (SMI)
  ○ 10,893 Disabled, 5,970 Non-Disabled Adults, 20,297 Newly Eligible Adults, 12,374 Non-Disabled Children, 3,100 Elders
• 30,540 identified with substance use disorder treatment needs
  ○ 4,998 Disabled, 4,070 Non-Disabled Adults, 17,883 Newly Eligible Adults, 2,934 Non-Disabled Children, 655 Elders</td></tr>
<tr><td>Project Area Impact:</td><td></td></tr>
<tr><td>Performance Measures
• 21% received behavioral health services from the BHO in 2015
• 29% of those identified with substance use treatment needs received treatment in 2015
• 27,635 Medicaid enroll lees with a serious mental illness and received care in 2015
• 34% of Adult (18+) Medicaid enrollees with depression diagnosis remained on antidepressants for 6 months.</td><td>Geographic Disparities
• Of the 27,583 Medicaid enrollees with SUD treatment needs, 61% reside in Snohomish County
• 27% of Medicaid enrollees in Island (3,364) and Whatcom (13,302) Counties were diagnosed with mental illness, Snohomish has the largest count with 34,312 Medicaid enrollees with a mental illness
• 85% of children (under 19) with Medicaid in Island County have a visit with PCP (4% lower than ACH average)
• 80% of children (2-6 years old) with Medicaid in Island county had a visit with a PCP (6% lower than ACH average)</td></tr>
</table>

[5] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

• 89% of children (Under 19) with Medicaid coverage had a visit with a PCP
• 43% of patients with behavioral health service needs received behavioral health treatment.
	• 24% of Medicaid adults with diabetes in Island received an eye exam (7% lower than average)
	• 76% of patients with diabetes in San Juan had blood sugar (HBA1c) check compared to 84% region-wide.
	Demographic Disparities
	• Among the 27,596 Medicaid enrollees diagnosed with depression:
	  ○ 77% are White
	  ○ 66% are women
	  ○ 85% were adults (19+)
	• American Indian/Alaskan Natives were 2x more likely to not receive follow-up care after hospitalization for mental illness
	Co-morbid Disparities
	• Patients with Substance Use Disorders, 65% more likely to not have received A1C checks

Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Toolkit Historical Data, HCA, released August 17, 2017. 4) ACH Profiles Future, DSHS/RDA, released April 11, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017. * Note: Regional Medicaid population counts differ slightly due to selected month and/or year of data and the reporting agency's definition of Medicaid population. Most behavioral health and substance abuse data products from HCA and/or DSHS-RDA include Medicaid only and Medicaid/Medicare dual-eligibles.	

Current State

National research indicates, 56% of Medicaid enrollees with a mental illness reported fair or poor health status, compared to 26% of enrollees without mental illness.[6] Adults living with serious mental illness (SMI) have worse health outcomes, resulting in early mortality (an average of 25 years earlier than adults without SMI) attributed to common, chronic health conditions such as respiratory problems, cancer, and heart disease.[7] Most Medicaid enrollees earn less than $25,000 per year,[8] annual out of pocket spending among enrollees was nearly four times greater among those with mental illness ($310) than among enrollees without a mental illness ($80).[9]

Failing to address the physical health and social determinant needs of Medicaid enrollees with or at-risk for behavioral health conditions adequately is both inequitable and expensive to our health care systems. In the North Sound ACH region, data supports the need for integrating primary care and behavioral health care and promoting a "whole person" approach in order to meet the health needs of high risk community members with co-occurring behavioral health and chronic disease diagnoses, ultimately improving quality of life and life expectancy.

[6] The Role of Medicaid for People with Behavioral Health Conditions, The Kaiser Commission on Medicaid and Uninsured, November 2009.

[7] National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: Parks, J., et al. Retrieved January 16, 2015

[8] Eligibility Overview Washington Apple Health (Medicaid) Programs, HCA, April 2017.

[9] The Role of Medicaid for People with Behavioral Health Conditions, The Kaiser Commission on Medicaid and Uninsured, November 2009.

Mental illness, substance abuse and chronic conditions exacerbate one another. The magnitude of these conditions on Medicaid enrollees in the North Sound are tremendous and evident in the various data provided by the HCA:

- Mental and behavioral disorders (14.5%) are the leading cause of hospitalizations for Medicaid enrollees.[10]
- 83,176 (33%) of jointly served (HCA/DSHS) Medicaid individuals have mental health needs.
- 30,350 (12%) of jointly served (HCA/DSHS) Medicaid individuals have substance abuse disorder treatment needs.
- 21,000 (8%) of jointly served (HCA/DSHS) Medicaid individuals were diagnosed with co-occurring disorders.
- 40,626 of Medicaid enrollees were diagnosed with a Mental Illness and one or more chronic condition.
- 20,135 of Medicaid enrollees were diagnosed with a Substance Use Disorder and one or more chronic condition.
- Adult Medicaid enrollees who were arrested in the last year are nearly five times as likely to need substance abuse treatment compared to those not arrested.[11]
- Adults with Medicaid and behavioral health needs were two times as likely to utilize the emergency department three or more times per year, those with co-occurring disorders were over four times as likely to visit the emergency department.[12]
- Medicaid adults with substance use disorders or co-occurring MI/SUD are more than 3 times more likely to be experiencing homelessness.
- Between 2012-2016, 607 individuals died from an opioid-related overdose in the North Sound, with Snohomish County accounted for 80% (488) of the opioid-related deaths during this timeframe—a rate 1.3 times higher than that for all of Washington.[13]
- Overall rate of suicide in the North Sound is 14.6 per 100,000 and varies considerably by county: Skagit (14.1), Snohomish (15.2) and Whatcom (15.8) county's rates are lower than the Washington State rates, while Island (19.9) and San Juan (18.5) are the highest in the North Sound ACH region.[14]

Several other North Sound ACH project areas will be implementing strategies designed to address the relationship between mental illness, substance use disorder, and chronic disease as well, including Diversion Interventions, Transitional Care, Addressing the Opioids Crisis, Chronic Disease, and Care Coordination.

Project Strategies

North Sound ACH intends to use the Collaborative Care model to normalize the integration of physical and behavioral health services. There are five core elements of the model: creating a patient-centered care team, measuring symptoms and treating to target, using population-based care tools, accountable care, and using evidence-based treatment. Both behavioral and physical health settings of outpatient care will use these elements to transform the systems of care delivery, and improve physical health and behavioral health outcomes. During the 2018 planning year, the North Sound ACH will adapt the model elements to the North Sound ACH region's diverse geographic and workforce resources and needs, implementing elements of the Collaborative Care model as appropriate to improve health outcomes and reduce health disparities across all community-based and geographic contexts.

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[10] RHNI Starter Kit, HCA, released May 8, 2017
[11] Utilization for MH Service Needs, RDA-DSHS, July 2017
[12] ACH Profiles: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017
[13] Opioid-related Deaths in Washington State 2006–2016, WADOH, May 2017
[14] RHNI Starter Kit, HCA, released May 8, 2017

There is strong evidence that integrating behavioral health services into physical health care improves patient outcomes while reducing cost of care for depression and anxiety disorders, as well as the control of diabetes and hypertension. Integration of behavioral health in primary care through the Collaborative Care model for people suffering from depression has reduced serious cardiovascular events compared to those receiving usual care years after treatment of depression, suggesting long-term benefits of the intervention. Integrated care in physical health care settings reaches a large population with behavioral health needs that do not currently have access to care and allows their condition to stabilize and improve before the use of crisis services or higher levels of care are needed.

In the Physical Health Care Setting

Leadership from large physical health care practices across the North Sound counties have agreed to implement the Collaborative Care model methods in their physical health care clinic settings, including:

- **Screening** for depression, and alcohol and opiate use as an expected component of physical health care. Screening may be expanded for additional conditions as experience and capabilities grow, and may include anxiety, PTSD, ADHD, and other substances of abuse.
- **Brief counseling interventions** for identified behavioral health conditions by behavioral health counselors embedded in the physical health care practice.
- **Medication Assisted Therapies for** depression and opiate abuse, which may expand as experience and capabilities grow. Primary Care practice leaders are committed to developing Suboxone treatment for opiate addiction identified within their physical health care systems to ensure access to Suboxone treatment.
- **Registry development** to track patients with identified behavioral health conditions.
- **Treat-to-target** those with identified behavioral health conditions.
- **Psychiatric Consultation** for physical health care providers, which in some practices may include direct patient consultation or tele-psychiatry depending on system capacity, geography, or other factors.
- **Referral** to specialty behavioral health services, including the need for improved referral mechanisms and information exchange with specialty behavioral health providers.

The physical health care practices involved maintain different levels of integration in this model, and the North Sound ACH will work with partners to identify and target strategies appropriate for smaller and rural practices. To help onboard and advance practices through the continuum of integration, individual practices will be evaluated based on several factors, and grouped into cohorts supported by the University of Washington Advancing Integrated Mental Health Solutions (UW AIMS) Center and Healthier Washington Practice Transformation Support HUB training to enhance learning and transformation.

In the Behavioral Health Setting

Behavioral health providers will pursue integrated care by adapting the Collaborative Care model elements into the behavioral health setting. Nationally, fewer models and metrics are available for integration of physical care into behavioral health settings. The North Sound ACH has identified two behavioral health providers leading the move to integration by providing access to physical care in the behavioral health practice setting. The North Sound ACH seeks to expand this work by engaging leadership from behavioral health practices across the North Sound ACH region to implement the following methods:

- **Screening** for chronic health conditions in clinic by a physical health provider.
- **Counseling interventions** connected to health behaviors and the maintenance or improvement in chronic health conditions using the existing workforce.
- **Physical health interventions** including prescribing and tracking changes in chronic physical health conditions.

- **Registry development** to track patients physical and behavioral health improvement and to identify people that aren't improving.
- **Treat-to-target** for both behavioral health and physical conditions as allowable by existing evidence based clinical tools.
- **Consultation** with physical health providers around complex health situations.
- **Referral** to specialty physical health providers for more complex physical health needs, specific conditions, or specialty screenings.

Behavioral health providers in the North Sound ACH region have training and experience in providing evidence-based interventions. Using regular symptom measurement tools, treating to target, population health tools, and managing chronic physical disease are new components for many behavioral health providers that will require training, implementation support and ongoing education.

Partnering with the UW AIMS Center, Healthier Washington Practice Transformation Support Hub and The National Council of Behavioral Health - Case to Care trainings, are all being considered to enhance existing efforts, expand the scope of integration, and reduce duplication of services. Further, the North Sound ACH is collaborating with North Sound ACH regional leaders in bi-directional integration projects such as the North Sound BHO, Compass Health, and PeaceHealth to ensure projects enhance and expand integration without duplicating existing efforts.

ACH Role & Supports for Partners

The North Sound ACH will support practice transformation by: convening the North Sound ACH Data & Learning team to address challenges and performance gaps and advise on solutions and course corrections; leading regional efforts to identify and implement health registries that are interoperable with existing systems (e.g. EDIE and OneHealthPort); using population health management technologies to identify key segments of target populations that are not responding to interventions, and assisting practices in connecting with tools, trainings, technologies, experts, etc. that can assist in improving responsiveness; supporting behavioral health and physical health practices in adapting to billing and coding changes by leveraging expertise from the UW-AIMS center; and participating in state efforts to mitigate regulatory barriers to integration.

Metrics and Health Outcomes

Bi-directional integration is part of broader health infrastructure transformation, and has the possibility of moving many health metrics for the North Sound ACH region. Metrics connected to chronic health conditions and medication adherence are improved by the implementation of health registries in both physical and behavioral health clinics. These include: Antidepressant Medication Management, Child and Adolescent Access to Primary Care Practitioners, Comprehensive Diabetes Care: Eye Exam (retinal) performed, Comprehensive Diabetes Care: Hemoglobin A1c Testing, Comprehensive Diabetes Care: Medical Attention for Nephropathy, and Medication Management for People with Asthma (5-64 years). These metrics are also improved by increasing physical health service access for the SMI population in behavioral health clinics that are currently underserved for these chronic health conditions, reducing disparities and improving overall health outcomes.

Early interventions, increased access to behavioral health care through bi-directional integration, and the associated increase in information sharing that occurs through financial and HIT integration will reduce unnecessary utilization of crisis services, emergency departments, and inpatient hospital stays for the SMI population. As such, the project will seek to induce movement in the following metrics: Follow-up after Discharge from ED for Mental Health, Alcohol or other Drug Dependence, Follow-up after hospitalization

for mental illness, Inpatient Hospital Utilization, Mental Health Treatment Penetration, and Outpatient Emergency Department Visits per 1000 Member Months.

Health Equity

The North Sound ACH will use health equity as a lens for all our project areas. In order to be truly transformational and meet the needs of our community, disparities by race/ethnicity, socioeconomic status, geographic area, and other categories must be brought to the forefront. In the bi-directional integration project area, strategies will be adapted when possible to each community to ensure that clinical and community interventions are both culturally appropriate and accessible (for example, hiring bilingual community health workers and clinic staff; hiring staff from within the communities they will serve; requiring training on cultural humility, undoing institutional racism, implicit bias, and more).

Lasting Impact

As the North Sound ACH region moves toward Fully Integrated Managed Care in 2020, the implementation of Bi-Directional integrated care will be a significant priority of the North Sound ACH and its partners. The implementation of population health management systems and Collaborative Care team structures will help partners sustain the integration of care beyond the Medicaid Transformation project. By putting whole person care – both physical and behavioral health services – in all health care delivery settings, this effort will produce a lasting impact in improve overall health for the population of the North Sound ACH region.

2A: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the bi-directional integration project area, the North Sound ACH has engaged stakeholders representing both community-based behavioral health service providers and physical health providers, each with an interest in coming together for the purpose of integration and forming workgroups. Workgroup leads included leadership staff from the BHO, and a regional community behavioral health provider: Compass Health.

In Spring 2017, the North Sound ACH began moving from broad stakeholder engagement into workgroups, comprised of potential partnering providers who serve or are interested in serving the Medicaid population. Eight workgroups were formed, with an open invitation extended to providers and stakeholders who wanted to engage. These included behavioral health and SUD providers, community-based organizations, county health and human services and public health leaders, physical health care providers, Tribal partners, health systems, and Managed Care Organizations. Two or more subject matter experts were invited to serve in a lead role for each workgroup, which were supported by North Sound ACH staff. As information from HCA became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to draft "Statements of Interest" highlighting their individual interest and ideas for project frameworks. Staff and workgroup leads compiled these submissions to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas at monthly face-to-face meetings with remote access for those who could not join in person. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking a strategy capable of incorporating participation from partnering providers, aiming to move the North Sound ACH region's pay-for-performance metrics. This dialogue included the subpopulations indicated in the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups,

a broad spectrum of partnering providers are represented in the Supplemental Workbook and remain a value for future engagement.

Concurrently, a coalition of health system physical health care providers agreed to become an advisory body to staff, wherein staff convene regular meetings, assist with agenda setting, scheduling, and note-taking. This Health System Advisory Coalition includes leadership from the largest hospital systems providing physical health care in the North Sound ACH region, regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. The group has self-reported coverage of over 205,000 Medicaid primary care assignees in the North Sound ACH region. Staff are continuing with further outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to ensure inclusion of physical health providers serving a significant majority of the Medicaid population, similar to the reach that the North Sound BHO has with providers working in behavioral health and SUD settings.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of Medicaid Transformation in the North Sound ACH region, especially after the North Sound ACH region's Interlocal Leadership Structure elected to move toward Fully Integrated Managed Care by 2020. Managed Care Organization partners are engaged on the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout. In the case of Care Coordination, the North Sound ACH has participated in a series of meetings with MCO partners and representatives of the North Sound ACH region's Health Home providers regarding coordination of these services in the development of the Pathways HUB. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication.

2A: Regional Assets, Anticipated Challenges and Proposed Solutions

The North Sound ACH has willing partners through the North Sound BHO network and Physical Health Care leaders for engagement in integration of care that provides services to a large portion of the Medicaid population.

Clinical Service Delivery and Expertise

- The North Sound ACH region has large Primary Care networks, including Providence, PeaceHealth, Sea Mar, Family Care Network, Snohomish CHC and Unity Care NW, with broad experience in integrated health and utilizing aspects of the Collaborative Care model including tele-psychiatry for remote clinic sites. They provide clinical expertise and implementation knowledge that is vital to successful implementation.
- The North Sound ACH region has two behavioral health providers, Compass Health and Lake Whatcom Center that have integrated physical health services into their behavioral health clinics. Compass Health has used a co-located model and Lake Whatcom Center directly hired physical health staff for integration of care using the Collaborative Care model.
- Skagit County's Screening, Brief Intervention and Referral to Treatment (SBIRT) initiative, focused on implementing SBIRT in all physical health care settings county-wide, increases the behavioral health services being provided in physical health settings in Skagit county. Because most delivery systems in Skagit County cross county borders, this initiative will be a regional benefit and serve as a potential pilot project for eventual spreading to the entire North Sound ACH region.

Nonclinical Service Delivery and Expertise

- The North Sound Interlocal Leadership Group of county governments, North Sound ACH, the BHO and a tribal representative, provides a venue for facilitating and discussing clinical integration of services prior to and after steps toward Fully Integrated Managed Care.
- County governments and community services provide significant non-clinical services to populations experiencing behavioral health service needs, including shelter, housing, employment services, nutrition, and other critical services that support patient outcomes and reduce readmission rates and ED utilization.

Data, Analytic Tools, and Infrastructure

- The North Sound Behavioral Health Organization (BHO) will provide administrative and data support to the clinical integration efforts in partnership with the ACH.
- All hospitals in the North Sound ACH region are connected to the EDIE/PreManage HIE infrastructure for reporting ED visits and hospitalization of patients. As physical health care and behavioral health clinics are connected to PreManage, this existing infrastructure will allow providers quick and seamless notification when any of their patients visit the ED or are admitted for physical health or psychiatric hospitalization.

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Anticipated Challenges	Possible Solutions
Implementation of Collaborative Care model not meeting performance measures, such as comprehensive diabetes screenings, behavioral health treatment penetration, or access to physical health care for Medicaid Expansion population.	• Convene data and learning team to review gaps in performance measures. • Explore reasons for performance gaps and consider revisions or enhancements to improve rate for target population. • Use population health management technologies to identify key target populations that are not responding to intervention. • Implement needed mid-course corrections, including integration of new partners or new strategies.
The North Sound ACH region's providers use a variety of health information systems with different population health registry capabilities.	• The North Sound ACH will explore health registries that are interoperable with existing systems. • Existing HIE systems such as EDIE and OneHealthPort can support population management across different systems and EHRs.
Billing and coding support will be needed for both behavioral health and physical health systems to bill for services not previously provided.	• Leveraging expertise from the UW-AIMS center and cross sector workgroup support can provide information on proper billing and coding.
The Substance Use Disorder providers are still adjusting to the BHO managed care system and clinical expectations and will need substantial support re: information technology and	• Engagement with SUD providers through the BHO provider group for evaluation of current capacity and needs. Connecting the SUD service agencies with the Healthier Washington Practice Transformation Support Hub and resources through the project plan can mitigate this barrier.

clinical systems to transition to integrated care.	
Reimbursement rates for traditional physical care services do not support the more complex and longer appointment times needed to serve a population with multiple co-morbid conditions and behavioral health symptom barriers.	• Implementation of the Collaborative Care model can assist in developing a team-based care approach and minimize the impact of such interventions on a provider's time. Exploring sustainability with the local Managed Care Organizations will be needed to continue integrated services. Team based care can result in improved performance for clinical quality measures and increased shared savings reimbursements to providers under value based payment contracts.
Access to Care Standards and BHO contract limitations will continue to exist prior to full financial integration creating contracting barriers with physical health systems and clinical bifurcation of service systems.	• Pursuing deemed licensure for integrated service providers or modification of the BHO state contract to allow financial payment can help mitigate this barrier.
Regulatory requirements of behavioral health services are not designed for the physical health care setting or brief therapy models.	• Connecting with state efforts to align service requirements and engaging with providers that have managed the requirements in a physical health care setting can assist to mitigate this barrier.
Limited workforce to build capacity. Bi-directional integration will require an increase in regional workforce.	• Both embedded behavioral health specialists in primary care environments and physical health providers in behavioral health clinics will be needed. • The model uses consultation in-person and through telehealth and training to assist the providers involved to practice at the top of their license to decrease workforce demand as much as possible.
Limited partner capacity (for training, implementing new programs, willingness to take on new projects)	• Support the dedication of provider time to Collaborative Care model trainings and workflow modification activities. • Identify financial opportunity for participation in Medicaid Transformation project through improved efficiency and outcomes that support organizational budgets beyond funding incentives. • Integrate and support front-line providers in planning and implementation process, so projects are appropriate to provider needs and capacity.
HIT/HIE systems not compatible with EHRs used by delivery systems or not functional for behavioral health integration purposes.	• Coordinate with vendors and systems to troubleshoot issues with interoperability/compatibility/functionality, including software updates and custom programming if no other solution available. • Explore contracts with other vendors who are able to provide more interoperable or functional solutions. • Train providers and clinical staff in use of HIT systems to improve functionality and engagement with population health management technologies.

2A: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.

As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular

monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

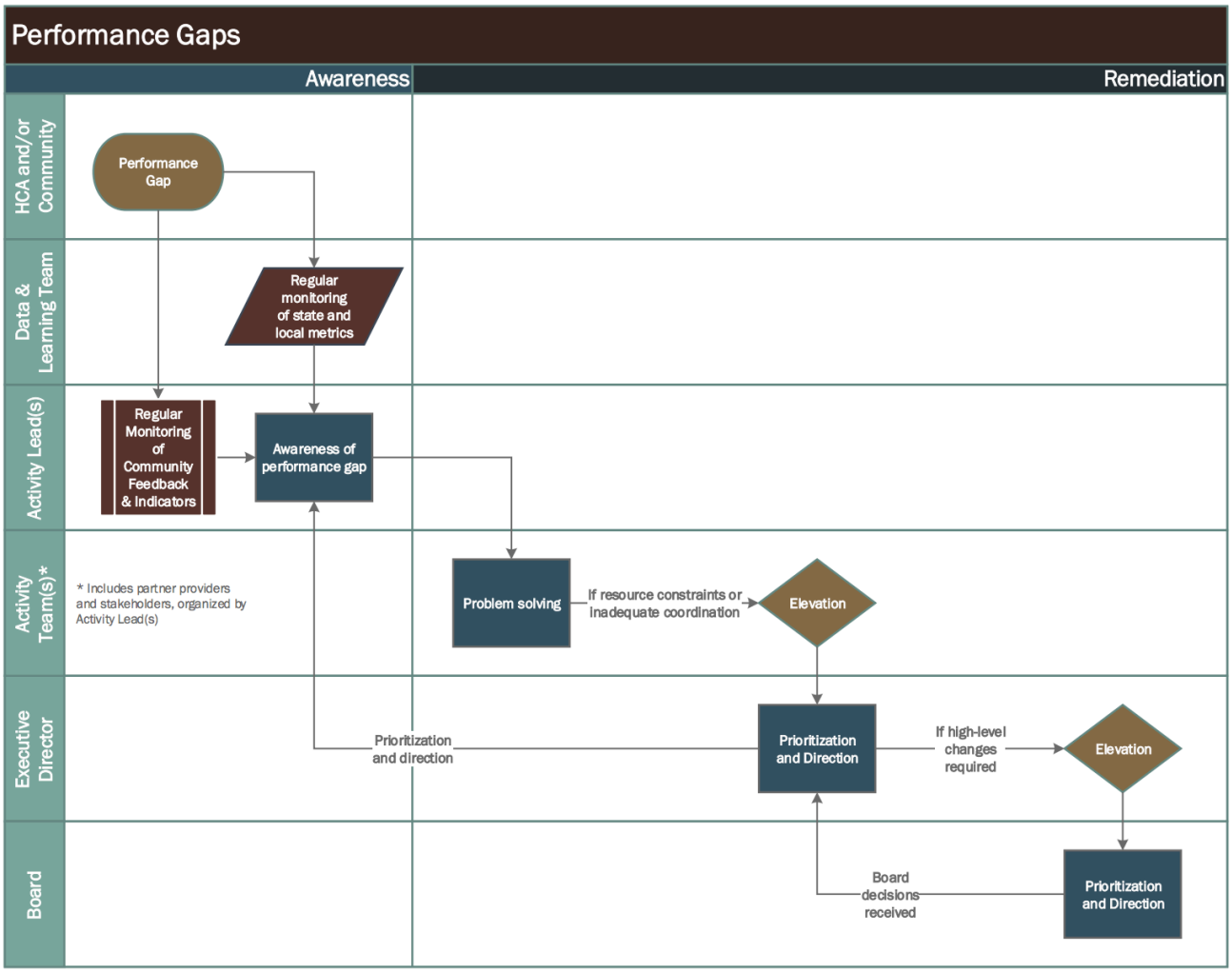

Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use

HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third-party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

2A: Project Metrics and Reporting Requirements

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

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

YES	NO
XX	

2A: Relationships with Other Initiatives

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

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

YES	NO
XX	

2A: Project Sustainability

The North Sound ACH is committed to working with partners in the North Sound ACH region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation project period. A virtuous cycle results when clinical transformation improves provider performance on clinical quality measures in value based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community, and community-based organizations to address upstream, social determinants of health. To ensure lasting impact we will optimize project strategies that hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster meaningful relationships among partnering providers, so implementation is realized on the regional level and extends beyond the Medicaid Transformation project.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the

North Sound ACH will seek to braid together DSRIP earnings with other sources, including philanthropy, and other investment by partners, including the Managed Care Organization partners. Philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged wherever possible.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices, and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements, as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between clinical settings and community-based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the North Sound ACH region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, childcare, employment, food access, environmental pollutants, etc. Additionally, the North Sound ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to ensure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building capacity for these providers in the long-term. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long-term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long-term, likewise driving increases in reimbursements for value-based contractual agreements.

Specific to bi-directional integration, opportunities for sustainability include exploring billing practices capable of supporting additional activities in clinical environments and leveraging the Pathways framework to sustain the activities of community health workers to improve care coordination systems among their own communities. Other areas include training and expansion in the use of Medicare billing codes for behavioral health providers that can support sustainable payments for integration of the Collaborative Care model in a physical health care setting, including for services provided by non-clinical behavioral health care managers.

2B: Transformation Project Description: Community Based Care Coordination

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

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

2B: Project Selection & Expected Outcomes

Introduction

In 2015, data from the North Sound region's county and hospital community health assessments in Whatcom, San Juan, and Skagit Counties identified care coordination as a priority for regional health systems. There are numerous existing care coordination efforts in the region, serving different populations, through different systems, and focusing on different needs. Some of these organizations, such as Health Homes Leads, and their contracted Care Coordination Organizations (CCOs), already support care coordination for specific high-risk populations in each of the North Sound ACH counties. However, there is an opportunity across the region to better coordinate care for all Medicaid enrollees, and address disparities in the populations represented in care coordination programs.

Target Populations

The target population for Community-Based Care Coordination strategies are Medicaid enrollees (adults and children) with one or more chronic disease or conditions (such as arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

The ACH will finalize a target population that is appropriate for Pathways and for non-duplicative collaboration with Health Homes. To ensure success in Pathways and avoid duplication with Health Homes, North Sound ACH will choose a target population that:

- Experiences disparities in health outcomes
- Has risk factors that can be addressed via existing Pathways

- Is currently served by organizational partners who are relevant to the population (e.g. culturally, geographically)
- Is not currently served by Health Homes, either due to PRISM (Predictive Risk Intelligence System) scores <1.0, insufficient Health Home capacity, or individuals' choice to opt out of the Health Home program
- Has potential to achieve better health outcomes as a result of care coordination
- Can produce sufficient cost savings to demonstrate potential for return on investment to the payer partners
- Experiences disparities or low engagement with existing care coordination systems due to systemic, geographic, or institutional barriers; and shows a strong likelihood of improved engagement and outcomes through culturally appropriate, community-level care coordination through Pathways

Targeted Universalism[1] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio. Possibilities include first-time expectant mothers, individuals with frequent contacts with the criminal justice system, patients with at least one behavioral health service need and chronic disease, and people experiencing homelessness or unstable housing. Lastly, we will select a pilot target population for whom we can design a project that will produce learning we can apply as we scale Pathways to additional populations and payers.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

North Sound Project Area Reach & Impact **Project Area 2B: Community-Based Care Coordination**

Potential Target Population Reach:
• 37,279 diagnosed with asthma, COPD (Pulmonary, low)
  ○ 5,997 Disabled, 3,280 Non-Disabled Adults, 11,406 Newly Eligible Adults, 13,159 Non-Disabled Children, 3,437 Elders
• 46,893 diagnosed with major recurrent depression (Psychiatric, low)
  ○ 8,654 Disabled, 5,505 Non-Disabled Adults, 18,389 Newly Eligible Adults, 11,655 Non-Disabled Children, 2,690 Elders
• 32,100 diagnosed (including duals) with hypertension (Cardiovascular, extra low)

[1] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

- 6,727 Disabled, 2,620 Non-Disabled Adults, 11,406 Newly Eligible Adults, 461 Non-Disabled Children, 7,688 Elders
- 17,243 diagnosed with drug abuse, dependence or psychosis (Substance abuse, low)
  - 3,422 Disabled, 2,571 Non-Disabled Adults, 9,860 Newly Eligible Adults, 903 Non-Disabled Children, 487 Elders
- 11,336 diagnosed with alcohol abuse, dependence or psychosis (Substance abuse, very low)
  - 1,844 Disabled, 1,295 Non-Disabled Adults, 7,138 Newly Eligible Adults, 719 Non-Disabled Children, 340 Elders

Project Area Impact

Performance Measures

- Pulmonary related diagnosis is the leading diagnosis among children with Medicaid coverage. (i.e. Viral pneumonias, chronic bronchitis, asthma)
- 29% of those discharged from ED for Alcohol and Other Drug (AOD) dependence received follow up care within 30 days
- 69% of those discharged from ED for mental illness received follow up care within 30 days
- 907 of 5,952 patients discharged from hospitals were readmitted within 30 days (15%)
- 5,847 Medicaid homeless adults, increased over the last three years
- 59% of Medicaid adults had a follow-up visit after discharge from emergency department for Mental Illness within 7 days.
- 15.3% of Medicaid enrollees discharged from hospital were readmitted within 30 days
- 12.3% of patients discharged from psychiatric inpatient care were readmitted within 30 days.

Geographic Disparities

- Snohomish County has the highest percentage (6%) of Medicaid enrollees with SUD and more than one chronic condition in the North Sound ACH region.
- Whatcom and Island counties, have the highest percentage (12%) of Medicaid enrollees with a mental illness and have more than one chronic condition.
- Readmission rate among Medicaid enrollees in Skagit County is 17%; 2% higher than regional average.
- Island County's outpatient emergency department visits rate of 59 per 1,000 member months is the highest in the North Sound ACH region.

Demographic Disparities

- Adult females are more likely to have poor mental health and asthma, while adult males are more likely to have diabetes and smoke.
- Adults with incomes under $25,000/year are more likely to experience higher rates of chronic conditions and risk factors.
- American Indian/Alaskan Natives and Whites were more likely to have poor mental health, asthma, not have a personal health care provider and smoke.
- Hispanic Medicaid enrollees 25% more likely to not follow up with PCP for care after hospitalization for mental illness within 30 days.
- American Indian/Alaskan Native Medicaid enrollees were 2x more likely to not receive follow-up care after hospitalization for mental illness.

	Co-morbid Disparities • Medicaid adults with substance use disorders or co-occurring MI/SUD are more than 3 times more likely to be experiencing homelessness • Medicaid adults with chronic cardiovascular, pulmonary, or metabolic diseases between 2 and 3 times more likely to not have active employment
Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Toolkit Historical Data, HCA, released August 17, 2017. 4) ACH Profiles Future, DSHS/RDA, released April 11, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017. 6) Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. 7) Chronic Disease Profiles (North Sound) WADOH, April 2016.	

Health Disparities

In the Medicaid claims data from the table above, we can see that indicators associated with the need for care coordination--such as medication management, readmission, and social determinants of health (e.g. lack of housing or employment) --show disparities across self-identified demographic groups, geographic regions, or co-occurring diagnoses. Patients who identify as Hispanic or Black have an increased likelihood of not remaining on prescribed medication for mental health needs through the maintenance phase.[2] Snohomish county shows the highest rate of co-occurring substance use disorder and chronic disease while Whatcom and Island show high regional rates of co-occurring mental health treatment needs and chronic disease.[3] Patients with such co-morbidities show much higher rates of homelessness, unemployment and more than 3 ED visits per year.[4] The existence of these disparities demonstrates insufficient system capacity to serve specific patient populations and a need to address them through culturally appropriate, community-based, and patient-centered care coordination.

Strategies/Model

Guided by the Targeted Universalism[5] concept, North Sound ACH will pursue a Care Coordination project using the Pathways Community HUB model. Establishing a Pathways Community HUB in the North Sound region will ensure that patients in the target populations receive robust, patient-centered care coordination through community health workers who can help them navigate resources: in the Pathways model, community-based care coordinators go to where patients are and work with them and their families to overcome social and economic barriers to managing their health. The region's Pathways Community HUB will connect more Medicaid enrollees with coordinated, community-based services, thus improving outcomes and reducing costs. Pathways provides a blueprint for sustainable and scalable care coordination, which will help ensure these improvements last.

The Pathways model will provide North Sound ACH and our partners with a formal structure for reducing duplication of care coordination services, achieving better health outcomes, and addressing the social determinants of health. In the Pathways model, services are reimbursed by payers, thus providing sustainability beyond the funded Medicaid Transformation period. Throughout the planning process, North

[2] Measure Decomposition Data, RDA/DSHS, released July 7, 2017.
[3] ACH Profiles Future, DSHS/RDA, released April 11, 2017.
[4] Measure Decomposition Data, RDA/DSHS, released July 7, 2017
[5] John A. Powell, Haas Institute. Targeted Universalism. 2017. Retrieved from http://haasinstitute.berkeley.edu/targeteduniversalism

Sound ACH has collaborated with MCOs and other partners to ensure a design for the HUB and a system that has payer buy-in, and the transformation built through Pathways lasts beyond the Medicaid Demonstration project. Additionally, North Sound ACH sees opportunities to pursue other sources of Pathways funding (e.g. private insurance payers, foundations) as we scale the model after the initial pilot phase.

Metrics and Outcomes

North Sound ACH intends for Pathways to support improvement on all the Project 2B Performance measures, as well as appropriate measures within the other project areas. The metrics that will show the most improvement will depend on the selected pilot target population and overlap with other project areas, including: Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence; Follow-up After Hospitalization for Mental Illness; Inpatient Hospital Utilization; Mental Health Treatment Penetration (Broad Version); Outpatient Emergency Department Visits per 1000 member months; Percent Homeless (Narrow definition); Plan All-Cause Readmission Rate (30 Days); and Substance Use Disorder Treatment Penetration.

Additionally, we expect to see the community-based care coordination provided through Pathways improve long-term health, social, and economic outcomes for patients due to the patient-centered support for improving social determinants of health.

Types of Partners

The North Sound ACH will serve as the Pathways HUB for the region. Relationships with providers, care coordination agencies, and other partners will be formalized in the coming planning year. To date, the types of providers we have engaged are:

- Health Home partners: our MCO and other Health Home lead partners are critical to our Care Coordination project because of the wealth of experience they bring in managing care coordination, because we are designing a Pathways-Health Homes complementary system that avoids duplication, and because Pathways can provide additional care coordination capacity in our region when Health Homes cannot serve all eligible Medicaid enrollees due to capacity limitations.
- Hospital and healthcare delivery systems will serve as sources of referrals into Pathways as well as hosts for community-based care coordinators, in addition to delivering care to Pathways clients.
- EMS and Government Services will be engaged as both referral systems as well as partners for monitoring and evaluating project success. In some cases, they may also serve as Care Coordination Agencies.
- Community-based organizations are key partners as Care Coordination Agencies, as well as routes for service delivery to Pathways clients and families.

After the pilot target population has been determined, Care Coordination Agencies in the region currently serving that population will be identified and engaged in implementation planning, including identification of care coordinators and managers for training. We expect to train a cohort of at least 20 care coordinators for the pilot project. Based on Pathways certification requirements and the experience of other HUBs, we expect each full-time care coordinator will carry a caseload of 25 to 30 clients with a balanced range of complexity, for a total of approximately 500 to 625 Medicaid enrollees served by Pathways in the pilot period.[6,7]

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[6] Rockville Institute. Pathways Community HUB Certification Pre-Requisites and Standards. Rev February 2017.

[7] Sartorious, P.J. Pathways Model Aligns Care, Population Health. Health Progress: Journal of the Catholic Health Association of the United States. May-June 2015.

Coordination and Avoiding Duplication

Our region's Health Homes Leads already provide care coordination services to high-risk individuals, with a total of 11,249 Medicaid patients enrolled in Health Home Care Coordination out of a total 13,591 patients eligible.[8] To date, North Sound ACH has met with MCO and other Health Home lead partners in four dedicated meetings to discuss and develop a regional care coordination model that avoids duplication of services. In the first conversations, the ACH and Health Homes partners approached this issue from the "Health Homes **vs**. Pathways" perspective--discussing and planning how to carve out space for each model to function independently of the other, with no overlap. By September 2017, the conversation evolved to "Health Homes **and** Pathways" with the ACH and Health Homes partners mapping processes and making plans for these two models to complement each other while avoiding duplication and creating a bi-directional referral system.

Planning conversations will continue, but so far North Sound ACH and Health Homes Leads have sketched out bi-directional referral relationships, and determined that Pathways can complement the work of Health Homes by targeting individuals who are in the Health Homes backlog (due to insufficient capacity); individuals who have opted out of Health Home enrollment, but may be receptive to another "door" to care coordination; and individuals who are not eligible for Health Home enrollment but would still benefit from care coordination (e.g., PRISM score below 1.5). Our goal is to design a model for Pathways/Health Home collaboration that successfully serves our region and that can be replicated in other ACH regions.

Summary

The North Sound ACH is working with its partners to design, pilot, and eventually scale a Pathways HUB to improve the health of the North Sound population, touching lives beyond the pilot target population and engaging diverse payers and funders in this transformation. We will start small and pursue excellence, continual improvement, and solid foundational partnerships in a pilot, and then plan for expansion to other populations within and possibly beyond the Medicaid population. Although the pilot target population will be small, the partnerships, systems, and shift of perspective toward paying for outcomes developed for Pathways populations will serve to improve our region's care coordination system as a whole, thereby benefiting additional populations.

2B: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the Care Coordination project area, the North Sound ACH has a broad level of engagement from stakeholders across the region for the Pathways framework including Tribal Nations, community-based organizations and others able to leverage community health workers into the effort and the clinical and other partners able to serve as referral sources. Workgroup leads in this area include a representative of a local FQHC: Sea Mar Community Health Centers, as well as a large health system partner: PeaceHealth.

In Spring 2017, the North Sound ACH began moving from broad stakeholder engagement into workgroups comprised of potential partnering providers who serve or are interested in serving the Medicaid population. Eight workgroups were formed, with an open invitation extended to providers and stakeholders who wanted to engage. These included behavioral health and SUD providers, community-based organizations, county health and human services and public health leaders, physical health care providers, tribal partners, health systems, and Managed Care Organizations. Two or more subject matter experts were invited to serve in a

[8] Data reported by HCA Health Home Contract Manager by email, October 2017.

lead role for each workgroup, which were supported by North Sound ACH staff. As information from HCA became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to craft draft "Statements of Interest" highlighting their individual and organizational interest and ideas for project frameworks. Staff and workgroup leads compiled these submissions to produce the outlines of a regional approach in each area.

Workgroups further refined these ideas at monthly face-to-face meetings with remote access for those who could not join in person. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking a strategy capable of incorporating participation from partnering providers, aiming to move the region's pay-for-performance metrics. This dialogue included the subpopulations indicated in the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum of partnering providers are represented in the Supplemental Workbook and remain a value for future engagement.

Concurrently, a self-formed group of health system primary care leaders agreed to become an advisory body to staff, wherein staff facilitate regular meetings, assist with scheduling, agendas and note-taking. This Health System Advisory Coalition includes leadership from the largest hospital systems providing primary care in the region, regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. The group has self-reported coverage of more than 205,000 Medicaid primary care enrollees in the region. Staff are continuing with outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to ensure inclusion of physical health providers serving a significant majority of the Medicaid population, similar to the reach that the North Sound BHO has with providers working in behavioral health and SUD settings.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of Medicaid transformation in our region. MCO partners are engaged on the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout the Medicaid Demonstration and beyond. In the case of Care Coordination, the North Sound ACH has participated in a series of meetings with MCO partners and representatives of the region's Health Home providers regarding coordination of these services in the development of the Pathways HUB. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication of efforts.

2B: Regional Assets, Anticipated Challenges and Proposed Solutions

The foundation of the regional assets that will support Project 2B is the collaborative nature of the diverse partners working to improve health in the North Sound Region. Since the inception of the North Sound ACH, organizations that have traditionally competed with each other have come together to collaboratively plan the transformation of our regional health system. This is demonstrated in the developing partnership with MCOs and Health Homes leads, who want to see Pathways succeed in our region by working in a complementary fashion with Health Homes.

Clinical Service Delivery and Expertise

- Clinical delivery systems and physical health care settings in our region have extensive experience with clinical care coordination and care management for their patients and may be selected to serve as Care Coordination Agencies, especially where they are currently employing community health workers.

Nonclinical Service Delivery and Expertise

- In the North Sound region, there are community-based organizations with extensive experience in serving high-risk populations with culturally appropriate services, including care coordination and resource navigation. Many of these organizations have expressed interest in Pathways and could serve as Care Coordination Agencies, with existing community health worker certified employees. These organizations include Snohomish Community Services, Opportunity Council, Community Action of Skagit County, and others.

Data, Analytic Tools, and Infrastructure

- The data backbone of Pathways Community HUB is the Care Coordination Systems platform, accessible in the cloud by online interface or mobile tablet application. It is interoperable with most of the regionally implemented EHR systems used by hospitals and physical health care providers, as well as capable of sending patient dashboards via direct messaging.
- The existing integration of CMT's EDIE platform at hospital systems region wide and the expansion of the twin CMT product PreManage to physical health care and behavioral health clinics will support the ACH in achieving improvement on follow-up after discharge measures, hospitalization rates, and ED utilization.

Workforce and Human Capital

There is a robust existing workforce of community health workers and care coordinators based in the Community Service Organizations and Federally Qualified Health Centers across the North Sound region, including:

- Health Home Care Coordination Organizations (CCOs) that provide care coordination services to high-risk Medicaid Enrollees. MCO and CCO partners may be able to support cross-training of Health Home care coordinators to also serve as Pathways community-based care coordinators.
- Community health workers (CHW) who are employed throughout the region, at Community Based Organizations and at Federally Qualified Health Centers.
- Other community based organization staff who serve in CHW-like roles but have not yet completed CHW training. Capacity building through training opportunities is an essential component for individuals and organizations which play a key care coordination role, but are not currently reimbursed for playing that role. In the Pathways HUB model, community health workers serve as care coordinators, and the North Sound ACH intends to leverage this existing workforce capacity to successfully engage the target populations where possible, and expand the workforce, especially among communities experiencing disparities, where CHWs with lived experience play a critical role as community liaisons.

Financial Resources

The North Sound ACH intends to establish a braided funding model to support care coordination services in the North Sound region, supplemented by Medicaid Transformation project funding and including the following sources:

- Managed Care Organizations
- Philanthropic and community development foundations such as Verdant Health Commission, Arcora Foundation, United Way, Chuckanut Foundation, or the Skagit Community Foundation
- Health care delivery systems

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Potential challenge	How will ACHs mitigate those challenges?
Currently, levels of care coordination differ among counties in the North Sound region (e.g. experience, capacity, ability to measure impact).	• Seek region-wide solutions to data collection and analysis that reduces the burden of monitoring project performance on individual agencies. • Invest in capacity building technology and workforce development that puts all regional partners on an equal playing field.
Geographical barriers to services is also a major challenge for North Sound residents. Any projects serving populations in San Juan, Island, or other remote locations will have significant challenges accessing services that require trips on ferries, bridges, or mountain passes.	• The North Sound ACH will evaluate potential target populations based on ability to overcome geographic barriers. The home visiting component of Pathways may be both an asset and a challenge for geographical barriers. • Improve access to and use of Medicaid Transport services that pay transportation costs for physical health appointments where there are barriers to transit.
Insufficient service capacity to meet the need is a major challenge for any care coordination project. Coordination of care, referral to services, and payment for completed pathways will only be effective if services exist to be referred into. For example, housing and employment are identified by partners as major gaps in services region-wide. The housing and employment pathways will be very difficult to close, even when patients receive care coordination and have appointments with the relevant service providers.	• Partner with housing agencies to streamline housing access. • Participate in opportunities to grow affordable housing stock in the region through targeted investments or ACH role as regional convener. • Establish relationships with employment services and workforce training centers to assist Pathways clients in obtaining work. • Use data gathered through Medicaid Transformation project activities, including closed/unclosed Pathway ratios, as evidence to motivate policymakers.
There are already robust care coordination systems in place in our region (such as Health Homes) that provide substantial care coordination services to high-need Medicaid clients and in which our provider and MCO partners have already invested deeply. To avoid duplication, improve outcomes, and lower costs, we will need a target population that is not already served by Health Homes that still has potential to produce cost savings and improve health outcomes.	• Our strategy for avoiding duplication with Health Homes has been to engage our MCO and Health Home leads from the beginning of our planning process, and work with them to create a care coordination system in our region that leverages both Pathways and Health Homes in the most efficient and effective manner possible. • Our MCO partners are experts in the Health Homes model, and North Sound ACH has engaged experts from the Pathways Model and Foundation for Healthy Generations to assist us in planning, engaging partners, and problem solving around Pathways. • Once the Pathways HUB is implemented and staff are hired, North Sound ACH and Health Home partners will hold cross-training sessions on the two models for staff, to ensure they understand how Pathways and Health Homes function and fit together.

An additional challenge in designing a complementary Pathways-Health Homes regional care coordination system will be data exchange, including eligibility determination and assignment of individuals to Pathways or Health Homes. The ACH will coordinate between CCS-the HIT infrastructure for Pathways--and Health Home lead organizations to ensure that patients referred into care coordination through the Pathways Community HUB are screened for receiving services through Health Homes.	• Determining eligibility for Pathways versus Health Homes will likely require exchange of data between the HUB and MCO partners. In late 2017 and 2018, North Sound ACH (as the Pathways HUB) and the MCOs will design a data-sharing system that facilitates eligibility determinations and protects privacy, and we will describe this arrangement in our contracts with the MCOs. We can draw on the experience and expertise of other Pathways HUBs and Pathways experts in doing so.
To participate in Pathways, care coordinators will be required to undergo training on the Pathways model. This training is intensive and expensive, and will likely present a financial barrier to smaller community-based organizations with limited staff capacity and financial resources.	• The North Sound ACH recognizes the importance and community connections of our region's smaller community-based organizations. These partners will be essential to successfully implementing Pathways in the North Sound region, particularly in working with populations facing health disparities. • North Sound ACH is committed to removing barriers to the participation of these critical partners, and is exploring strategies for doing so. One possible strategy could be for the ACH to subsidize the Pathways training fees for CHWs working in small CBOs with limited budgets. We will continue to discuss improving feasibility with our partners as the pilot project plan takes shape.
HIT/HIE systems not compatible with EHRs used by delivery systems or not functional for care transitions purposes.	• Coordinate with vendors and systems to troubleshoot issues with interoperability/compatibility/functionality, including software updates and custom programming if no other solution available. • Explore contracts with other vendors who are able to provide more interoperable or functional solutions. • Train providers and clinical staff in use of HIT systems to improve functionality and engagement with population health management technologies.
Challenges in patient information sharing across organizations (confidentiality/HIPAA)	• Facilitate the development and spread of Release of Information agreements and Business Associate Agreements across delivery systems and community-based organizations to share patient information such as care plans and hospitalization status for better care coordination and patient management.

2B: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality

improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.
As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

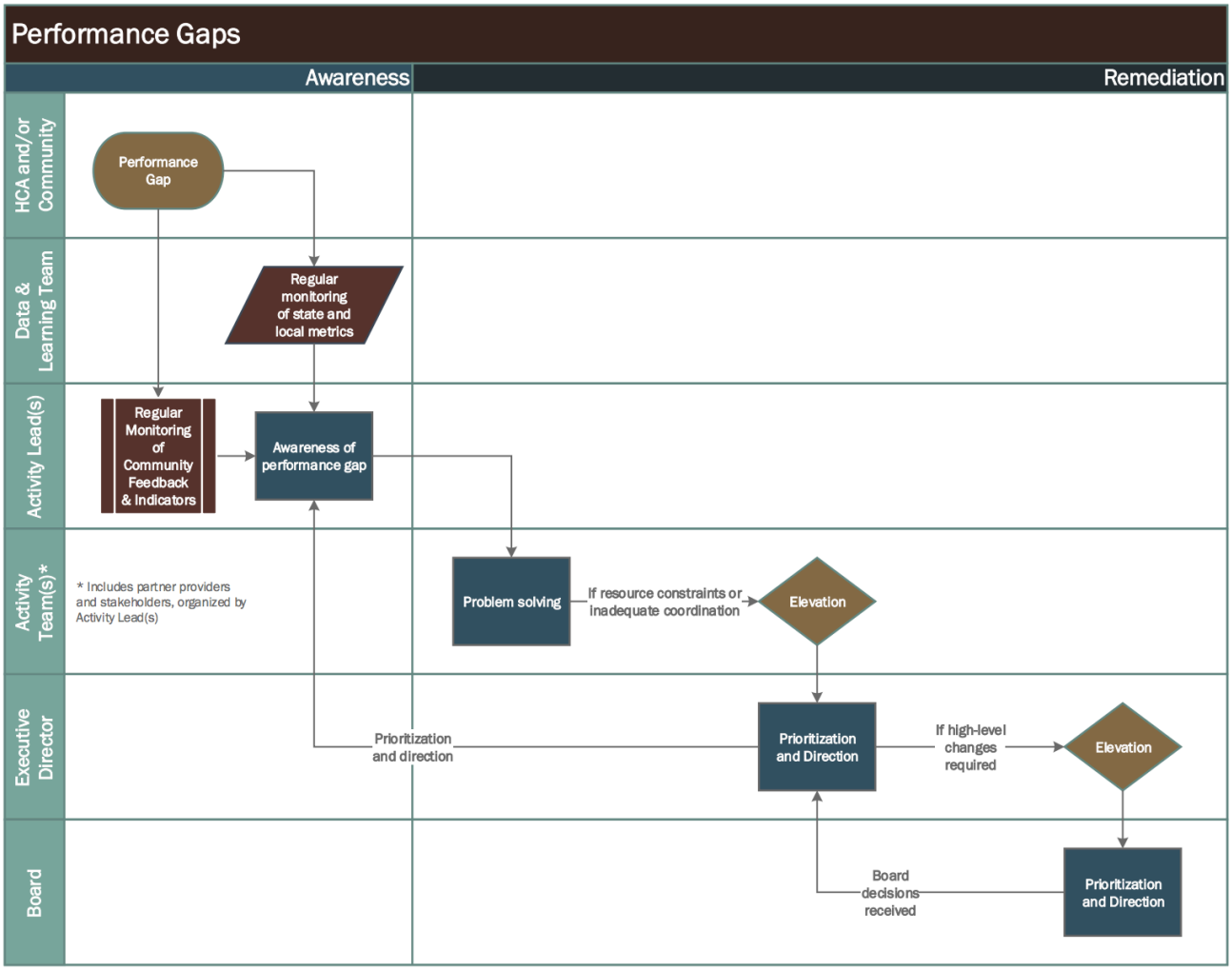

Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North

Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

2B: Project Metrics and Reporting Requirements

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

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

YES	NO
XX	

2B: Relationships with Other Initiatives

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

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

YES	NO
XX	

2B: Project Sustainability

The North Sound ACH is committed to working with partners in our region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation project period. With our partners, we will work toward achieving a "virtuous cycle," which occurs when clinical transformation improves provider performance on clinical quality measures in value-based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community and community-based organizations to address upstream, social determinants of health. To ensure lasting impact, we will optimize project strategies that hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster relationships among partnering providers, so implementation is realized on the regional level and when Medicaid Transformation project dollars are no longer available, the relationships and transformative changes will continue.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to braid together DSRIP earnings with other sources, including Managed Care Organization partners. Additionally, philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices, and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements, as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between clinical settings and community-based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, childcare, employment, food access, environmental pollutants, etc. Additionally, the ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to ensure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building capacity for these providers in the long-term. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long-term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long-term, likewise driving increases in reimbursements for value based contractual agreements.

Specific to Care Coordination, the Pathways Community HUB Model is unique among other North Sound ACH Transformation projects with a built-in payment mechanism to support community-based care coordination. As the system stands up and shows value, long-term sustainability becomes possible through partnering with Managed Care Organizations, as well as other streams of funding (such as philanthropic supports) and other, non-Medicaid populations who would bring in other insurance payers and support the Pathways HUB infrastructure through additional reimbursement possibilities.

2C: Transformation Project Description: Transitional Care

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

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

2C: Project Selection & Expected Outcomes

Introduction: Current State

Transitioning between different care settings can be challenging for any patient, but high-risk patients are especially at risk for negative outcomes due to insufficient transitional care planning. While there is a relatively low population of Medicaid enrollees admitted to inpatient hospitals, mental health facilities, or incarcerated compared to target populations in other project areas, they are a significantly more expensive population for delivery systems, Managed Care Organizations, and county governments to manage and care for. Based on the Medicaid Transformation project toolkit, the high cost of care for patients receiving care in these settings, and priorities identified by partners, we have identified three areas of care transitions that the North Sound ACH will focus on: Transitions from Inpatient Hospitalization; Transitions from Inpatient Mental Health and Substance Use Disorder (SUD) Treatment Facilities; and Transitions from Incarceration. The strategies used to improve transitions in each of these areas will build upon and add to existing work to improve transitions of care in the North Sound region.

Target Population

The target population for Transitional Care strategies are Medicaid enrollees in the North Sound region transitioning from intensive settings of care or institutional settings, including enrollees discharged from acute care to home or to supportive housing, and enrollees with SMI discharged from inpatient care, or client returning to the community from prison or jail.

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

Targeted Universalism[1] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

<table>
<tr><th colspan="2">North Sound Project Area Reach & Impact
Project Area 2C: Transitional Care</th></tr>
<tr><td colspan="2">Potential Target Populations Reach:
• 52,634 diagnosed with Serious Mental Illness (SMI)
  ○ 10,893 Disabled, 5,970 Non-Disabled Adults, 20,297 Newly Eligible Adults, 12,374 Non-Disabled Children, 3,100 Elders
• 15,029 diagnosed with both Substance Use Disorder Treatment Need and Serious Mental Illness
  ○ 3,565 Disabled, 2,123 Non-Disabled Adults, 7,822 Newly Eligible Adults, 1,154 Non-Disabled Children, 365 Elders
• 4,715 Adults (18+) who were incarcerated
• 76 Adults (18+) who were in acute inpatient psychiatric stays that followed by an acute psychiatric readmission within 30 days</td></tr>
<tr><td>Project Area Impact:</td><td></td></tr>
<tr><td>Performance Measures
• 59% of Medicaid adults had a follow-up visit after discharge from emergency department for Mental Illness within 7 days.
• 20% of Medicaid adults had a follow-up visit after discharge from emergency department for alcohol or other drug dependence within 7 days.
• 15.3% of Medicaid enrollees discharged from hospital were readmitted within 30 days
• 12.3% of patients discharged from psychiatric inpatient care were readmitted within 30 days.</td><td>Geographic Disparities
• Readmission rate among Medicaid enrollees in Skagit County is 17%, 2% higher than regional average.
• Island County's outpatient emergency department visits rate of 59 per 1000 Member Months is the highest in the region.
Demographic Disparities
• Hispanic enrollees 25% more likely to not follow up with PCP for care after hospitalization for mental illness within 30 days.
  ○ 75% more likely to be readmitted within 30 days after discharge for psychiatric inpatient care.</td></tr>
</table>

[1] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

	Co-morbid Disparities • Mental health service needs increase the likelihood of readmission by about half. • Medicaid enrollees with diagnosed chronic diseases such as CVD or Diabetes as much as doubled their likelihood of readmission.
Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Toolkit Historical Data, HCA, released August 17, 2017. 4) ACH Profiles: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017.	

Existing Work

Transitions from Inpatient Hospitalization

All hospitals in the North Sound ACH region have implemented various models of transitional care planning for successful discharge and readmission prevention. PeaceHealth St. Joseph Hospital in Bellingham implemented a successful early demonstration of the Care Transitions Intervention (CTI) model in 2008 with a pilot project called Stepping Stones – resulting in a 9% decrease in 30-day readmissions and improved outcomes for patients after discharge. The Stepping Stones project provides a building block for care transitions work in the North Sound ACH region and the master trainers from this project are an asset that can be used to train future transition coaches.

Evaluations of previous implementations of the CTI model have identified a need for additional collaboration with home health services and enhanced family caregivers to improve outcomes and reduce barriers to hospital discharge and post-hospital success. Some of these barriers include the inability to maintain continuous care with primary care providers, lack of transportation, food and prescription needs, in-home caregiving and coordination, and other social barriers that potentially can prolong care and healing. Along these lines, Providence Health and Services in Everett has developed a transitional care pilot program in collaboration with Homage Senior Services and Northwest Justice Project, a publicly funded legal aid agency that provides medical-legal assistance. This program is designed to connect community members to necessary social supports and improve health outcomes, including connection to legal services and enhanced patient advocacy.

As the North Sound ACH coordinates with regional hospital partners to reduce inpatient hospitalization and readmission rates, these existing activities will serve as a strong foundation for identifying and piloting successful care transition strategies. These strategies will be targeted to specific Medicaid patient populations using data on inpatient hospital utilization and readmission rates for Medicaid patients as well as engagement from partners, to enhance and expand care transitions activities without duplicating existing work.

Transitions from Inpatient Mental Health and Substance Use Disorder (SUD) Treatment Facilities

The North Sound Behavioral Health Organization (BHO) currently contracts with Compass Health to provide staffing to ensure North Sound residents enrolled in Medicaid who are discharged from inpatient mental health settings are connected with services intended to prevent re-hospitalization. Compass Health currently utilizes a staffing model of two teams of clinicians and peer counselors at six facilities in Skagit, Snohomish, and Whatcom counties, serving residents of all five counties in the region.

North Sound BHO issues Compass Health a list of North Sound residents enrolled in Medicaid who have been admitted to one of these inpatient psychiatric facilities. A member of the team contacts the facility to

determine if the individual is still there and the estimated discharge date. At least once prior to discharge, the clinician and Certified Peer Counselor meet with the client and the discharge planner in person to engage the client, discuss the discharge plan, and identify potential barriers to following through on the discharge plan.

Upon discharge, the team supports the client in following through on the discharge plan, connecting with resources and supports. Compass Health provides this support for approximately 30 days, until the client is connected with necessary supports to prevent re-hospitalization.

Transitions from Incarceration

There are currently jail transitions services (JTS) programs in place at facilities across the region. In Snohomish County, while incarcerated, inmates self-refer or are referred into the JTS program. Once eligibility is established, staff conduct a brief mental health assessment and a comprehensive needs assessment and enroll the individual into JTS. A clinician from an agency of the inmate's choice comes into the jail prior to release, meets with the individual and develops a plan for the days immediately post-release, often to include housing or shelter and accessing benefits.

Upon the inmate's release, contracted agencies have 90 days within which to provide supportive services. These services can include, but aren't limited to:

- assistance in accessing transportation and phone service,
- connections to employment service providers,
- SUD and MH assessments to determine eligibility for ongoing treatment,
- an appointment with a psychiatric medication prescriber,
- assistance in navigating benefits systems including ABD, SSI benefits and HEN
- assistance with connecting to potential housing resources
- connection to a primary care provider,
- coordination of behavioral health and physical health services.

Additional work includes ensuring they are enrolled in Medicaid, facilitating meetings with the MCOs and their members who are incarcerated to collaborate around healthcare needs, identifying high-utilizers with behavioral health issues and creating robust plans to help ensure services are in place at time of release, initiating Medication Assisted Treatment (MAT) in jail and facilitating MAT medication to begin the day of release, completing SUD assessments and facilitating classes for inmates in jail, as well as facilitating placement in residential treatment at release.

Strategies

Cross-cutting strategies for Care Transitions

Regardless of the target populations or the strategies employed, there are significant infrastructure gaps that will need to be addressed to allow traditional and non-traditional providers to better serve and coordinate care for patients/clients. Some of the cross-cutting strategies for improving transitions from all care settings include:

- Support widespread adoption and expansion of HIE tools such as PreManage for care management at physical health, behavioral, social service providers--including jail-based health providers. Access to these tools will help providers identify when shared clients have entered the ED and share care plans across clinical settings so care and services are coordinated and not duplicated.
- Build capacity to serve targeted populations: across all three strategies, we will need to expand capacity for services to be delivered to the identified target populations and to make sure we can sustain the workforce for the projects.
- Establishment of sustainable funding sources for transitional care planning, through value-based payment systems for health care providers or dedicated county funding for jail transition services.

- Integration of behavioral health screening in non-behavioral health provider settings through the collaborative care model, whether in inpatient physical health facilities or at booking in jails to identify which patients need behavioral health services. By standardizing and spreading this, we allow for quicker coordination with behavioral health providers to engage patients in services as well as reduction in stigma around behavioral health needs.
- Additionally, we expect that implementation of the Pathways Community HUB will positively impact most of the care coordination measures for Transitional Care, because of the importance of effective community-based care coordination for follow-ups after discharge, hospitalization, ED utilization, and readmission.

Jail Transitions: Reentry into the Community

During the planning phase, the North Sound ACH will convene partners from jail services and law enforcement in each of our five counties to share lessons and collaborate on collective activities to improve jail transitions for their systems. Partners have suggested additional strategies to improve transitions for the jail population, including:

- Business Associate Agreements between county services and the BHO and MCOs, which would allow jail-based physical health providers to better coordinate care. The current contract with the BHO provides reports on which inmates are enrolled with the BHO so that the jail can collaborate with behavioral health providers on medication management. With the move toward Fully Integrated Managed Care, these same BAAs will need to be put in place with the MCOs.
- Use of criminogenic risk assessment tools to target inmates who are most likely to benefit from the services provided. Criminogenic screens help to determine which inmates are most likely to re-offend and most likely to benefit from the interventions provided.

Across all of the target population areas and strategies, the North Sound ACH will work closely with regional partners to ensure that projects enhance and do not duplicate existing efforts, gathering partners across the five counties to share successful strategies in their sectors. As plan implementation begins, these cross-county conversations will help identify areas of overlap and synergy to improve coordination and reduce redundancy of work.

Transitions from Inpatient Care

Through a deliberative process, review of evidence-based care transitions models, and evaluation of current care transitions activities in the region, our partners have identified the Care Transitions Intervention (CTI) model as the key strategy for reducing hospital length of stay and readmissions rates. This model, as outlined in the Medicaid Transformation Demonstration Toolkit, uses transition coaches, transition planning and enhanced care management to support patients discharging from acute inpatient care. This selection was based on the demonstrated regional success of CTI at reducing readmission rates and improving patient outcomes. Additionally, implementation can be supported by drawing on existing assets, including local CTI master trainers who can "train the trainer" at all settings which elect to integrate the CTI model--building a community of transition coaches out of an existing workforce. The North Sound ACH will coordinate with regional hospital partners to explore implementation of the CTI model in their systems. Past or current implementations of the CTI model, such as that at PeaceHealth St. Joseph's Hospital, will be drawn upon to establish best practices and spread experience in the model. Additionally, enhancements of the CTI model to integrate community services and in-home assistance for patients after discharge, such as at Providence Medical Center Everett, will be evaluated for feasibility of implementation at additional hospital settings or mental health facilities.

Medical Respite care for people experiencing homelessness is also a potential element of our post-acute transitions strategy. This model can serve patients with comorbid disorders who have been recently treated

at medical facilities and ready for discharge but lack housing. The goal of the model is to provide short-term, medically assisted housing that allows the patient to stabilize medically and begin the process of engaging in behavioral health services and connecting with stable housing. Existing respite programs and pilot programs will be assessed for support and enhancement to build capacity.

ACH Role and Support for Partners

The North Sound ACH will improve health in the region by supporting the creation of a transitional care infrastructure and continuum that benefits Medicaid enrollees and providers in the highest-risk, highest-cost settings of care. Partner organizations directly serving Medicaid enrollees transitioning between care settings will implement the strategies selected for this project area, and the North Sound ACH's role will be to support them in doing so successfully and with maximum impact in the target populations.

Examples of roles the ACH will play in establishing the care transitions infrastructure include:

- working with partners to identify and address challenges in engaging the target populations;
- working with leadership of partner organizations to:
    - increase protected time for trainings and work flow modifications to support successful transitions,
    - identify opportunities for partners to see organizational budget savings based on improved efficiency
    - achieve buy-in to transformative change of front-line staff;
- developing and brokering relationships between service providers to expand the resources available to Medicaid enrollees;
- collaborating with MCOs and delivery system leadership to develop funding mechanisms that solve reimbursement challenges;
- facilitating the use of interoperable HIT and Release of Information agreements across partners;
- demonstrating the financial value of these interventions to funders, health systems, and other stakeholders who can potentially provide additional, sustainable financial support.

Metrics

Based on the application of the cross-cutting transitions strategies, jail population specific strategies, and implementation of the Care Transitions Intervention model we aim to achieve success in the following Toolkit metrics:

- Inpatient Hospital Utilization
- Outpatient Emergency Department Visits per 1000 member months
- Percent Homeless (Narrow Definition)
- Follow-up After Discharge from ED or Hospitalization for Mental Health, Alcohol or Other Drug Dependence
- Plan All-Cause Readmission Rate (30 Days)
- Percent Arrested

Health Equity

The North Sound ACH will use health equity as a lens for all our project areas. In order to be truly transformational and meet the needs of our community, disparities by race/ethnicity, socioeconomic status, geographic area, and other categories must be brought to the forefront. In the Transitional Care project area, strategies will be adapted when possible to each community to ensure that clinical and community interventions are both culturally appropriate and accessible (for example, hiring bilingual community health workers and clinic staff; hiring staff from the communities they will serve; requiring training on cultural humility, undoing institutional racism, implicit bias, and more).

Lasting Impacts

In an effort to produce long-term and sustainable results, efforts have focused on ensuring a wide variety of partners participate in this project area. Having the five counties involved in this effort will help to standardize processes, gain efficiencies where they are needed in our healthcare settings, and provide education and additional resources that have not been represented until now in all of the groups participating. It will enable partners to be proactive in the approaches, to successfully collect key data, and to measure the benefits for the larger population over the course of this project and beyond.

Additionally, it will be crucial to connect these transitions efforts into the processes built out in Project 2B: Community Care Coordination. The Pathways HUB could provide a sustainable platform for health workers to continue to connect patients to the social services and supports necessary for them to be successful upon leaving the hospital, jail, or mental health treatment facility.

With all of these strategies aligned, the critical focus must be on providing more standardized transitions for target populations, including ensuring access to any of the services of most immediate need for patients, whether they be behavioral health services or housing, food, employment, or others. The overarching goal is to build a stronger and healthier community and provide ongoing education and resources to ensure sustainability in the North Sound counties.

2C: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date, or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the Care Transitions project area, the North Sound ACH had high levels of engagement from clinical inpatient partners, community based organizations, tribal nations, and county governments, among others, which is essential to the project area's success. Workgroup Leads include representatives from a large regional health system: Providence Medical Center, and a Managed Care Organization partner: Amerigroup.

In Spring 2017, the North Sound ACH began moving from broad stakeholder engagement into workgroups, comprised of potential partnering providers who serve or are interested in serving the Medicaid population. Eight workgroups were formed, with an open invitation extended to providers and stakeholders who wanted to engage. These included BH and SUD providers, Community Based Organizations, county health and human services and public health leaders, primary care providers, tribal partners, health systems, and Managed Care Organizations. Two or more subject matter experts were invited to serve in lead roles for each workgroup, which were supported by North Sound ACH staff. As information from HCA became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to craft draft "Statements of Interest" highlighting their individual interest and ideas for project frameworks. Staff and workgroup leads compiled these submissions to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas at monthly face to face meetings with remote access for those who could not join in person (which was essential for this process to be accessible for more remote partners, especially those in San Juan county). North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including identifying target populations and strategies for incorporating participation from partnering providers, aiming to move the region's Pay for Performance metrics. This dialogue included the subpopulations indicated in the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum

of partnering providers are represented in the Supplemental Workbook and remain a value for future engagement.

Concurrently, a coalition of health system physical health care providers agreed to become an advisory body to staff, wherein staff convene regular meetings, assist with agenda setting, scheduling, and note-taking. This Health System Advisory Coalition includes leadership from the largest hospital systems providing primary care in the region, regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. The group has self-reported coverage of more than 205,000 Medicaid primary care assignees in the region. Staff are continuing outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to ensure inclusion of physical health providers serving a significant majority of the Medicaid population, similar to the reach that the North Sound BHO has with providers working in BH and SUD settings.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of Medicaid Transformation in our region. Managed Care Organization partners are engaged at the Board of Directors, at the Program Council, and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout. In the case of Care Coordination, the North Sound ACH has participated in a series of meetings with MCO partners and representatives of the region's Health Home providers regarding coordination of these services in the development of the Pathways HUB. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication.

2C: Regional Assets, Anticipated Challenges and Proposed Solutions

While the Transitional Care Project Area concerns three separate, distinct target populations, there exists a wealth of shared resources for managing care transitions in those three areas across all five counties.

Clinical Service Delivery and Expertise

Physical and behavioral health providers are critical to supporting patients transitioning out of inpatient care and maintaining the stability of their conditions. Hospital systems such as PeaceHealth and Providence bring existing experience implementing Care Transitions Interventions model, including master trainers who can expand the transition coach workforce by training trainers. Jail physical health services and county governments provide all-encompassing physical health care to patients incarcerated at jails across the region.

Nonclinical Service Delivery and Expertise

Successful transitions of care – whether from inpatient physical and behavioral health settings or from incarceration – rely on access to robust community services and factors such as housing, nutrition, and social support. Each county in the North Sound ACH region has a robust network of county government services and community-based services that can be leveraged to support patients during care transitions.

An existing partnership between Homage Senior Services and Providence Regional Medical Center, Everett also represents a regional asset as a pilot demonstration of enhanced care transitions that could be spread to other hospital and health systems.

Data, Analytic Tools, and Infrastructure

A critical element in managing care transitions will be electronic communication of care plans and patient status across care delivery settings, including hospitals, inpatient behavioral health facilities, long-term care

facilities, primary care providers, and behavioral health providers. Most of these settings have implemented EHRs or are in the process of implementing an EHR.

The expansion of CMT's EDIE/PreManage platform also presents an asset to the North Sound ACH region in achieving better transitions of care for patients, as it will notify outpatient providers in both primary care and behavioral health settings when patients are hospitalized or visit the ED.

In 2016 the Snohomish County Jail implemented an electronic medical health record system, CorEMR. This implementation and access to data by staff has allowed more efficient sharing of information and better collaboration between the county's Human Services staff and jail-based physical health staff. The success of this model will be examined and disseminated to encourage adoption of similar strategies in other counties in the North Sound ACH region where possible.

Workforce and Human Capital

The Care Transitions Intervention (CTI) model for inpatient care transitions relies on transition coaches with specialized training to support patients in developing care transition plans and maintaining their health stability. There is at least one master trainer in the CTI model who can support the training of additional transition coaches across the region, reducing the overall cost of the training and improving sustainability of the strategy.

Financial Resources

The North Sound ACH intends to establish a braided funding model to support transitional services in the North Sound region, supplemented by Medicaid Transformation project funding and including the following sources:

- Managed Care Organizations;
- Philanthropic and Community Development foundations such as Verdant Health Commission, United Way, Chuckanut Foundation, or the Skagit Community Foundation; and
- Health care delivery systems.

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Anticipated Challenges	Possible Solutions
Implementation of Care Transitions model not meeting performance measures, such as inpatient hospitalization rate or readmission rate for Medicaid Expansion population.	• Convene Quality Improvement team to review gaps in performance measures • Explore reasons for performance gaps and consider revisions or enhancements to improve rate for target population • Use population health management technologies to identify key target populations that are not responding to intervention. • Implement needed mid-course corrections, including integration of new partners or new strategies.
Limited partner capacity (for training, implementing new	• Support the dedication of provider time to care transition trainings and workflow modification activities

programs, willingness to take on new projects)	• Identify financial opportunity for participation in transformation project through improved efficiency and outcomes that supports organizational budgets beyond funding incentives. • Integrate and support front-line providers in planning and implementation process, so that projects are appropriate to provider needs and capacity.
Lack of resources such as housing or home health services for patients transitioning out of hospitalization	• Build relationships and connections with additional county services to assist patients in obtaining housing. • Explore opportunities to develop medical respite model.
Challenges with reimbursement for additional time or services associated with Care Transitions Intervention	• Collaborate with delivery system leadership and MCO partners to develop funding mechanisms that pay for performance on reducing hospital readmissions and length of inpatient stay. • Perform financial analytics that demonstrate value in transitional care improvement strategies. • Highlight benefits of improved care transitions services for reducing total cost of care and increasing shared savings reimbursements under value based payment contractual agreements.
HIT/HIE systems not compatible with EHRs used by delivery systems or not functional for care transitions purposes.	• Coordinate with vendors and systems to troubleshoot issues with interoperability/compatibility/functionality, including software updates and custom programming if no other solution available. • Explore contracts with other vendors who are able to provide more interoperable or functional solutions. • Train providers and clinical staff in use of HIT systems to improve functionality and engagement with population health management technologies.
Challenges in Patient information sharing across organizations (confidentiality/HIPAA)	• Facilitate the development and spread of Release of Information agreements and Business Associate Agreements across delivery systems and community-based organizations to share patient information such as care plans and hospitalization status for better care coordination and patient management.
Inability to obtain funding for expanding/spreading successful strategies across regional partners.	• Facilitate site visits for stakeholders and decision makers with ability to provide needed funds, so that the value of the models can be experienced first-hand. • Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to transitional care planning.

2C: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.

As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing

site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

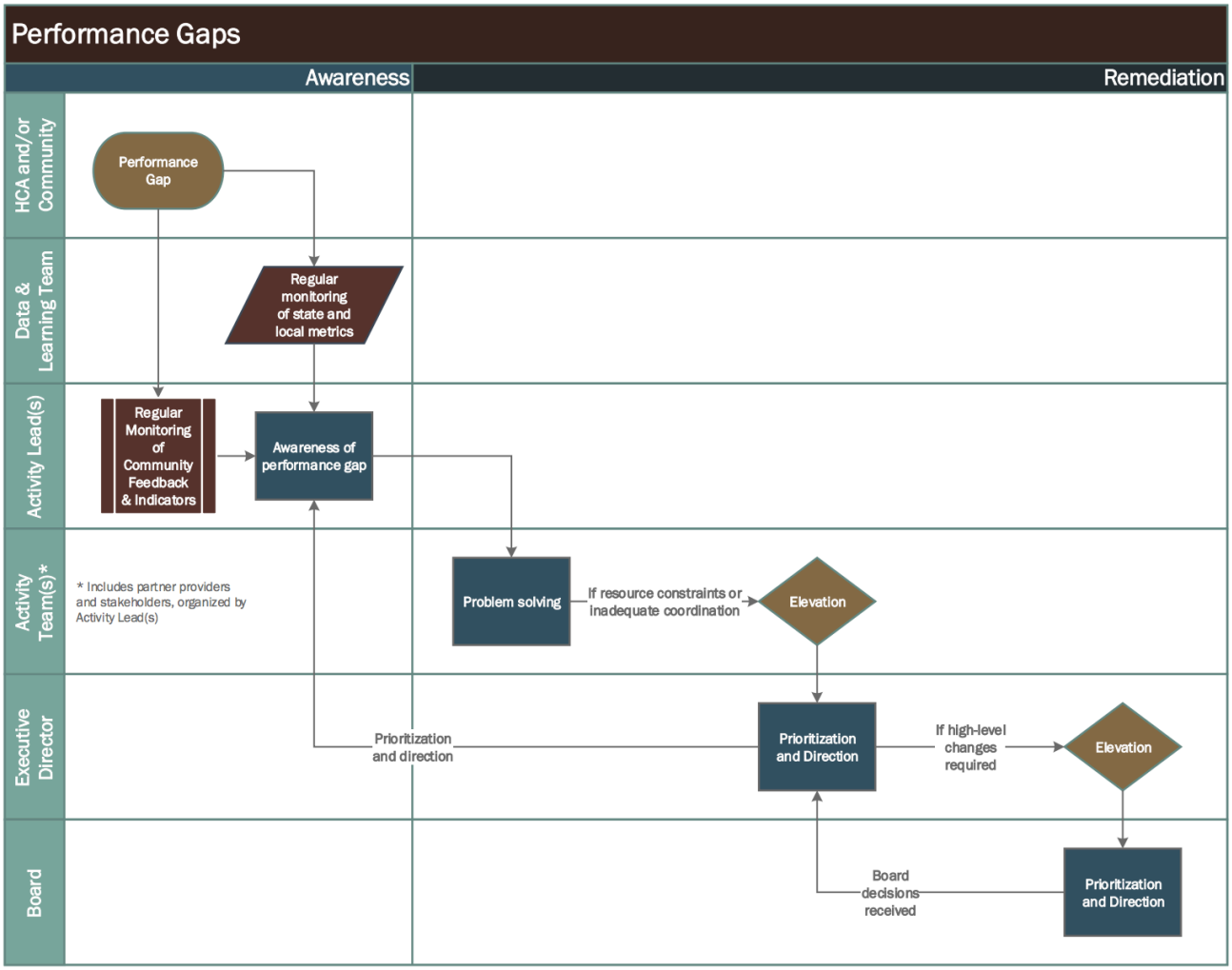

Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third party registries. These platforms can provide a picture of regional

performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE,

Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

2C: Project Metrics and Reporting Requirements

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

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

YES	NO
XX	

2C: Relationships with Other Initiatives

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

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

YES	NO
XX	

2C: Project Sustainability

The North Sound ACH is committed to working with partners in the North Sound ACH region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation Project period. A virtuous cycle results when clinical transformation improves provider performance on clinical quality measures in value based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community and community-based organizations to address upstream social determinants of health. To assure lasting impact, we will optimize project strategies that hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster relationships among partnering providers, so implementation is realized on the regional level and when Medicaid Transformation Project dollars are no longer available, the relationships and transformative changes will continue.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to "braid" together DSRIP earnings with other sources, including Managed Care Organization partners. Additionally, philanthropic support and investment from foundations and community

development organizations at the local, state, and federal level will be pursued and leveraged wherever possible.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements, both current and future as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between clinical settings and community based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, child care, employment, food access, environmental pollutants, etc. Additionally, the North Sound ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to ensure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building capacity for these providers in the long-term. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long term, likewise driving increases in reimbursements for value based contractual agreements.

Specific to the Transitional Care, when strategies outlined in the Transitional Care project area are successful at reducing hospital readmissions, hospital systems will not only see a reduction in spending but will see a reduction in penalties through other contractual arrangements. These funds can be reinvested back into systems to expand Transitional Care support and to serve more Medicaid patients. Additionally, cost savings from reduced recidivism in jails can be reinvested in expansion of jail transitions programs.

2D: Transformation Project Description: Diversion Interventions

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

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

2D: Project Selection & Expected Outcomes

Introduction Current State

Throughout the North Sound region, many of our most vulnerable and medically compromised residents have overlapping physical health, mental health, substance use disorder, housing instability, and legal challenges, resulting in repeated, often avoidable contact with the emergency system, including emergency medical services (EMS) and law enforcement. While reducing the likelihood of individuals receiving coordinated and consistent care and increasing their risk of homelessness, arrest, and serious illness, this frequent contact also has a negative impact on health and community systems such as hospital emergency departments (ED) and our county jails -- overburdening staff and increasing costs.

These costs are felt by the Medicaid system as a whole, and costs are disproportionately impacted by high-risk, "high utilizer" individuals' use of health systems and resources: a recent study published by Kaiser Permanente Community Benefit indicated that high utilizers account for only 5% of Medicaid enrollees, yet account for more than 50% of overall program spending.[1] Local emergency medical care and law enforcement systems also lack the staff and administrative capacity to provide the high-intensity, cross-sector care planning needed to provide appropriate, effective care and result in positive health outcomes for high utilizer community members with complex needs.

Throughout our region, many of the most vulnerable and medically compromised residents have overlapping legal, medical, behavioral health, and housing instability issues compounded by chronic disease that result in repeated, expensive, and often avoidable contact with the emergency medicine, crisis care, and criminal justice systems. However, health systems and EMS partners across the North Sound ACH region believe that the avoidable use of these high-cost health care resources can be prevented by providing appropriate alternatives through EMS and community-based care coordination.

Target Population

The target population for Diversions Intervention strategies is Medicaid eligible and Medicaid enrolled persons in the North Sound region who have complex medical and social needs, as well as frequent contact

[1] https://www.chcs.org/media/HighUtilizerReport_102413_Final3.pdf

with law enforcement and/or EMS providers. In our region, this population will include individuals with complex co-occurring diagnoses including mental health challenges, substance use disorder, or chronic illnesses (such as diabetes, heart disease, or asthma), individuals who access the EMS system for a non-emergent condition, who may also be experiencing social barriers to health like housing instability, transportation barriers, and lack of employment.

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

Targeted Universalism[2] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

North Sound Project Area Reach & Impact **Project Area 2D: Diversion Interventions**

Potential Target Population Reach:
• 7,418 Adults (18+) who experienced homelessness
• 4,715 Adult (18+) who were incarcerated
• 40,626 diagnosed with a Mental Illness and one or more chronic condition
  ○ 14,651 diagnosed MI and any cardiovascular condition
  ○ 14,238 diagnosed MI and any pulmonary condition
  ○ 4,330 diagnosed MI and Type 1 or Type 2 Diabetes
• 20,135 diagnosed with a Substance Use Disorder and one or more chronic condition
  ○ 8,335 diagnosed SUD and any cardiovascular condition
  ○ 7,410 diagnosed SUD and any pulmonary condition
  ○ 2,001 diagnosed SUD and Type 1 or Type 2 Diabetes
• 52,634 diagnosed with Serious Mental Illness (SMI)

[2] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

- 10,893 Disabled, 5,970 Non-Disabled Adults, 20,297 Newly Eligible Adults, 12,374 Non-Disabled Children, 3,100 Elders
- 37,279 diagnosed with asthma, COPD (Pulmonary, low)
  - 5,997 Disabled, 3,280 Non-Disabled Adults, 11,406 Newly Eligible Adults, 13,159 Non-Disabled Children, 3,437 Elders
- 32,100 diagnosed with hypertension (Cardiovascular, extra low)
  - 6,727 Disabled, 2,620 Non-Disabled Adults, 11,406 Newly Eligible Adults, 461 Non-Disabled Children, 7,688 Elders
- 22,390 diagnosed with Type 1 or 2 diabetes
  - 5,868 Disabled, 1,501 Non-Disabled Adults, 8,080 Newly Eligible Adults, 608 Non-Disabled Children, 6330 Elders

Project Area Impact:	

Performance Measures
• Average of 44 ED visits per 1,000 member months
• Of the 7,940 Medicaid patients arrested in 2015, 4,715 had mental health service needs.
• 12% of the 7,418 homeless had mental health service needs
• Rates of homelessness among Medicaid enrollees has increased since 2014
	Geographic Disparities
	• Island County has an average of 59 visits per 1,000 member months (15 visits higher than ACH average)
	• Snohomish county has the highest rate (6%) of enrollees with SUD and more than one chronic condition.
	• 12% of enrollees with a mental illness have more than one chronic condition with in Whatcom and Island counties.
	Demographic Disparities
	• Among the 27,596 Medicaid enrollees diagnosed with depression:
	  ○ 77% are White
	  ○ 66% are women
	  ○ 85% were adults (19+)
	• American Indian/Alaskan Natives were 2x more likely to not receive follow-up care after hospitalization for mental illness
	• Individuals identified a Black (68% more likely) or American Indian/Alaskan Native (39% more likely) are more likely to have experienced homelessness.
	• 38% more likely to be arrested if self-identified Black and 156% more likely to be arrested if self-identified as American Indian Alaskan Native.
	Co-morbid Disparities
	• Patients with Substance Use Disorder almost 5 times more likely to be arrested.
	• Greater than 3 Emergency Department Visits:
	  ○ 2x more likely if any Mental Health Need
	  ○ 2.5x more likely if Severe Mental Illness
	  ○ 3.4x more likely if Substance Use Disorder Treatment Need
	  ○ 4.5x more likely when Co-Occurring MI/SUD"
	  ○ 3x more likely if diagnosed with Type 1 Diabetes, w/o complications

	o 2x more likely if diagnosed with Type 2 Diabetes and Asthma/COPD.
Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Toolkit Historical Data, HCA, released August 17, 2017. 4) ACH Profiles: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017.	

Alignment with Regional Priorities

This project area aligns with regional priorities as identified in the most recent Community Health Needs Assessments, Community Health Improvement Plans, and Community Health Assessments conducted by counties, hospital systems, and community-based organizations in our region - specifically around reducing homelessness and increasing access to supportive housing services, improving regional safety, and increasing access to crisis care for behavioral health. Additionally, many local communities have identified homelessness as a growing crisis, and have dedicated (or are planning to dedicate) significant resources toward addressing this issue. Strategies in the Diversion Interventions project area will focus not only on reducing unnecessary Emergency Department Utilization, but also reducing homelessness and unnecessary criminal justice encounters.

Project Strategies

Recognizing the current burden to North Sound's health and community systems due to the lack of high-intensity, cross-sector care plans that address high utilizers' needs, North Sound ACH will support coordinated and wrap-around care through community paramedicine and complex case care coordination. Both strategies will improve health outcomes for high-risk, high utilizer individuals in our region, and use a patient-centered, evidence-based approach to meeting the complex needs of these community members, as well as address regional priorities like homelessness. Both strategies engage first responders as key partners, on both the Fire and Police continuums.

The goals of this project are to improve health outcomes for the target population by supporting the development and implementation of coordinated systems that address the complex needs of high utilizers. This includes improving access and care coordination for people with complex needs, which should also result in reduction of unnecessary cost and inappropriate utilization in health care, social service, criminal justice, and emergency systems.

1. Expansion of Community Paramedicine Program

While emergency services are a critical component of the health care system, they are too frequently used to treat unmet, rather than emergent, needs with high-cost, short-term solutions. Connecting patients with appropriate care that address complex medical needs using long-term, coordinated solutions is essential to improving health outcomes while also reducing unnecessary cost and utilization. This ultimately impacts individual outcomes, while also ensuring resources can be targeted to population health needs by enabling health systems to respond in effective and efficient ways.

Community Paramedicine programs serve as a bridge between Emergency Departments (EDs) and long-term case management and care providers. Community Paramedics act as an alternative to EDs, by working in partnership with other social service agencies to expedite coordinated care and referrals. Because community paramedics can meet community members where they live, they are better able to identify and address barriers to accessing care and addressing health challenges, as well as broader social determinants of health. Successful community paramedicine programs focus on efficiency and effectiveness in connecting people

with timely and appropriate levels of care, therefore reducing the overall strain placed upon the emergency health care system. Community Paramedicine programs also have the potential for decreasing the burden placed on clinics, allowing them to offer more in-home care options, resulting in improved overall care management and enhancing the patient experience.

Community Paramedicine programs have the potential to significantly improve the health of underserved and vulnerable populations, which has been demonstrated by current pilot projects within the North Sound region, in Snohomish and Whatcom counties.

Existing Work

There are two community paramedicine programs currently in operation in the North Sound region: one in Whatcom County, and one in Snohomish County.

- *Community Paramedic Program in Whatcom County (Bellingham Fire Department):* The Community Paramedic program of the Bellingham Fire Department was established in 2014. The purpose of the program is to help connect frequent utilizers of 911 services for non-emergent medical needs to more appropriate services. The benefit of the program is two-fold-- citizens are connected to medical and social services that better meet their needs and it creates capacity for the Fire Department to more quickly respond to true emergencies. The Community Paramedic program most frequently serves citizens dealing with complex medical issues including substance abuse, mental illness and complications related to aging, disability, fall-risk and homelessness by assessing their needs and coordinating their care with appropriate community resources.[3]
- *Snohomish County (Fire District 1):* The Community Paramedic Program in Fire District 1 began in 2014 as the first program of its kind in the state. It is funded by a grant from Verdant Health Commission. South Snohomish County Fire & Rescue (SSCFR) partners with Compass Health to identify and assist area residents whose needs go beyond a simple medical fix. Patients who have called 911 two times in 24 hours or three times over 30 days are automatically referred to the program. Hospital and social service staff may also make referrals. The community paramedic follows up with at-risk patients through a telephone call or a home visit to identify underlying causes and needs related to the use of 911 services. In addition to a medical assessment, a home safety survey is conducted to prevent falls and other risks. A mental health counselor and a peer counselor from Compass Health work out of SSCFR headquarters to assist in responding to behavioral and social service needs. SSCFR partners with more than 50 social service agencies that can provide patients with non-medical assistance that is often less costly and more effective in meeting their true needs. The goal is to help clients remain in their home. The program is free to patients – part of the services paid for through property taxes that support SSCFR. The Snohomish County Community Paramedic program currently serves around 300 individuals.[4]

2. Care Coordination Collaboratives for Complex Cross-System Cases

When persons in the target population require engagement efforts that exceed the scope of the Community Paramedic program, they will be referred for Care Coordination of Complex Cross System Cases. The cross-system diversion and care management component of this project area is a collaborative among existing and developing local hub-and-spoke networks engaged in cross-system identification and care coordination of complex cases, to enhance and link networks. The intent is to support local care coordination structures by pooling resources for shared functions and utilities, particularly around tools for information sharing and methods of engagement of complex, high-cost individuals.

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[3] https://www.cob.org/gov/dept/fire/Pages/community-paramedic.aspx

[4] http://www.firedistrict1.org/our-services/emergency-medical-services/community-paramedic

Two programs will be used as the models for this project: the Chronic-Utilizer Alternative Response Team (CHART) in Everett for cases referred from law enforcement, fire, hospital and corrections, and the Ground-level Response and Coordination Engagement (GRACE) in Bellingham which provides intensive case management for people experiencing homelessness and 911 high utilizers. Both programs have been operating in some capacity for more than two years, demonstrating promising results that will be expanded to meet the Project 2D performance metrics across the North Sound Region.

Existing Work

There are currently two community paramedicine programs in operation in the North Sound region: GRACE in Whatcom County and CHART in Snohomish County.

- *Ground-level Response and Coordinated Engagement (GRACE):*
  GRACE blends elements of the Law Enforcement Assisted Diversion model (LEAD) and the Jail Transition and Emergency Department Diversion models, while incorporating homeless outreach strategies to address unmet needs of high utilizers before arrest or contact with EMS. GRACE represents a partnership among the City of Bellingham, Whatcom County Health Department, the Opportunity Council, PeaceHealth St. Joseph Medical Center, and Whatcom Alliance for Healthcare Advancement targeting Whatcom County residents who have frequent contact with police, fire, hospitals, courts and jail. GRACE provides connections to behavioral and physical health services and treatment to address underlying causes, or unmet needs, that result in avoidable high-utilization of services. Community-based case managers coordinate with law enforcement, fire, corrections, emergency medical providers, and hospitals to collaborate on strategies to meet patients utilizing multiple systems, in order to provide a coordinated approach to services, prevent unnecessary use of emergency departments, reduce duplication, and track and manage care.
- *CHronic-Utilizer Alternative Response Team (CHART):*
  The CHART program consists of a team of criminal justice, emergency response, social service, and research partners collaborating to reduce the impact of chronic utilizers on those systems. CHART also contains elements of the LEAD and the Jail Transition and Emergency Department Diversion models. The CHART program's goal is to decrease the system impacts associated with the disproportionate overlapping service utilization by high-risk, high utilizer individuals, and improve the lives and health outcomes for these individuals. In Snohomish County, a core team consisting of representatives from the Everett Police Department, Everett Fire Department, Snohomish County Department of Human Services, Snohomish County Jail, the Everett City Attorney's Office, and Providence Regional Medical Center Everett works with patients to help craft an alternative care plan for high utilizers, such as connection to substance use disorder treatment and mental health services, public defenders, social workers, or other medical professionals. The CHART program has identified five systems that were typically over utilized: Police, Fire, Courts, Jail and the Emergency Department. Their clients were those who had more than six contacts with three or more of the systems above in a six-month time frame. Many of the clients had no interaction with services outside of the five systems listed above, and due to lack of information sharing between the five agencies, little was known about the severity of needs. Many clients were using jail as a housing option, and with little to no family or other source of support, many relied on EMS to meet their medical needs that could be otherwise met in a physical health care setting, exacerbating ED usage and overburdening EMS services. CHART has shown great promise in meeting its goal of reducing unnecessary and repeated systems' utilization among the target population and early results are promising, including a 78% decrease in arrests, an 80% decrease in Emergency Medical Service

contacts and a 92% decrease in jail days for CHART participants, saving costs to taxpayers and freeing up those services to respond to emergencies.[5]

The North Sound ACH plans to build on successes in other regions as well. For example, the Harborview High Utilizer Case Management Team in King County has shown success with a Care Coordination for Complex Cross System Cases project, and reports that regular meetings of providers across sectors has resulted in better care for high-risk, high utilizer patients. Two programs similar to CHART and GRACE, King County's Familiar Faces program and a high utilizer care collaborative through Pierce County Fire & Rescue have shown promise at meeting the needs of complex high utilizers, improving health outcomes, and reducing the burden to EMS and law enforcement systems. Collaborating across regions will be essential to identifying and implementing best practices and lessons learned to ensure high-quality, high-impact programs that improve the lives of North Sound residents and Washingtonians.

Population Health Management and Data Sharing

Taken together, the two components of this project area (Community Paramedicine and Care Coordination of Complex Cross System Cases) are expected to significantly impact the performance measures associated with this project area (Outpatient ED visits per 1000 member months, Percent Homeless, and Percent Arrested). However, true project success will be difficult to achieve without changing the way that health information is shared across sectors. A key transformative piece of this Diversions project, in conjunction with other proposed projects of the North Sound ACH, is the potential for organizing cross-system, patient-centered collaboration among local networks, supported by real-time data sharing and care planning technologies, as well as the opportunity to braid funding from multiple sources (city, county, state, federal and private) on behalf of shared goals for health and public safety. Existing Health Information Exchange technologies in use in this region will be examined to assess if they can be expanded or used more effectively to support high utilizer populations, such as EDIE/Pre-Manage and Image Trend. Health information Technology and data sharing transformation in this project area will link closely with similar efforts happening in all project areas, especially the Community-Based Care Coordination (around the Pathways Community HUB), Transitional Care, Bi-Directional Integration, Addressing the Opioid Crisis, and Chronic Disease.

Intersection with Pathways Community HUB Model

The expectation is that these strategies, once implemented, will ultimately link with the regional Pathways HUB, serving as contracted care coordination agencies (CCAs), and using interoperable or shared data systems and standard pathways operational protocols. Likely pathways utilized will be Behavioral Health, Housing, Medical Home, Medication Management, and Social Service Referral. Partners already engaged in five communities in the North Sound region (Everett, South Snohomish County, Lynnwood, Whatcom County, and Skagit County) include first responders (fire, paramedic and law enforcement), hospital systems, health providers, social service providers, corrections, housing agencies and local government.

ACH Role & Supports to Partners

The North Sound ACH will improve health in the region by supporting the creation of community supports for high-risk, high-utilizer Medicaid enrollees that prevents and provides alternatives to the Emergency Department and incarceration. This work will occur in the highest-risk, highest-cost settings of care. Partner organizations directly serving Medicaid enrollees who engage with emergency services or law enforcement will implement the strategies selected for this project area, and the North Sound ACH's role will be to support them in doing so successfully and with maximum impact in the target populations (which will be finalized in 2018).

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[5] https://everettwa.gov/DocumentCenter/View/6958

Examples of roles the ACH will play in establishing the diversion infrastructure in the North Sound Region include:

- Working with partners to identify and address challenges in engaging the target populations;
- Acting as convener for regular cross-sector collaboration meetings during the planning and implementation phases;
- Working with leadership of partner organizations to:
    - increase protected time for trainings (including trainings in cultural humility, which the ACH would likely not lead, but can assist in connecting providers with trainers and potentially provide financial support)
    - identify opportunities for partners to see organizational budget savings based on improved efficiency
    - achieve buy-in to transformative change of front-line staff;
- Developing and brokering relationships between emergency service providers and social service providers to expand the resources available to Medicaid enrollees;
- Collaborating with MCOs and delivery system leadership to develop funding mechanisms that solve reimbursement challenges;
- Facilitating the use of interoperable HIT and Release of Information agreements across partners;
- Demonstrating the financial value of these interventions to funders, health systems, and other stakeholders who can potentially provide additional, sustainable financial support;
- Considering the needs of the entire North Sound Region to ensure that strategies are implemented which promote access to services for Medicaid enrollees in rural and remote areas as well as urban areas;
- Sharing learnings from other ACH regions with planning partners when developing implementation plans.

Metrics

The strategies in this project area are intended to positively impact the Outpatient ED visits measure. Both strategies will address Pay for Reporting metrics like active care plans, HIE, scaling up the number of partners participating, and increasing partner capacity. The Care Coordination for Complex Cross System cases will be the primary strategy to address the Pay for Performance metrics of Percent Homeless and Percent Arrested, but collaboration with work happening across project areas will be essential to truly impacting these outcomes.

Health Equity

This project will serve populations experiencing complex health challenges, including poverty, housing instability, chronic pain, addiction, mental health challenges, and more. Often, the communities hardest hit by these challenges are people of color, and people who have come from generational poverty. Dedicating resources to meet the needs of these populations and think creatively about mechanisms to improve systems to better help people and their families find health and stability can make a significant impact on health disparities and inequity in our communities. Paramedics and care coordinators will need to be trained in cultural humility, motivational interviewing, and how to recognize implicit bias when supporting patients.

Lasting Impacts

By demonstrating success in diverting high utilizers from Emergency Departments and law enforcement when appropriate, as well as establishing coordinated care teams across sectors to support high-need community members, this project has the potential to create lasting change, and significantly improve health outcomes while reducing costs for hospitals, law enforcement, and emergency medical service providers.

Additionally, this project will likely increase the target population's connection to physical health care providers, reduce jail time and prevent additional criminal charges, while providing an important connection to social services, including housing.

This project is also poised to provide benefits to the Medicaid population in the North Sound region through increasing the capacity of EMS and emergency departments to respond to other emergency needs; by dramatically reducing costs across the Medicaid system; and by implementing care coordination for high-risk community members, which can result in decreased homelessness, a priority for the North Sound region.

2D: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date, or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the Diversion Interventions project area, the North Sound ACH has a high level of engagement from the region's Emergency Medical Services (EMS) leadership, especially regional Fire Chiefs, as well as representatives of county governments responsible for institutional oversight for target facilities and essential to realizing a successful project plan. Workgroup leads includes representatives from the Arlington Fire Department, and Whatcom County Human Services.

In Spring 2017, the North Sound ACH began moving from broad stakeholder engagement into workgroups, comprised of potential partnering providers who serve or are interested in serving the Medicaid population. Eight workgroups were formed, with an open invitation extended to providers and stakeholders who wanted to engage. These included behavioral health and substance use disorder (SUD) providers, community-based organizations, county health and human services and public health leaders, physical health care providers, tribal partners, health systems, and Managed Care Organizations. Two or more subject matter experts were invited to serve in a lead role for each workgroup, which were supported by North Sound ACH staff. As information from HCA became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to draft *Statements of Interest* highlighting their individual interest and ideas for project frameworks. Staff and workgroup leads compiled these submissions to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas at monthly face-to-face meetings with remote access for those who could not join in person. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking a strategy capable of incorporating participation from partnering providers, aiming to move the region's Pay for Performance metrics. This dialogue included the subpopulations indicated in the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum of partnering providers are represented in the Supplemental Workbook and remain a value for future engagement.

Concurrently, a self-formed group of health system primary care leaders agreed to become an advisory body to staff, wherein staff facilitate regular meetings, assist with scheduling, agendas and note-taking. This Health System Advisory Coalition includes leadership from the largest hospital systems providing primary care in the region, regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. The group has self-reported coverage of more than 205,000 Medicaid primary care assignees in the region. Staff are continuing with further outreach to other partnering providers, including

those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to assure inclusion of physical health providers serving a significant majority of the Medicaid population, similar to the reach that the North Sound BHO has with providers working in BH and SUD settings.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of Medicaid Transformation in our region. Managed Care Organization partners are engaged at the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout. In the case of Care Coordination, the North Sound ACH has participated in a series of meetings with MCO partners and representatives of the region's Health Home providers regarding coordination of these services in the development of the Pathways HUB. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication.

2D: Regional Assets, Anticipated Challenges and Proposed Solutions

Assets

The foundation of the regional assets that will support this project is the collaborative nature of the diverse partners working to improve health in the North Sound region. Since the inception of the North Sound ACH, organizations that have traditionally competed with each other have come together to collaboratively plan the transformation of our regional health system. Diversion intervention strategies will build on the many assets in our region, including strong commitments from diverse partners to meet the needs of complex, high-need community members and connecting them to appropriate support services, while reducing strain on emergency services and the criminal justice system.

Key assets for this project area include:

- **Pending Legislation**
  Legislation is pending that would support Community Paramedics, including legislation that would provide legal liability release for EMS to allow paramedics to transport patients to a non-Emergency Department destination such as a physical health care clinic or behavioral health provider and legislation that would allow EMS providers to be reimbursed for community work. The North Sound ACH will continue to advocate for policy change that will enable our systems to more effectively meet the needs of community members.

- **Pilot Program Success**
  The success of pilot programs for both Community Paramedicine (in Whatcom and Snohomish counties) and care coordination for complex cross-system cases (CHART and GRACE) present strong assets for this project area. These programs have a strong potential for scalability and broader scope of practice. Lessons learned from these pilots will guide the planning and implementation phases for this project area.

- **Broad Cross-Sector Support**
  The North Sound region has a strong network of diverse partners that will work together to support some of our community's highest need, vulnerable members. This support includes both dedicating staff time, expertise, resources, and funding toward standing up and sustaining Community Paramedicine and Care Coordination for Complex Cross-System Cases beyond the Medicaid Transformation Project.

Additional regional assets include (but are not limited to):

- **Clinical Service Delivery and Expertise**
  Our region has many medical and behavioral health providers, particularly emergency care providers, that are an asset to work in this project area:
  - 911 Emergency Support Services
  - Advanced Life Support (ALS) providers across five counties
  - Community Paramedicine programs (Bellingham and Snohomish County)
  - Hospitals and Emergency Departments (such as Providence, PeaceHealth, Skagit Regional, Swedish, and Island)
  - Primary Care Providers (such as Family Care Network)
  - Federally-Qualified Health Centers (such as Sea Mar, Unity Care NW, and Community Health Center of Snohomish County)
  - Behavioral Health Service providers (such as the North Sound BHO, Compass Health, and Sunrise Services)
  - Skilled Nursing Facilities
  - Tribal Health Clinics (including substance use disorder treatment)
  - Managed Care Organizations

- **Nonclinical Service Providers and Expertise**
  In the North Sound region, there are community-based organizations with extensive experience in serving high-risk, high utilizer populations with culturally appropriate services. Many of these organizations work closely with EMS/Fire and law enforcement agencies including:
  - Law Enforcement (Police and Sheriffs, including Tribal law enforcement)
  - Jails (including Tribal jails)
  - Court Systems
  - County Human Service departments
  - Community Action Agencies (the Opportunity Council, Community Action of Skagit County, Snohomish Community Action Partnership)
  - Homeless Outreach Service Providers
  - Transportation services (such as taxi services, public transit)
  - Housing services (such as the Opportunity Council, Lydia Place, Catholic Community Services, Mercy Housing, etc.)
  - Homeless shelter providers (such as Lighthouse Mission)
  - Other social service organizations
  - Charitable faith-based organizations
  - Food Banks
  - Veteran Support Services

- **Data, Analytic Tools, and Infrastructure**
  Many systems and tools are in place in our region that can be leveraged or expanded on, both to improve communication between providers and systems, and provide rich sources of relevant population and patient-level data that can help the North Sound ACH target and monitor key populations, house analytic and reporting infrastructure, etc., including:
  - Emergency Department Data (EDIE)
  - EMS Data (ESO, etc.)
  - Fire Data (ESO, ZOLL, etc.)
  - Primary Care and other hospital data (EPIC, EDIE/Pre-Manage, ZOLL, etc.)
  - Jail Data (Jail Inmate Lookup Service (JILS))
  - Arrest Data (from police and sheriff departments)
  - Behavioral Health Data

- Housing and homelessness data (Point In Time Counts, Homeless Management Information System (HMIS)

- **Workforce and Human Capital Assets**
  There is a robust clinical, and nonclinical workforce across the North Sound region, including:
  - Community Paramedics
  - Basic Life Support, Advanced EMT, Paramedics
  - Community Health Workers
  - Law enforcement (police, sheriff)
  - Jail service providers
  - Social Workers and Case Managers
  - Law-enforcement embedded social workers
  - Outreach services (for example, Opportunity Council's Homeless Outreach Team)

This region also has several education and training programs to support development of a qualified workforce, including:

- Everett Community College
- Whatcom Community College
- Skagit Valley College
- Bellingham Technical College
- Edmonds Community College
- Western Washington University

Financial Resources

The North Sound ACH intends to establish a braided funding model to support diversion services in the North Sound region, supplemented by Medicaid Transformation project funding and including the following sources:

- Managed Care Organizations
- Philanthropic and Community Development foundations such as Verdant Health Commission, United Way, Chuckanut Health Foundation, etc.
- City, county, and state funding
- Revenue from proposed state legislation

Community Relationships

Many relationships and coalitions are assets to this project in the North Sound Region. The following relationships between health care systems, emergency service providers, social service providers, law enforcement, city and county governments, and more can be leveraged to engage target communities, support patient engagement, and foster community buy-in, such as:

- Cross-Sector Coordinated Care programs for high utilizers, such as CHART and GRACE
- County Coalitions on Homelessness

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Anticipated Challenges	Proposed Solutions

Project has difficulty meeting performance metric targets, especially Percent Arrested and Percent Homeless	• The ACH will engage implementation planning teams in embedding tracking mechanisms in their implementation plans, including surveys, regular automated or manual reports of metrics, and other means for tracking success. Quality Improvement Plans will be integrated into the implementation strategy using rapid-cycle process improvement strategies to identify points of failure and improvement early for quick response. Quality Improvement teams will also convene, based either in the implementation planning teams or the data and learning team, to regularly review metrics and assess areas of change or improvement. • The ACH Data and Learning team will support the strategy through the development of a suite of monitoring and evaluation measures that provide an ongoing, actionable dashboard for project progress. Included in this will be ongoing survey-based assessments of training effectiveness and project implementation to partnering providers, regular review of clinical quality measures aligned with toolkit pay for performance measures, HCA reports on performance measure benchmarks, and other heuristic metrics for assessing project implementation success. Clinical quality measures will be pulled for tracking and quality improvement purposes, based on reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform or cloud-based registries. • Modifications to project plans will occur after the data and learning teams or implementation planning teams identify and report gaps or areas of improvement to the Program Council. ACH staff and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Managed Care Organizations could be engaged in this component, to assist ACH staff and partners in workflow redesign and lean process improvement activities. • The ACH will identify potential sources of outside technical assistance to support this process, including Qualis Health, Providence CORE, Kaiser Permanente Washington Health

	Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations. • Work with project partners to identify and understand barriers or limitations that contribute to the inability to meet these metrics. • Outreach to other ACHs, as well as state and national experts on reducing arrest and homeless rates, to learn successful strategies to address performance issues. • Consider investing ACH resources (including staff time) in more upstream efforts to reduce homelessness and arrest rates (investing in housing, advocacy at the city, county, and state levels, etc.)
Geographic barriers, resulting in limited capacity in more remote/rural areas and transportation barriers for Medicaid enrollees in these areas.	• The North Sound ACH will prioritize flexibility when developing implementation plans, and ensure that mobile services (such as mobile dentistry, mobile needle exchange/substance use disorder treatment, etc.), telehealth, and home visiting services are possibilities for populations in particularly rural or remote areas (such as the San Juan Islands or east Whatcom, Skagit, and Snohomish counties). • Allocate ACH resources to improve access to, use of, and reimbursement for Medicaid Transport services. • Utilize monitoring and continuous improvement processes to quickly identify when geographic barriers are impacting access to services.
Lack of affordable, available housing in the North Sound region resulting in inability to reduce homelessness, and unstable housing limits improvement in health outcomes.	• Outreach to other ACHs, as well as state and national experts on reducing homelessness, to learn successful strategies to address performance issues. • Consider investing ACH resources (including staff time) in more upstream efforts to reduce homelessness rates (investing in housing, advocacy at the city, county, and state levels, etc.)
Challenges with reimbursement for services by Apple Health (services not covered/reimbursement rate is insufficient/lack of provider understanding around billing procedures)	• Exploring sustainability with the local Managed Care Organizations will be needed to continue integrated services. • Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services and EMS services

	• Work together with the HCA to ensure that reimbursement rates for services (especially for behavioral health services, or services for Medicaid adults) are sufficient for providers to cover their costs and continue to provide services for Medicaid patients. • Leveraging expertise from the UW-AIMS center and cross sector workgroup support can provide information on proper billing and coding.
Health Information Technology/Exchange (HIT/HIE) challenges, including interoperability of multiple systems, implementation challenges with new systems (such as Pathways), barriers to data sharing between providers/systems (including protected health information), concerns around public disclosure and liability issues	• Utilize a mutually agreed-upon Release of Information (ROI) that can be used by partner providers in this project area, to ensure that patients' Protected Health Information (PHI) can be shared across agencies and agencies remain HIPAA-compliant. • Set up regular data/HIT round tables with partner providers to identify concerns around HIE, data sharing, and challenges around implementing new systems. • Work together with the HCA to ensure that reimbursement rates for services (especially for behavioral health services, or services for Medicaid adults) are sufficient for providers to cover their costs and continue to provide services for Medicaid patients. • The ACH will work with partners to identify any legal or regulatory barriers to sharing data and health information across providers or systems (laws around Public Disclosure; criminal history sharing; 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records, for example), and advocate where possible to remove these barriers. • There are some legal barriers to data sharing, including but not limited to Public Disclosure, HIPAA, and criminal history sharing, that many partners are concerned about. These concerns and legal issues will need to be addressed before the project is implemented. • Engagement with partner providers for evaluation of current capacity and needs around Medicaid reimbursement and billing. Connect partner providers with the Healthier Washington Practice Transformation Support HUB and resources through the project plan could mitigate this barrier.

	• In late 2017 and 2018, North Sound ACH (as the Pathways HUB) and the MCOs will design a data-sharing system that facilitates eligibility determinations and protects privacy, and the North Sound ACH will describe this arrangement in contracts with the MCOs. The ACH can draw on the experience and expertise of other Pathways HUBs and Pathways experts in doing so. • Work with leaders of the Pathways Community HUB to ensure that Pathways technology is able to integrate with existing HIT in use by partner providers. • Potentially leverage ACH resources to pay for data migration costs and set up of new systems, as well as staff training on the new system.
Many programs/initiatives with shared goals make it difficult to avoid overlap, or define boundaries between existing services and new services	• Meet with leadership of existing programs/initiatives to understand areas of overlap and potential synergies, as well as clear boundaries. • Tailor ACH projects to eliminate areas of overlap and target strategies to further the goals and public impact of both initiatives. • Set up regular round tables of both ACH project partners and stakeholders in this work to share learnings, avoid overlap and duplication, and identify opportunities to increase impact for all programs.
Challenges identifying long-term funding outside the Medicaid Transformation Project	• Utilizing monitoring and continuous improvement processes, regularly evaluate project performance to be able to clearly communicate project impact to potential outside funders, as well as demonstrate a commitment to effectiveness. • Collaborate with MCOs to identify opportunities that align long-term objectives and achieve total cost of care savings in line with needed investments. • Dedicate ACH resources to Identify additional funding sources, including in-kind support, local community development foundations, philanthropic foundations, other state and federal programs and “angel investors”. • Partner with other ACHs to achieve economies of scale. • Facilitate site visits for stakeholders and decision makers with ability to provide needed

	funds, so that the value of the models can be experienced first-hand. • Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to transitional care planning. • Advocate for city, county, and state-level allocation of funds to cover Diversion programs for "high utilizers", including Community Paramedicine and Cross-Sector Coordinated Care Teams. • Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services and EMS services.

2D: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project

Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.

As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

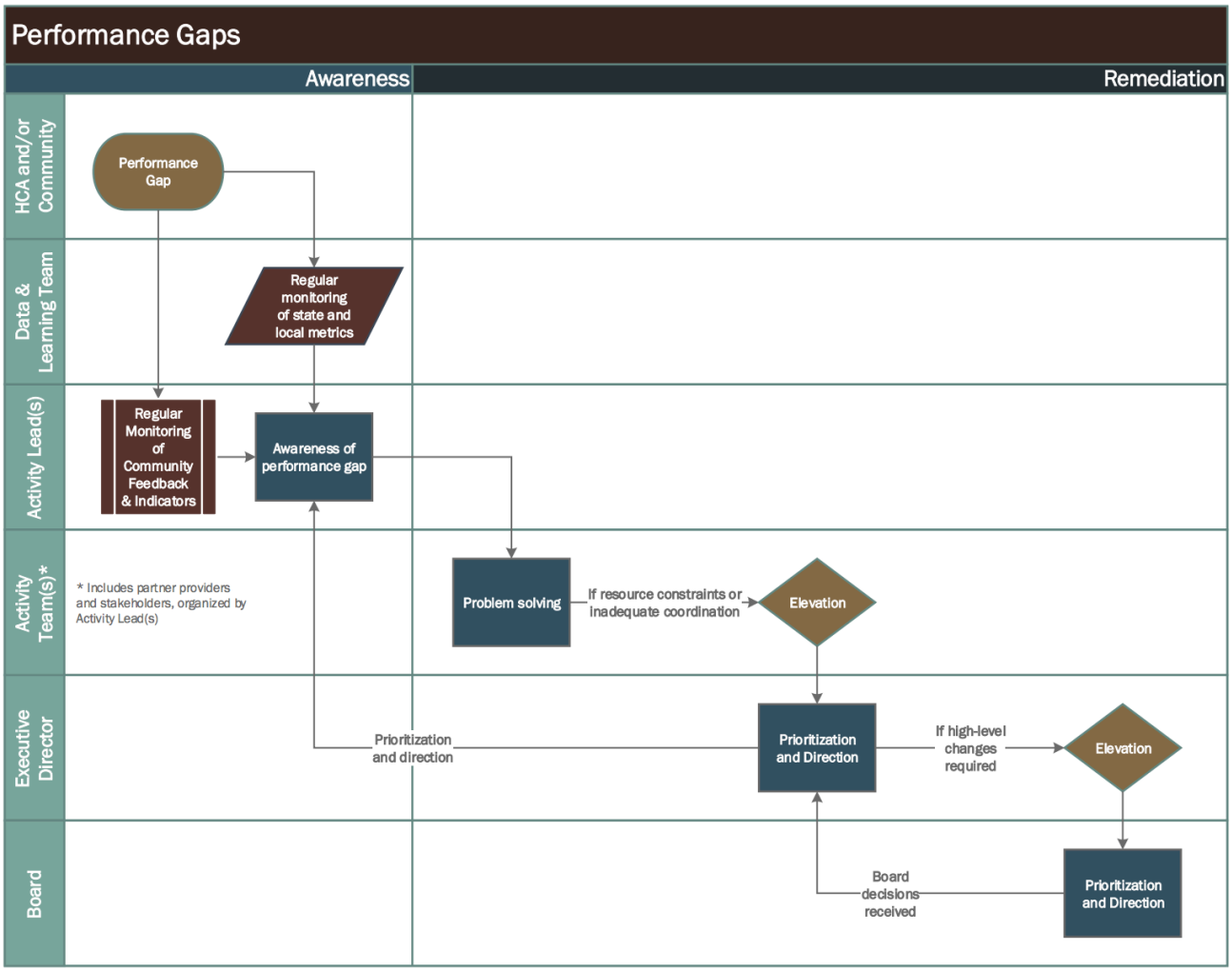

Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and

improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

2D: Project Metrics and Reporting Requirements

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

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

YES	NO
XX	

2D: Relationships with Other Initiatives

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

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

YES	NO
XX	

2D: Project Sustainability

The North Sound ACH is committed to working with partners in our region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation Project period. A virtuous cycle results when clinical transformation improves provider performance on clinical quality measures in value-based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community, and community-based organizations to address upstream, social determinants of health. To ensure lasting impact, we will optimize project strategies that not only result in improved health, but hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster meaningful relationships across partnering providers, to ensure sustainable transformation beyond the Medicaid Transformation project.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to braid together DSRIP earnings with other sources, including Managed Care Organization partners. Additionally, philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged wherever possible.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements, both current and future as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between

clinical settings and community based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, childcare, employment, food access, environmental pollutants, etc. Additionally, the ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to ensure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building long-term capacity for these providers. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long-term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long-term, likewise driving increases in reimbursements for value based contractual agreements.

Specific to Diversions, substantial opportunities for sustainability exist by improving the ability of systems, including clinical, community-based and criminal justice to better serve a high-risk, high-cost target population. Reducing ED utilization through Community Paramedicine and better connecting target populations with physical health care through care coordination will create savings that can be reinvested to support long-term sustainability.

3A: Transformation Project Description: Addressing the Opioid Use Public Health Crisis

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

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

3A: Project Selection & Expected Outcomes

Introduction- Why the Project is Needed

Communities across Washington, including the North Sound region, are currently experiencing an opioid crisis. Approximately 600 individuals die each year in Washington State from opioid overdose with an increasing proportion of those deaths involving heroin. Between 2012 and 2016, 607 individuals died from an opioid-related overdose (intentional, unintentional and undetermined) in the North Sound. Snohomish County, North Sound's largest county in the North Sound region, accounted for 80% (488) of the opioid-related deaths during this timeframe—a rate 1.3 times higher than that for all of Washington. Additionally, three of North Sound's five counties experienced opioid-related death rates higher than the state average, including Snohomish, Skagit and Island counties.

According to the DSHS Research and Data Analysis Division's RDA Report 4.92: "Drug overdoses disproportionately impact Medicaid enrollees, with Medicaid enrollees about six times more likely than the general population to have a fatal overdose involving opioid[s]." May 2017 Prescription Monitoring Program (PMP) data show Snohomish and Skagit Counties have higher opioid usage rates overall, while Island County's rate of Oxycodone and Whatcom County's use of Hydrocodone both exceed state rates, placing these populations at high-risk for Substance Abuse Disorder (SUD)-related morbidity and mortality. The table illustrates opioid trends in the five North Sound counties relative to Washington State as a whole.

Opioid Trends in the North Sound				
	Increases in Annual Rates (per 100,000): 2002-2004 to 2011-2013 (*ADAI*)			Opioid Overdose Death Rate (per 100,000): 2012-2016 (*DOH*)
	Publicly-funded treatment admissions for any opiate	Deaths attributed to any opiate	Crime Lab cases involving any opiate	
Island County	525%	77%	239%	10.9
San Juan County	368%	*Data not available*	*Data not available*	*Data not available*
Skagit County	367%	42%	182%	11.2
Snohomish County	321%	69%	-11%	12.4
Whatcom County	309%	23%	122%	7
WA State	197%	31%	86%	9.6
Data Source: Opioid Trends Across WA State (ADAI Info Brief). Caleb Banta-Green, April 2015.				

Target Population

The target population for Opioid Use Public Health Crisis strategies are Medicaid enrollees in the North Sound region, including youth, who currently use, misuse or abuse opioids, or are at-risk of using, or otherwise negatively impacted by the opioid epidemic. Opioid use is a significant public health issue in the North Sound region: this region has the highest number of Medicaid enrollees in Washington State with a diagnosis of opioid use or dependence (10,138) with 37,546 enrollees reporting using opioids, 8,075 identified as "heavy users". Opioid death rates in Island, Skagit, and Snohomish counties are higher than the state average. The opioid crisis disproportionately impacts younger adults, and significantly impacts a person's likelihood to be arrested or experience homelessness.

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

Targeted Universalism[1] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology.

[1] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

<table>
<tr><th colspan="2">North Sound Project Area Reach & Impact
Project Area 3A: Addressing the Opioid Use Public Health Crisis</th></tr>
<tr><td colspan="2">Potential Target Population Reach:
• 10,138 enrollees with a diagnosis history opioid abuse/dependence (highest in the state)
• 8,065 enrollees are heavy opioid users
• 1,694 providers prescribing opioids
• 30,540 identified with substance use disorder treatment need:
  ○ 4,998 Disabled, 4,070 Non-Disabled Adults, 17,883 Newly Eligible Adults, 2,934 Non-Disabled Children, 655 Elders
• 17,243 diagnosed with drug abuse, dependence or psychosis (Substance abuse, low)
  ○ 3,422 Disabled, 2,571 Non-Disabled Adults, 9,860 Newly Eligible Adults, 903 Non-Disabled Children, 487 Elders</td></tr>
<tr><td>Project Area Impact:</td><td></td></tr>
<tr><td>Performance Measures
• 37,546 total enrollees using opioids
• Of the 10,138 enrollees with a diagnosis history opioid abuse/dependence:
  ○ 10.9% on Buprenorphine
  ○ 19.2% on Methadone
• Of 37,546 opioid users on Medicaid, 8,075 are defined as “heavy users”</td><td>Geographic Disparities
• Opioid deaths rates in Island, Skagit and Snohomish county’s are higher than state average
• 61% of Medicaid enrollees with SUD treatment needs reside in Snohomish County
• Skagit County has the highest rate of drug law violations among adolescents (10-17) and adults (18+)
Demographic Disparities
• Majority of the 8,065 heavy opioid users are Women at 5,052.
• Adults 20-39 have the highest counts of a diagnosis history of opioid abuse/dependence.
• Non-Hispanic Whites and Non-Hispanic AI/AN have the highest rates of diagnosis history of opioid abuse/dependence.
Co-morbid Disparities
• Medicaid adults with substance use disorder treatment need are almost five times more likely to be arrested and 3.5 times more likely to experience homelessness.
• Greater than 3 Emergency Department Visits:
  ○ 3.4x more likely if Substance Use Disorder Treatment Need
  ○ 4.5x more likely when Co-Occurring MI/SUD</td></tr>
</table>

Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Profiles: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017. 4) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017. 5) Community Risk Profiles, RDA/DSHS, July 2017. 6) Opioid-related Deaths in Washington State 2006–2016, WADOH, May 2017.

Current Efforts to Address the Opioid Crisis

Most local jurisdictions in the North Sound ACH region have struggled with the effects of the opioid crisis in their communities. Partners from criminal justice, social services, healthcare and other systems have collaborated to develop innovative responses to this crisis and related homelessness, crime, and overdose deaths, but the need continues to overwhelm the resources available in North Sound communities. To address the mismatch in needs and resources, the North Sound Behavioral Health Organization (BHO), together with consultants and regional partners in public health, behavioral health systems, physical and behavioral health providers, county human services, non-profit substance use disorder treatment providers, experts from the University of Washington, and others developed a comprehensive regional plan, entitled the North Sound BHO Opioid Reduction Plan (ORP) which serves as the foundation of the North Sound ACH approach to this project.

As the primary funder of behavioral health services for the regional Medicaid population, the North Sound BHO developed the ORP to mirror the State's plan with regional, county-level and Tribal coordination activities designed to support state-level strategies and help further the four goals of prevention, treatment, reduction of overdose deaths, and enhanced data capacity. Over the course of several months in late 2016 and early 2017, regional stakeholders from multiple disciplines and jurisdictions shared how the epidemic has impacted their respective domains, and helped identify barriers and solutions to eliminate or mitigate the challenges their constituents and communities have faced as a result. The ORP's recommendations and proposed activities reflect information and ideas gathered from a total of 40 interviews, focus groups and conversations with key leaders and community groups. Many of the ORP's activities extend beyond the immediate reach of the BHO, relying on the collective efforts of multiple partners to make the best use of blended resources.

The North Sound ACH plans to partner with the BHO and other regional partners in the execution of the ORP and implement collaborative strategies that coordinate strategies beyond the current scope of the BHO's efforts. The ACH will leverage external resources while coordinating with other regional stakeholders to avoid duplication of efforts and create the synergy needed to achieve the desired outcomes and meet the required metrics within the Medicaid Transformation project. Those already engaged with the North Sound ACH and BHO to implement the ORP include North Sound Counties' Human Services and Health Departments, Tribal partners, drug courts and law enforcement, as well as numerous local primary and behavioral health care providers. The opioid epidemic is complex and the challenges are immense. Only a highly-coordinated, collaborative, and multi-disciplinary approach will be able to make positive and sustainable impact.

Opioid Workgroup Recommendations

Building on the North Sound ORP, this project will implement seven community-prioritized strategies to address the opioid crisis in the North Sound ACH region through prevention, treatment, overdose prevention, and recovery. These strategies are described in detail in the sections below.

Model

In accordance with the Project Toolkit, these strategies are based on evidence-based models, as well as the recommended resources for identifying promising practices. In particular, these strategies are in alignment

with the 2017 Washington State Interagency Opioid Working Plan. The project area's strategies also follow the four-pronged approach described in the toolkit:

1. **Prevention**: Prevent Opioid Use and Misuse
2. **Treatment**: Link Individuals with Opioid Use Disorder (OUD) with Treatment Services
3. **Overdose Prevention**: Intervene in Opioid Overdoses to Prevent Death
4. **Recovery**: Promote Long-Term Stabilization and Whole-Person Care (*Toolkit*)

Strategies

Activities	Impacts
Social marketing and public awareness	Changing community norms/practices to reduce opioid availability
Safe medication storage and disposal	
Improve opioid prescribing practices	
Prevention education for youth	Outreach, education, and early intervention to connect high risk individuals with treatment and reduce hospitalization/ED visits
Mobile treatment and outreach	
Increase SBIRT services in the region	
Scale up comprehensive opioid treatment, Medication Assisted Treatment (MAT)	
Increase availability and use of Naloxone	
Enhance or expand community recovery services	
Expand workforce capacity to address the epidemic	Ensure available/effective treatment to increase penetration rate/outcomes

1. **Prevention – Prevent Opioid Use and Misuse**
   - **Prescribing Practices**: Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain:
     - Support efforts to promote prescribing best practices following the Recommended Clinical Guidelines and in accordance with the updated HCA Opioid Prescribing Policy (recommended Clinical Guidelines include the WA AMDG's Interagency Guideline on

Prescribing Opioids for Pain and the CDC Guidelines for Prescribing Opioids for Chronic Pain)
    - Dovetail with state efforts around the Prescription Monitoring Program (PMP)
    - Train providers on best practices around prescribing practices through the Six Building Blocks model
- **Social Marketing and Public Awareness**: Together with the Center for Opioid Safety Education and other partners, raise awareness and knowledge of the possible adverse effects of opioid use (including overdose) among opioid users, while reducing stigma around treatment and recovery programs:
    - Utilize a social marketing agency to design a media campaign around stigma reduction and prevention messaging. Link to the information hub and app being developed by the Snohomish Health District that assists members of North Sound communities looking for resources, treatment options, treatment agencies, bed spaces, steps in transition and recovery supports.
- **Safe Medication Storage and Disposal**: Promote safe home storage and appropriate disposal of prescription pain medication to prevent misuse and addiction, especially among youth:
    - Promote patient access to safe, DEA-approved, convenient medication take-back options.
    - Create and disseminate promotional materials to promote community engagement around safe medication storage and disposal. Partner with pharmacies on distributing these materials.
    - Provide medicine safe storage lock boxes to patients with opioid prescriptions.
    - Coordinate with local Stewardship Ordinances around pharmaceutical take-back programs.
- **Prevent Opioid use in Youth and Families**:
    - Conduct a regional resource assessment/gaps analysis of primary prevention services, especially in elementary and middle schools; then expand evidence-based prevention programming to fill identified gaps in coordination with regional partners.
    - Develop intergenerational prevention, intervention, treatment and recovery support services for families starting with the family members and significant partners of OUD-affected individuals to promote healing and wellness. This is an opportunity to utilize the Pathways Community HUB model that will be implemented in the Care Coordination project area.
    - Expand screening practices into existing youth access points to identify risks for OUD. Coordinate efforts to leverage services for youth by facilitating collaborations between local stakeholders, including child welfare/foster care, juvenile justice, the North Sound BHO, coalitions, schools, ESD 189 and health care.

2. Treatment – Link individuals with OUD to treatment services

- **Increase Provider Capacity to Screen and Refer to Treatment**: Build capacity of health care providers to recognize signs of possible opioid misuse, effectively identify OUD, and link patients to appropriate treatment resources. This is an opportunity to collaborate with other project areas including Bi-Directional Integration of Physical and Behavioral Health and Care Coordination.
    - Increase SBIRT services across the North Sound Region: Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice for adults entering a healthcare or other service provider setting to receive universal screening for substance use disorder and early intervention for individuals showing signs of SUD.
    - Facilitate coordination between primary health care and OUD treatment systems to promote system improvements, such as screening, collaborative treatment models, co-location of services and integrated pain management services.
- **Expand Access to and Utilization of Treatment**, particularly Medication Assisted Treatment (MAT): Expand access to, and utilization of, clinically appropriate evidence-based practices for OUD treatment in communities, particularly MAT:

- Scale up the Comprehensive Opioid Treatment Model:
  - Increase access to evidence-based MAT for individuals who struggle with OUD.
  - Provide comprehensive services such as behavioral health care, primary care, and nurse care management for this complex patient population.
  - Coordinate with and expand the North Sound Hub & Spoke Project.
- Mobile Treatment and Outreach: Fund mobile treatment vans (providing outreach, assessment, treatment referral, waivered prescriber of Buprenorphine options, syringe exchange, Naloxone distribution, public health nurses, MHPs, housing case management and oral health) across the region, especially for rural and remote locations such as Eastern Whatcom, Skagit and Snohomish Counties, as well as San Juan and Island Counties.

- **Expand Workforce Capacity to Address the Epidemic**:
  - Increase the number of OUD service providers by promoting CDPs and para-professional Nurse Care Managers, Behavioral Health Aides, Outreach Workers and Case Managers as career paths, by providing tuition waivers and funding for professional development.
  - Increase the number of waivered prescribers to provide MAT by partnering with health care partners to reduce barriers for physicians and mid-level health professionals to become certified to prescribe Buprenorphine.
  - Create a coordinated regional system of diverse multi-disciplinary para-professional care coordinators specializing in outreach and engagement, connecting OUD-affected persons with concierge-level "no wrong door" access to MAT, recovery coaching, case management and essential supports, such as housing, in a variety of community locations. Begin by coordinating existing staff (Outreach workers, Nurse Care Managers, Case Managers, Behavioral Health Aides) already in place at treatment agencies, health care facilities and community service agencies and expand from there.
- **Expand Access to Treatment for Underserved Populations:**
  - *Youth:* Expand youth intervention, treatment and recovery support capacity into the community, including outreach and/or case management in schools, youth shelters, juvenile court and other venues where youth are found, to catch early use and connect youth with treatment. Support the implementation of Teen Intervene, an evidence-based, youth SBIRT model.
  - *Criminal Justice System:* Expand access to and utilization of MAT in the criminal justice system by partnering on work happening in the Transitional Care project area around the development of comprehensive transitional services for individuals with OUD being released from jail and Department of Corrections, ensuring continuity of care and stable housing.
  - *Access to treatment at syringe exchanges:* Support efforts to expand syringe exchange programs and provide co-located services such as treatment outreach, Buprenorphine prescribing, housing case management, distribution of Naloxone, primary care nurses, MHPs and other care coordination services.
  - *Maternal and Child Health:* Identify and treat OUD among pregnant and parenting women (PPW) and Neonatal Abstinence Syndrome (NAS) among newborns

3. **Overdose Prevention – Intervene in opioid overdoses to prevent death**
   - **Education**: Educate individuals who use heroin and/or prescription opioids, and those who may witness an overdose, on how to recognize and appropriately respond to an overdose. Utilize service networks, such as syringe exchange, outreach and other community programs to disseminate preventive information to individuals and families impacted by OUD. Together with the Center for Opioid Safety Education, promote awareness and understanding of Washington State's Good Samaritan Law.
   - **Increase Availability and Use of Naloxone**: Make system-level improvements to increase availability and use of Naloxone. Partner with the BHO, Counties, the University of Washington,

Tribal nations, housing providers, hospitals, emergency services, syringe exchange programs and other stakeholders to expand the availability and use of Naloxone, and promote awareness of the Good Samaritan Law, especially for high risk populations, such as individuals being released from jail, detox or residential services. Casinos and other Tribal properties will also be areas of focus for Naloxone expansion.

- **Coordinate Overdose Prevention Efforts**: Facilitate partnerships between hospitals, EMS and other first responders to connect persons who experience overdose with Naloxone kits, outreach, engagement and treatment services.

4) Recovery: Promote long-term stabilization and whole-person care

- **Support Community Recovery Services**: Enhance or establish community-based recovery support systems, networks, and services designed to improve treatment access and retention and support long-term recovery.
    - Develop partner capacity to employ recovery coaches, behavioral health aides, peer counselors and other paraprofessionals to enhance the care coordination network to support people in their recovery long-term.
    - Facilitate enhanced connections between treatment stakeholders and the larger recovery community, including 12 Step groups, Recovery Cafes and faith-based recovery programs. Utilize these partnerships to increase understanding of MAT and its effectiveness in treating OUD to reduce the stigma associated with its use.
    - Work collaboratively with Tribal nations, Counties, the North Sound BHO, the Oxford House system, and other partners to fund and develop additional housing for those in need of, or engaging in OUD treatment, including expanding the network of Recovery Houses available for Tribal members, other individuals and other communities in need.
    - Facilitate conversations between regional stakeholders and supported employment resources to explore the feasibility of offering vocational services and life skills training on-site at treatment facilities, recovery centers and other strategic venues to help recovering individuals fully transition back into their communities.
    - Reduce barriers by supporting the development of system incentives for the colocation of treatment and recovery services in centralized locations. "One-Stop" campus models and integrated care sites mitigate transportation challenges for those seeking services.
- Support Whole Person Health in Recovery: Connect Substance Use Disorder providers with primary care, behavioral health, social service and peer recovery support providers to address access, referral and follow-up for services. Collaborate with partners working on Bi-Directional Integration of Physical and Behavioral Health and Care Coordination projects.

Considerations for Addressing Health Equity and Disparities

The North Sound ACH region comprises a full continuum of geographic, socio-economic and demographic diversity that impacts the makeup of local communities. From urban to suburban, rural to frontier, assorted islands to the mainland, with military, agricultural and tribal communities, the Canadian border to the north and King County to the south, the North Sound's variety requires localized, tailored, community-driven approaches to meet the unique needs of its people.

As described in the sections above, the opioid epidemic has impacted some communities disproportionately and region-wide data show that substance use disorder treatment needs in the Medicaid population are greater for certain segments of the population. As we continue to plan, further data analysis will be necessary in order to identify root causes of opioid abuse and implement culturally appropriate targeted interventions. The eight Tribal nations within the North Sound Region and multiple service providers who specialize in providing such care are key partners in the proposed strategies. By the submission of our Project Portfolio, three of the eight Tribal partners will have active opioid treatment programs and all activities rely on the

partnerships of agencies already serving diverse populations such as Sea Mar. Also, the North Sound BHO requires its contractors to provide appropriate culturally competent SUD services to diverse communities and monitors agencies' effectiveness when conducting quality oversight audits. Collaboration is a cultural norm in the North Sound region, and that history of partnership will ensure collaborative solutions to addressing the health disparities that exist here.

Metrics

The strategies described above will address the reporting and performance metrics for this project area, as well as support movement of metrics in project areas with shared measurements and goals, such as Bi-Directional Integration of Physical and Behavioral Health Care, Care Coordination, and others. In particular, this project aims to reduce emergency department and hospital admissions by reducing overdose rates. It aims to increase Substance Use Disorder treatment penetration and utilization of MAT by expanding existing programs and increasing the workforce capacity in this area. Finally, by addressing prescribing practices and educating providers and patients, this project aims to reduce the number of patients on high-dose chronic opioid therapy and patients with concurrent sedative prescriptions.

Lasting Impacts

By demonstrating success in preventing opioid use and addiction, increasing access to treatment and long-term recovery services, and preventing overdoses, this project has the potential to create lasting change for people experiencing or at-risk for opioid use disorder in our region, and significantly reduce the devastating impact opioids (pharmaceutical or heroin) have on our communities, especially for young people. By addressing prevention, and addressing prevention for youth and families, this project will also benefit the entire Medicaid population by reducing the reach and impact of the opioid epidemic.

3A: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the Addressing the Opioid Use Public Health Crisis project area, the North Sound ACH has benefitted from extensive pre-existing community organizing and planning led by the North Sound BHO in their formation of an Opioid Reduction Plan. These efforts predated the work of the ACH and created a smooth glide path to stakeholder engagement. Workgroup leads in this area include representatives the North Sound BHO and Skagit County Public Health.

The North Sound ACH began a process of moving from broader stakeholder engagement into targeting partnering providers based on those currently serving or interested in serving a greater proportion of the Medicaid population in the spring of 2017. This engagement began with the formation of eight workgroups in each of the Toolkit project areas. An open invitation was extended to providers and stakeholders who saw an interest or retained a specialty in a certain project area and wished to engage. These included behavioral health and SUD providers, community-based organizations, county governments, primary care providers, health systems, Managed Care Organizations and health departments. Two or more volunteer subject matter experts from the community were invited to serve alongside staff in a lead role for each workgroup. As more information on the Medicaid Transformation became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to draft "Statements of Interest" highlighting their individual and organizational interest and ideas for project frameworks. Staff and workgroup leads then gathered these submissions and reflected back a compilation of content to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas during dialogue at monthly face-to-face meetings with remote access capability. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking a strategy capable of incorporating participation from partnering providers across the region, while also aiming to move their respective pay-for-performance metrics. This dialogue on target populations, partnering providers already serving and committed to serve the Medicaid population, and effective strategies honed the focus of the workgroups onto Medicaid enrollees, including the subpopulations indicated by the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum of partnering providers are represented and remain a value for future engagement.

Concurrently, a coalition of health system primary care agreed to become an advisory body to staff, wherein staff convene regular meetings, assist with scheduling, agendas and note-taking. The Health System Advisory Coalition includes members from the largest hospital systems providing primary care in the region, all the regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. Collectively, the group has self-reported coverage of over 205,000 Medicaid primary care assignees in the region. Staff are continuing with further outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to assure inclusion of those serving a significant majority of the Medicaid population. Plans to similarly convene partnering providers working in behavioral health and SUD settings will ensure a broad spectrum is represented for the purposes of bi-directional integration.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of the Medicaid Transformation and efforts at systems transformation in our region. Managed Care Organization partners are engaged on the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus far provided significant expertise and guidance to the project planning and will continue to do so throughout. In the case of Care Coordination, the North Sound ACH has participated in a series of meetings with MCO partners and representatives of the region's Health Home providers regarding coordination of these services in the development of the Pathways HUB. Through existing governance channels and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication efforts across the region.

3A: Regional Assets, Anticipated Challenges and Proposed Solutions

Assets

The foundation of the regional assets that will support this project is the collaborative nature of the diverse partners working to improve health in the North Sound region. Since the inception of the ACH, organizations that have traditionally competed with each other have come together to collaboratively plan the transformation of our regional health system. Strategies in this project area will build on the many assets in our region, including strong commitments from diverse partners to prevent and treat opioid use disorder, while promoting access to treatment and recovery and reducing overdose deaths. Key assets are described below.

Existing Work and Partnerships

The North Sound ACH benefits from the collaborative relationships that already exist and will work to expand the network of partners involved in these efforts. The North Sound Opioid Reduction Plan (ORP) is built on a foundation of collaboration resulting from multi-jurisdictional partners assessing factors contributing to the crisis from a regional perspective. The ORP's overarching strategy is to collaborate and coordinate with partners to develop or expand comprehensive strategies to reduce the opioid epidemic's

impacts in the North Sound ACH region and beyond. The plan lays out regional and local strategies developed by the BHO and the five counties within the North Sound, to reduce the effects of the opioid epidemic in their communities. Tribal-specific coordination strategies are also included, based on the specific needs of the eight Tribal nations in this region.

The scope of the opioid problem is immense but many resources already exist in the form of services, partnerships and pilot projects. The opioid crisis has already spawned new partnerships and innovative service models, such as outreach to people experiencing homelessness, partnerships with law enforcement to distribute Naloxone, integration of primary care and emergency care with SUD treatment, embedding social workers into schools, and more. These innovative partnerships and models provide a strong basis for the work ahead.

Assets in the North Sound ACH region include (but are not limited to):

Clinical Service Delivery and Expertise

North Sound has a network of SUD treatment providers, as well as primary care providers, emergency service providers, behavioral health service providers, and others, including:

- The North Sound BHO
- Behavioral Health Agencies (Compass Health, Sunrise, etc.)
- Narcan/Naloxone prescribers and distributors (for overdose prevention)
- Needle Exchanges (including mobile needle exchange)
- Hub-and-Spoke grant recipient (Dr. Adam Kartman, Cascade Medical Advantage)
- Hospitals (including PeaceHealth, Providence, Skagit Regional, Island Hospital, Swedish, etc.)
- Federally Qualified Health Centers (Sea Mar, Unity Care NW, Community Health Center of Snohomish County, etc.)
- Primary Care Provider systems (such as Family Care Network, etc.)
- Substance Use Disorder Treatment Centers (inpatient, outpatient)
- Dental Clinics (in FQHCs as well as private dentists, who are Opioid prescribers)
- Pharmacies (in hospital systems as well as private)
- Managed Care Organizations
- Tribal Substance Use Disorder clinics, including but not limited to:
    - Lummi Chemical Addiction Recovery and Education (CARE)
    - Swinomish Indian Tribal Community's didgwálič Wellness Center (*new*)
    - Tulalip Tribes Chemical Dependency Programs
    - Upper Skagit Indian Tribe Chemical Dependency Treatment Program
    - Nooksack Alcohol and Chemical Dependency program
    - Stillaguamish Tribe Island Crossing Counseling Services

Nonclinical Service Delivery and Expertise

In the North Sound ACH region there are many nonclinical, government or community-based organizations focused on addressing the opioid crisis, including:

- Law Enforcement (police, sheriff, and jails)
- Emergency Medical Services (EMS)
- Advocacy groups (Restoration One)
- Housing Service Providers (Opportunity Council, Catholic Community Services, etc.)
- Social Support Service Providers (Pioneer Human Services, Catholic Community Services, etc.)
- Schools (potential to address youth prevention) - high schools, middle schools
- County Human Service providers
- Advocates with lived experience of addiction or their family members (Ohana in Skagit County, North Sound ACH Community Leadership Council members, etc.)

Data, Analytic Tools, and Infrastructure

North Sound ACH plans to leverage or expand on data tools and infrastructure to improve communication between providers and systems, and provide rich sources of relevant population and patient- level data that can help the North Sound ACH target and monitor key populations, house analytic and reporting infrastructure, etc., such as:

- Prescription Monitoring Program (PMP)
- Overdose data
- Emergency Department Data (EDIE)
- EMS Data (ESO, etc.)
- Primary Care and other hospital data (EPIC, EDIE/Pre-Manage, ZOLL, etc.)
- Jail Data (Jail Inmate Lookup Service (JILS))
- Arrest Data (from police and sheriff departments)
- Behavioral Health Data
- Coroner reporting (opioid-related deaths)

Workforce and Human Capital Assets

There is a robust existing clinical, and nonclinical workforce across the North Sound region, including:

- Waivered Prescribers, Chemical Dependency Professionals (opportunities exist for growth)
- Nurse Care Managers
- Basic Life Support, Advanced EMT, Paramedics
- Community Health Workers
- Law enforcement (police, sheriff)
- Jail service providers
- Social Workers and Case Managers
- Law-enforcement embedded Social Workers
- Outreach services (for example, Opportunity Council's Homeless Outreach Team)
- Public Health professionals
- Pharmacists
- Regional experts (creators of North Sound Regional Opioid Plan)
- Harm reduction advocates, and advocates for Medication Assisted Therapy

The North Sound ACH region also has several education and training programs to support growth in this workforce, including:

- Whatcom Community College
- Skagit Valley College
- Bellingham Technical College
- Western Washington University

Financial Resources

The North Sound ACH intends to establish a braided funding model to support strategies to address the opioid crisis in the North Sound region, supplemented by Medicaid Transformation project funding and including the following sources:

- Managed Care Organizations
- Philanthropic and Community Development foundations
- Tribal funding sources for Tribal services
- City, County, State, and federal funding to address the opioid crisis

Community Relationships

The North Sound has extensive relationships and coalitions between health care systems, social service providers, advocates, people with lived experience, law enforcement, city and county governments, and others that will be leveraged to engage target populations, support patient engagement, and foster community buy-in. Examples include:

- Community coalitions, such as the Opioid Workgroup Leadership Team (Skagit County)
- Community support groups, such as Ohana (peer support for families of people with OUD)

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Anticipated Challenges	Proposed Solutions
Project has difficulty meeting performance metric targets	• The ACH will engage implementation planning teams in embedding tracking mechanisms in their implementation plans, including surveys, regular automated or manual reports of metrics, and other means for tracking success. Quality Improvement Plans will be integrated into the implementation strategy using rapid-cycle process improvement strategies to identify points of failure and improvement early for quick response. Quality Improvement teams will also convene, based either in the implementation planning teams or the data and learning team, to regularly review metrics and assess areas of change or improvement. • The ACH Data and Learning team will support the strategy through the development of a suite of monitoring and evaluation measures that provide an ongoing, actionable dashboard for project progress. Included in this will be ongoing survey-based assessments of training effectiveness and project implementation to partnering providers, regular review of clinical quality measures aligned with toolkit pay for performance measures, HCA reports on performance measure benchmarks, and other heuristic metrics for assessing project implementation success. Clinical quality measures will be pulled for tracking and quality improvement purposes, based on reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform or cloud-based registries.

	• Modifications to project plans will occur after the data and learning teams or implementation planning teams identify and report gaps or areas of improvement to the Program Council. ACH staff and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Managed Care Organizations could be engaged in this component, to assist ACH staff and partners in workflow redesign and lean process improvement activities. • The ACH will identify potential sources of outside technical assistance to support this process, including Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations. • Work with project partners to identify and understand barriers or limitations that contribute to the inability to meet these metrics • Outreach to other ACHs, as well as state and national experts, to learn successful strategies to address performance issues
Geographic barriers, resulting in limited capacity in more remote/rural areas and transportation barriers for Medicaid enrollees in these areas.	• The North Sound ACH will prioritize flexibility when developing implementation plans, and ensure that mobile services (such as mobile dentistry, mobile needle exchange/substance use disorder treatment, etc.), telehealth, and home visiting services are possibilities for populations in particularly rural or remote areas (such as the San Juan Islands or east Whatcom, Skagit, and Snohomish counties). • Allocate ACH resources to improve access to, use of, and reimbursement for Medicaid Transport services. • Utilize monitoring and continuous improvement processes to quickly identify when geographic barriers are impacting access to services.
Lack of affordable, available housing in the North Sound ACH region resulting in inability to reduce homelessness, and unstable housing limits improvement in health outcomes.	• Outreach to other ACHs, as well as state and national experts on reducing homelessness, to learn successful strategies to address performance issues • Consider investing ACH resources (including staff time) in more upstream efforts to reduce homelessness rates (investing in housing,

	advocacy at the city, county, and state levels, etc.)
Challenges with reimbursement for services by Apple Health (services not covered/reimbursement rate is insufficient/lack of provider understanding around billing procedures)	• Exploring sustainability with the local Managed Care Organizations will be needed to continue integrated services. • Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services and prevention services • Work together with the HCA to ensure that reimbursement rates for services (especially for behavioral health services, or services for Medicaid adults) are sufficient for providers to cover their costs and continue to provide services for Medicaid patients. • Leveraging expertise from the UW-AIMS center and cross sector workgroup support can provide information on proper billing and coding.
Health Information Technology/Exchange (HIT/HIE) challenges, including interoperability of multiple systems, implementation challenges with new systems (such as Pathways), barriers to data sharing between providers/systems (including protected health information), concerns around public disclosure and liability issues	• Utilize a mutually agreed-upon Release of Information (ROI) that can be used by partner providers in this project area, to ensure that patients' Protected Health Information (PHI) can be shared across agencies and agencies remain HIPAA-compliant. • Set up regular data/HIT round tables with partner providers to identify concerns around HIE, data sharing, and challenges around implementing new systems. • The ACH will work with partners to identify any legal or regulatory barriers to sharing data and health information across providers or systems (laws around Public Disclosure; criminal history sharing; 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records, for example), and advocate where possible to remove these barriers. • Engagement with partner providers for evaluation of current capacity and needs around Medicaid reimbursement and billing. Connect partner providers with the Healthier Washington Practice Transformation Support Hub and resources through the project plan could mitigate this barrier. • In late 2017 and 2018, North Sound ACH (as the Pathways HUB) and the MCOs will design a

	data-sharing system that facilitates eligibility determinations and protects privacy, and the North Sound ACH will describe this arrangement in contracts with the MCOs. The ACH can draw on the experience and expertise of other Pathways HUBs and Pathways experts in doing so. • Work with leaders of the Pathways Community HUB to ensure that Pathways technology is able to integrate with existing HIT in use by partner providers. • Potentially leverage ACH resources to pay for data migration costs and set up of new systems, as well as staff training on the new system.
Many programs/initiatives with shared goals make it difficult to coordinate, avoid overlap, or define boundaries between existing services and new services	• Meet with leadership of existing programs/initiatives to understand areas of overlap and potential synergies, as well as clear boundaries, and opportunities for coordination. • Tailor ACH project to eliminate areas of overlap and target strategies to further enhance the goals and public impact of current initiatives • Set up regular round table of both ACH project partners and stakeholders in this work to share learnings, avoid overlap and duplication, and identify opportunities to increase impact for all programs.
Challenges identifying long-term funding outside the Medicaid Transformation project	• Utilizing monitoring and continuous improvement processes, regularly evaluate project performance to be able to clearly communicate project impact to potential outside funders, as well as demonstrate a commitment to effectiveness. • Collaborate with MCOs to identify opportunities that align long-term objectives and achieve total cost of care savings in line with needed investments • Dedicate ACH resources to Identify additional funding sources, including in-kind support, local community development foundations, philanthropic foundations, other state and federal programs and “angel investors”. • Partner with other ACHs to achieve economies of scale • Facilitate site visits for stakeholders and decision makers with ability to provide needed funds, so that the value of the models can be experienced first-hand.

	• Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to transitional care planning. • Advocate for city, county, state, and federal-level allocation of funds to address the Opioid Crisis • Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services and prevention services
Community stigma and or political issues around Opioid crisis limit progress of project strategies	• The social marketing strategy of this project seeks to address this stigma by educating the public around the importance of this work and reducing fears, and demonstrating that these services need to exist in accessible locations • Advocacy and education to city and county councils, law enforcement agencies, neighborhood advisory groups, community development boards, and more to educate them on the need for more treatment facilities, harm reduction services like needle exchanges, and the importance of carrying Naloxone to reduce overdose deaths
Pathways Community HUB Model does not include pathways for Opioid Use Disorder or Substance Use Disorder - concern that Pathways for Care Coordination will fail to address this issue in the target population for that project area	• The North Sound ACH will work closely with Dr. Sarah Redding and Pathways leaders to adapt the model to meet the needs in this project area, and/or embed connection to substance use disorder treatment into the 20 existing pathways • Utilizing the monitoring and continuous improvement processes, identify if there are barriers to closing certain pathways for the target population, and if more collaboration regarding opioid use disorder treatment and prevention is needed.

3A: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking.

Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.

As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g.

through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

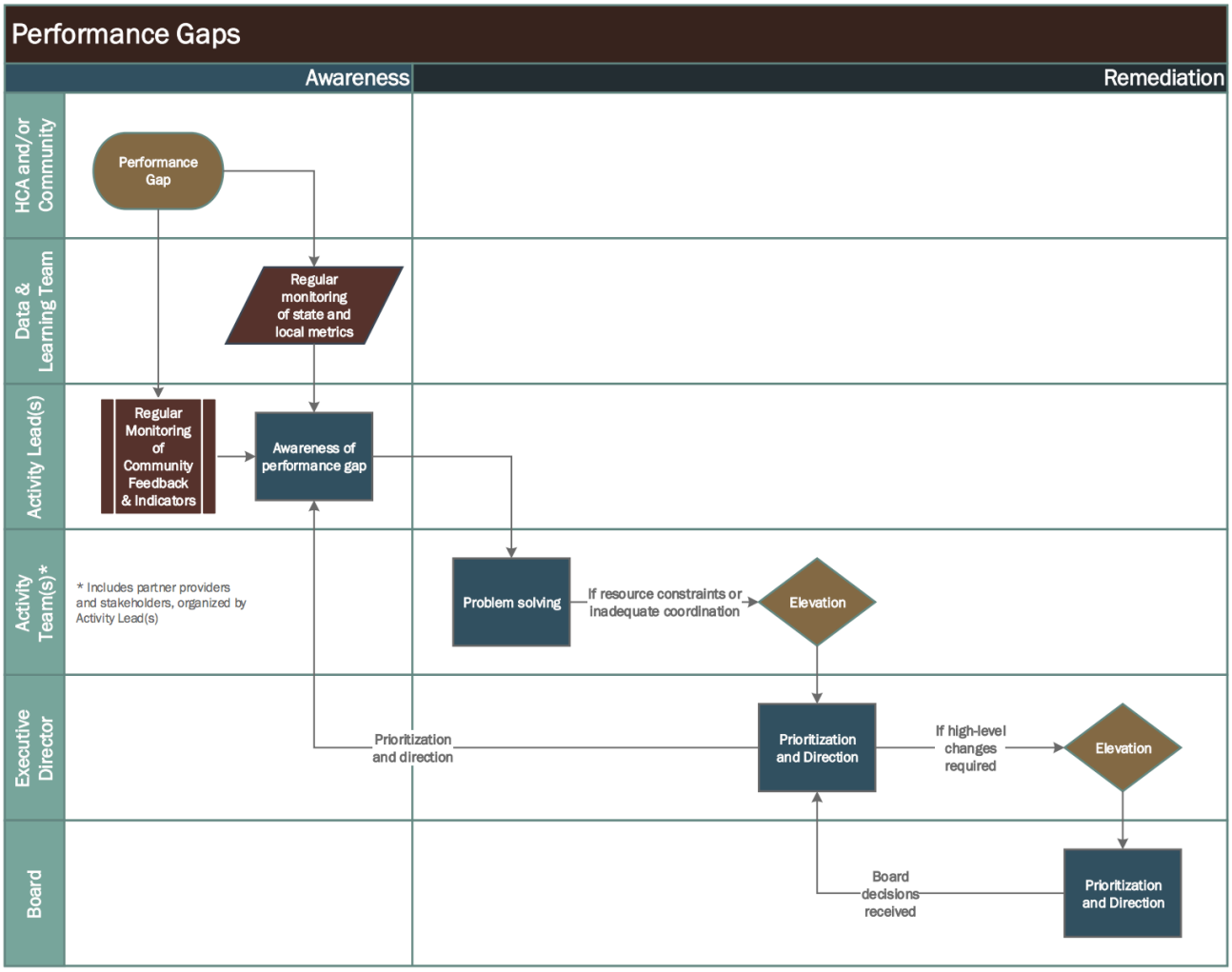

Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

3A: Project Metrics and Reporting Requirements

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

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

YES	NO
XX	

3A: Relationships with Other Initiatives

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

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

YES	NO
XX	

3A: Project Sustainability

The North Sound ACH is committed to working with partners in the North Sound ACH region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve sustainable solutions that positively impact Washington's health system transformation beyond the Medicaid Transformation period. A virtuous cycle results when clinical transformation improves provider performance on clinical quality measures in value-based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community, and community-based organizations to address upstream, social determinants of health. To ensure lasting impact, we will optimize project strategies that not only will improve health outcomes, but hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster meaningful relationships among partnering providers and other stakeholders that will support sustained transformation beyond the Medicaid Transformation.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to braid together DSRIP earnings with other sources, including Managed Care Organization partners. Additionally, philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged wherever possible.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices, and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between clinical settings and community-based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, childcare, employment, food access, environmental pollutants, etc. Additionally, the ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to ensure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building capacity for these providers in the long-term. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long-term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long-term, likewise driving increases in reimbursements for value-based contractual agreements.

Specific to opioids, improving community-based and clinical systems' ability to effectively serve persons experiencing Opioid Use Disorder (OUD) holds great potential to provide long-term solutions through cost savings associated with prevention efforts, improved engagement and access to treatment, overdose prevention and promoting long-term recovery. These savings can then be reinvested to continue the path to sustainability.

3B: Transformation Project Description: Reproductive and Maternal Child Health

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

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

3B: Project Selection & Expected Outcomes

Introduction- Why the Project is Needed

In the North Sound region in 2016, there were 5,981 births to women with Medicaid coverage. 62% of those women received prenatal care in their first trimester of pregnancy.[1] In Washington State, pregnant women who are at or below 185% of the Federal Poverty Level are eligible for Medicaid. Births from unintended pregnancy are more than twice as common among women on Medicaid (53%) than those not on Medicaid (23%). Unintended pregnancy is a significant risk factor for late prenatal care, low birth weight, prenatal exposure to drugs and alcohol, domestic violence, and disruption of progress towards educational goals and financial security. The estimated Medicaid costs for unintended pregnancies in Washington in 2010 was $220 million. The annual cost for contraceptive care to prevent these pregnancies would have been $335 per person — or a total cost of approximately $7 million.[2]

Nationally, for every $1 invested in publicly funded contraception and family planning services, just over $4 are saved in Medicaid costs the following year.[3] Long Acting Reversible Contraceptives (LARC) are the most effective contraceptive method to help women plan and space their pregnancies. In Washington State, providing 6,250 eligible women per year with LARC would decrease unintended pregnancies by 10% by 2020.[4] Reducing unintended pregnancy and increasing the proportion of pregnancies that are planned will have significant positive impacts on women and families, including positive maternal and infant health outcomes, lower household costs, higher financial stability, higher educational attainment for women, and increased employment opportunities – as well as reduced costs to the Medicaid system.

While reducing unintended pregnancies can have a significant impact on family well-being, families with young children are still in need of support so that as a region, we can promote childhood physical and mental health and reduce traumatic adverse childhood experiences. Across the North Sound region, economic challenges (e.g., living wage jobs, housing, childcare) as well as behavioral health challenges, substance use

[1] RHNI Starter Kit, HCA, released May 8, 2017
[2] https://www.doh.wa.gov/Portals/1/Documents/1500/MCH-UP2013.pdf
[3] https://www.doh.wa.gov/Portals/1/Documents/Pubs/930-142-UnintendedPregnancyPrevention.pdf
[4] https://www.doh.wa.gov/Portals/1/Documents/Pubs/930-142-UnintendedPregnancyPrevention.pdf

disorders, and domestic violence impacts a significant proportion of families with young children. Unmitigated family stress due to these issues has profound impacts on the health and development of young children, setting a poor foundation for health and well-being across the lifespan. Each county in the region has expressed interest in enhancing early identification and linkage of families to needed supports as early as possible in the prenatal through early childhood period. Regionally, low rates of well-child visits for children on Medicaid (61%) indicate missed opportunities to support families, provide anticipatory guidance and referrals, and ensure young children receive important prevention services (e.g., developmental and family risk screenings, and immunizations).

Alignment with Regional Priorities

This project area aligns with regional priorities as identified in the most recent Community Health Needs Assessments, Community Health Improvement Plans, and Community Health Assessments conducted by counties, hospital systems, and community-based organizations in our region - specifically around improving access to care for children and youth, reducing Adverse Childhood Experiences (ACEs) including preventing and addressing childhood physical abuse, increasing access to prenatal care, and increasing childhood immunization rates.

Target Population

The target population for Reproductive and Maternal and Child Health strategies are Medicaid eligible and enrolled women of reproductive age (15-44 years of age) and their partners, Medicaid eligible and enrolled children (under 19 years of age) and their families.

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

Targeted Universalism[5] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

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[5] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

North Sound Project Area Reach & Impact Project Area 3B: Reproductive and Maternal/Child Health	
Potential Target Population Reach: • 43,207 women (15-44) with Medicaid coverage • 5981 women with Medicaid coverage gave birth in 2015 • 127,981 children (<19 years) with Medicaid coverage • 18,211 women with Medicaid coverage who were diagnosed with depression	
Project Area Impact:	
Performance Measures • 12% of all children under the age of 2 have completed their required toddler immunization series. • 61% of children 3-6 with Medicaid coverage have had at least one well-child visit • North Sound rate for access to LARC in 8.2%, San Juan shows the lowest in the region at 5%.	**Geographic Disparities** • Skagit shows the highest rate of low birth weight outcomes, accounting for 6.6% of total Medicaid births. • Skagit (63%), Whatcom (62%) and Snohomish (61%) have the lowest rates of prenatal care for women with Medicaid. • Island (39%) and San Juan (40%) rates of Chlamydia screening for women with Medicaid are the lowest in the region. **Demographic Disparities** • 66% of the 27,596 Medicaid enrollees diagnosed with depression are women **Co-morbid Disparities** • Disabled women (18-24) are 3x less likely to be screened for chlamydia. • 61% of Medicaid enrollees with mental illness and one or more chronic conditions are women (24,696).
Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Toolkit Historical Data, HCA, released August 17, 2017. 4) ACH Profiles: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017. 6) Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015 7) Chronic Disease Profiles (North Sound) WADOH, April 2016.	

Project Goals

The main goals of the project are to reduce unintended pregnancy, increase healthy planned pregnancies, strengthen and support young families, and promote early childhood health and well-being, setting the foundation for good health across the life course.

Strategies

1. Increase capacity of physical health care and behavioral health care practices throughout the North Sound Region to reduce unintended pregnancy and support healthy planned pregnancies.

There are two strategies that will be used to increase the capacity of physical health care and behavioral health care practices to reduce intended pregnancies and support healthy planned pregnancies:

a) **Establish the systems and supports needed to integrate and evaluate One Key Question® pregnancy intention screening, counseling and support into physical health care practices and behavioral health settings, with a focus on settings serving low-income (at or below 185% FPL), 15-30 year women**. The One Key Question® screening asks patients "*Would you like to become pregnant in the next year*?" with optional responses including Yes, No, Unsure, and OK Either Way. This screening will help providers determine the level of contraceptive care appropriate for each patient and have a discussion about family planning. One Key Question® is an evidence-based strategy and considered a best practice for contraceptive counseling to improve utilization of effective reproductive health strategies, including pregnancy intention counseling, healthy behaviors and risk reduction, effective contraceptive use, safe and quality perinatal care, interconception care, and general preventive care.[6] Providers in diverse settings (including physical health care providers, behavioral health care providers, specialty providers, case managers, social workers, and more) will be trained on this screening method and how to connect patients with access to contraceptive methods if desired.

b) **Link pregnancy intention screening and counseling with access to effective contraception, particularly Long-Acting Reversible Contraception (LARC), as well as preconception care, counseling, and risk reduction for those planning for pregnancy.** This is the critical next step to screenings like One Key Question®: once patients have identified that they do not want to become pregnant in the next year (or are unsure or OK either way), a discussion of effective contraception methods is essential. Providers will be trained in how to counsel patients on highly effective methods like LARC (including Intrauterine Devices, implants, or injections), as well as how to provide these methods to patients. Pregnancy intention counseling and LARC placement is also done with postpartum women to support healthy family planning and pregnancy spacing. The North Sound ACH's regional partners deem access to LARC and Postpartum Access to LARC as priorities to ensure that the North Sound ACH region is successful at reducing unintended pregnancies.

Key Partners for implementing these strategies include:

- Mt Baker Planned Parenthood
- Planned Parenthood of the Great Northwest and Hawaiian Islands
- Resilient Generation
- Health Care Providers including: Federally Qualified Health Centers, Tribal health centers, Family Practice providers, OB/Gyn providers, Nurse Midwives, Pediatricians, school based clinics, military bases, student health centers (colleges and universities), behavioral health settings, Substance Use Disorder treatment providers, and more
- Home visiting programs, care coordinators
- Intensive case management coordinators
- Needle exchanges
- State and federal programs like WIC, Maternal Support Services (MSS), Nurse Family Partnership, Early Head Start, Parents as Teachers
- Early intervention specialists
- Child Abuse Prevention specialists and organizations
- Community Action agencies (e.g., Opportunity Council, Skagit Community Action)
- Local Health Jurisdictions
- Teen pregnancy programs
- Community Service Office (TANF programs)
- WA Department of Children, Youth, and Families
- Domestic Violence support programs

[6] http://healthystartepic.org/wp-content/uploads/2015/08/BS1OneKeyQuestionIntro2016.pdf

- Hospital systems, including Emergency Departments
- Service providers to immigrant communities

Metrics

The strategies described above will have a positive impact on the pay-for-performance metrics described in the Toolkit for this project area. They are designed to increase access and utilization of contraceptive care (both moderate or most effective contraceptive methods, and postpartum access to contraceptive care), increase access and utilization of Chlamydia screening, and increase access and utilization of Prenatal Care.

Building on Existing Work

These strategies will build on existing work happening in our region, around the state, and nationally. The North Sound ACH Early Win Project was focused on increasing access to LARC in our region, conducting provider training, patient outreach, and an assessment that can be built on for implementing additional work on expanding access to highly effective contraceptive methods. This Early Win project was successful in conducting well-attended, well-received provider training, and the North Sound ACH will continue to build on the energy around this project. Implementation will braid funding from the Medicaid Transformation with financial support from Kaiser Permanente. We will also partner with several agencies focused on unintended pregnancy prevention and the promotion of healthy, intended pregnancies, such as Upstream USA, The National Campaign to Prevent Teen and Unplanned Pregnancy, The Bixby Center for Global and Reproductive Health, and the WA Department of Health Family Planning Program.

2. Increase capacity of physical health care practices in North Sound Region to support the health and development of young children and their families

The strategy used to increase capacity of physical health care practices to support the health and development of children and their families is the HealthySteps model implemented in targeted practices serving large numbers of pediatric patients covered by Medicaid. HealthySteps adds a child development professional (HealthySteps Specialist) to the practice, as an integral part of the physical health care team. The model supports implementation of *Bright Futures* recommendations (the evidence-based model listed in the Toolkit to promote well-child visits), supports early childhood behavioral health integration into pediatric physical health care, and includes opportunities to ensure identification of parental behavioral health concerns and support parental connections to family planning for healthy pregnancy spacing.

Key Partners for implementing the HealthySteps program include:

- Pediatric and Family Practice providers serving pediatric Medicaid patients
- Federally Qualified Health Centers and Tribal health centers
- Local Health Jurisdictions
- Regional early learning coalitions
- Whatcom Taking Action
- Service providers focused on immigrant communities

Metrics

These strategies will positively impact the following pay-for-performance metrics listed in the toolkit for this project area: increase Well-child Visits (15 months and 3-6 years); improve Childhood Immunization Status by increasing immunization rates; improve Mental Health Treatment Penetration (especially around maternal depression and early childhood behavioral health needs); improve Substance Use Disorder Treatment Penetration for women and children; and increase access to contraceptive care.

Building on Existing Work

These strategies will build on existing work happening in our region, around the state, and nationally. The HealthySteps model was recently implemented at Madigan Army Medical Center outside of Joint Base Lewis-McChord, providing an opportunity for regional knowledge transfer and identification of best practices. This project will also partner with and build on the work of the P-TCPi (Pediatric Transforming Clinical Practice Initiative) through the WA Department of Health and the Washington Chapter of the American Academy of Pediatrics, and the WA Department of Social and Health Services' Frontiers of Innovation Program and their *First 1,000 Days* initiative.

3. Ensure that vulnerable children and families are considered high-priority populations across all Medicaid Transformation Demonstration efforts, particularly behavioral health integration (behavioral health, substance use disorder) and care coordination efforts.

Given the strong evidence that adverse childhood experiences (ACEs) have a significant impact on adulthood behavioral health challenges, substance use disorder, chronic disease, and more, a key part of this project is to address the health of children before, during, and after pregnancy in all Medicaid Transformation Demonstration project areas. This will give the North Sound ACH's project portfolio a strong prevention and upstream focus. The strategy will focus on integrating pregnancy intention and family planning services, as well as considering the needs of pregnant women and children into the project areas of Bi-Directional Integration of Primary Care and Behavioral Health, Care Coordination (utilizing the Pathways Community Hub model), Care Transitions, Diversion, Addressing the Opioid Crisis, Oral Health, and Chronic Disease. Key partners in this work include, but are not limited to housing providers, transportation providers, community action agencies, DSHS Community Service Offices, Behavioral Health providers, Local Health Jurisdictions, and faith-based health ministries.

ACH Role & Supports to Partners

The North Sound ACH will improve health in the region by supporting clinical transformation and upstream interventions that promote healthy, intended pregnancies, positive birth outcomes, and child health in the Medicaid population. Primary care providers as well as specialty providers serving women, children and families (as well as community-based organizations) will implement the strategies selected for this project area, and the North Sound ACH's role will be to support them in doing so successfully and with maximum impact in the target populations (which will be finalized in 2018).

Examples of roles the ACH will play in supporting partners in this project area in the North Sound Region include:

- Working with partners to identify and address challenges in engaging the target populations;
- Acting as convener for regular cross-sector collaboration meetings during the planning and implementation phases;
- Working with leadership of partner organizations to:
    - increase protected time for trainings (including provider trainings around LARC and One Key Question, which the ACH would likely not lead, but can assist in connecting providers with trainers and potentially provide financial support)
    - identify opportunities for partners to see organizational budget savings based on improved efficiency
    - achieve buy-in to transformative change of front-line staff;
- Developing and brokering relationships between providers to expand the resources available to Medicaid enrollees;
- Collaborating with MCOs and delivery system leadership to develop funding mechanisms that solve reimbursement challenges;

- Demonstrating the financial value of these interventions to funders, health systems, and other stakeholders who can potentially provide additional, sustainable financial support;
- Considering the needs of the entire North Sound Region to ensure that strategies are implemented which promote access to services for Medicaid enrollees in rural and remote areas as well as urban areas;
- Sharing learnings from other ACH regions with planning partners when developing implementation plans.

Metrics

Integrating a focus on reproductive, maternal, and child health into all project areas will support this project area in positively impacting the pay-for-performance metrics listed in the toolkit, by increasing Mental Health Treatment Penetration for women and children, and increasing Substance Use Disorder Treatment Penetration for women and children. It will also help move metrics in other areas such as pediatric oral health treatment metrics and Percent Homeless for families with children.

Lasting Impacts

This strategy in particular will benefit the entire Medicaid population, not just women and children. By looking upstream at preventing adverse childhood experiences among low-income families, we can seek to reduce other factors that impact maternal child health, such as poor behavioral health outcomes, crime rates, and homelessness, as examples.

Health Equity

The North Sound ACH will use health equity as a lens for all our project areas. In order to be truly transformational and meet the needs of our community, disparities by race/ethnicity, socioeconomic status, geographic area, and other categories must be brought to the forefront. In the Reproductive, Maternal, and Child Health project area, strategies will be adapted when possible to each community to ensure that clinical and community interventions are both culturally appropriate and accessible (for example, hiring bilingual community health workers and clinic staff; hiring staff from the communities they will serve; requiring training on cultural humility, undoing institutional racism, implicit bias, and more).

3B: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the Reproductive and Maternal Child Health project area, a spirited and determined group of advocates from the public sector, community-based organizations and clinical providers have come together to advocate for this population across all elements of the Medicaid Transformation. Workgroup leads include representatives from Planned Parenthood and Whatcom County Public Health.

Upon news of a successful agreement for the Medicaid Transformation, the North Sound ACH began a process of moving from broader stakeholder engagement into targeting partnering providers based on those currently serving or interested in serving a greater proportion of the Medicaid population. This engagement began with the formation of eight workgroups in each of the Toolkit project areas. An open invitation was extended to any and all providers and stakeholders who saw an interest or retained a specialty in a certain project area and wished to engage. These included behavioral health and SUD providers, community-based organization, county governments, physical health care providers, health systems, Managed Care Organizations, and health departments. Two or more volunteer subject matter experts from the community

were invited to serve alongside staff in a lead role for each workgroup. As more information on the Medicaid Transformation became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to craft draft "Statements of Interest" highlighting their individual and organizational interest and ideas for project frameworks. Staff and workgroup leads then gathered these submissions and reflected back a compilation of content to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas during dialogue at monthly face-to-face meetings with remote access capability. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking strategies capable of incorporating participation from partnering providers across the region, while also aiming to move their respective pay-for-performance metrics. This dialogue on target populations, partnering providers already serving and committed to serve the Medicaid population, and effective strategies honed the focus of the workgroups onto Medicaid enrollees, including the subpopulations indicated by the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum of partnering providers are represented and remain a value for future engagement.

Concurrently, a coalition of health system physical health care providers agreed to become an advisory body to staff, wherein staff convene regular meetings, assist with agenda setting, scheduling, and note-taking. This Health System Advisory Coalition includes members from the largest hospital systems providing physical health care in the region, all the regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. Collectively, the group has self-reported coverage of over 205,000 Medicaid primary care assignees in the region. Staff are continuing with further outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to ensure inclusion of those serving a significant majority of the Medicaid population.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of the Medicaid Transformation and efforts at systems transformation in our region. Managed Care Organization partners are engaged on the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout. In the case of Care Coordination, the North Sound ACH has participated in a series of meetings with MCO partners and representatives of the region's Health Home providers regarding coordination of these services in the development of the Pathways HUB. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication.

3B: Regional Assets, Anticipated Challenges and Proposed Solutions

Assets

The foundation of the regional assets that will support this project is the collaborative nature of the diverse partners working to improve health in the North Sound region. Since the inception of the ACH, organizations that have traditionally competed with each other have come together to collaboratively plan the transformation of our regional health system. Strategies in this project area will build on the many assets in our region, including strong commitments from diverse partners to reduce unintended pregnancies, support healthy pregnancies, reduce adverse childhood experiences, and support health throughout the life cycle. Key assets are outlined below.

Existing Work to Build Upon

The success of the North Sound ACH's Long Acting Reversible Contraception (LARC) Early Win project (2016-2017) is a strong asset for this project area. The North Sound ACH LARC Early Win project included conducting provider trainings around LARC counseling and insertion, and patient outreach and education. Significant work has already been done to connect with regional partners and identify resources needed to successfully expand on this project. The North Sound ACH is currently conducting an evaluation of the Early Win project, and results from this evaluation will leveraged for implementing additional work as part of the Transformation Project. This Early Win project was successful in conducting well-attended, well-received provider trainings. Kaiser Permanente provided significant support for the LARC Early Win project, and has committed to providing additional financial support into 2018. The North Sound ACH will leverage additional financial and in-kind support from several agencies focused on unintended pregnancy prevention and the promotion of healthy, intended pregnancies, such as Upstream USA, The National Campaign to Prevent Teen and Unplanned Pregnancy, The Bixby Center for Global and Reproductive Health, and the WA Department of Health Family Planning Program, all of which are offer training to providers.

The Washington Department of Health and Washington Chapter of the American Academy of Pediatrics' Pediatric Transforming Clinical Practice Initiative (P-TCPI) is currently working with clinicians around the state to ensure that practices are able to support early childhood whole-person health and provide coordinated, family-centered, high-quality (and cost-effective) care for children. Additionally, Washington's participation in the national Frontiers of Innovation (FOI) initiative is a significant asset to this work-- FOI and its First 1,000 Days project is a collaboration between the Center on the Developing Child at Harvard University and five Washington State agencies (Department of Social and Health Services (DSHS); Department of Early Learning (DEL); Health Care Authority (HCA); Department of Health (DOH); and The Office of the Superintendent of Public Instruction (OSPI), and aims to implement science-based program, practice, policy, and system changes to improve outcomes for vulnerable young children and families. Finally, we can look to the recent implementation of the HealthySteps model at Madigan Army Medical Center outside of Joint Base Lewis-McChord as an opportunity for regional knowledge transfer and identification of best practices, which will be critical as the North Sound ACH works to implement this model in our region.

Lessons learned from these projects will guide the planning and implementation phases for the Reproductive, Maternal & Child Health project area.

Maternal and Child Health as a Regional Priority

This project area aligns with regional priorities as identified in the most recent Community Health Needs Assessments, Community Health Improvement Plans, and Community Health Assessments conducted by counties, hospital systems, and Community Based Organizations in our region - specifically around improving access to care for children and youth, reducing adverse childhood experiences (ACEs) including preventing and addressing childhood physical abuse, increasing access to prenatal care, and increasing childhood immunization rates. The North Sound region has a strong network of diverse partners that will work together to support improving health outcomes for infants and children. This support includes both dedicating staff time, expertise, resources, and funding toward standing up and sustaining programs that align with the priorities described above.

Additional assets in our region include (but are not limited to):

Clinical Service Delivery and Expertise

North Sound has dedicated reproductive health, pediatric, Family Practice providers, and other providers ready to work in this area, including:

- Family Planning clinics (Planned Parenthood of the Great Northwest and Hawaiian Islands affiliated clinics)
- Federally Qualified Health Centers (Sea Mar, Unity Care NW, Community Health Center of Snohomish County, etc.)
- Tribal health centers
- Family Practice providers
- OB/Gyn practices
- Nurse Midwives
- Pediatricians and pediatric practices (such as Skagit Pediatrics)
- School based health (school nurses, and school based health centers under development)
- Military medical services (U.S. Naval Air Station Whidbey Island)
- Student health centers (colleges and universities)
- Behavioral Health providers (North Sound BHO, Compass Health, Sunrise Services, etc.)
- Hospital systems (such as PeaceHealth, Skagit Regional, Providence, Island Hospital, etc.)
- Emergency Departments
- Managed Care Organizations
- Clinical Transformation support (Pediatric Transforming Clinical Practice Initiative (P-TCPI), etc.)

Nonclinical Service Delivery and Expertise

In the North Sound region there are many nonclinical, government or community-based organizations focused on supporting reproductive, maternal, and child health, such as:

- State and federal programs (WIC, Maternal Support Services (MSS), Nurse Family Partnership, Early Head Start, Head Start, Healthy Start, Parents as Teachers, TANF, etc.)
- Early intervention specialists
- Child Abuse prevention specialists and organizations (Brigid Collins Family Support Center, Dawson Place Child Advocacy Center, etc.)
- Community Action Agencies (e.g., Opportunity Council, Skagit Community Action, etc.)
- Local Health Jurisdictions
- Graduation Reality and Dual Role Skills (GRADS) program (Snohomish and Whatcom County)
- Domestic Violence support programs (DVSAS)
- Early Learning organizations (Whatcom Center for Early Learning, YMCAs, Northwest Educational Service District, NW Early Learning coalition, etc.)
- Housing and social service providers for families and youth (Lydia Place, Northwest Youth Services, Cocoon House, YWCA, Catholic Community Services, Lutheran Community Services, etc.)
- Reproductive Health advocates (Planned Parenthood Action Fund, etc.)

Workforce and Human Capital Assets

While there is opportunity for workforce expansion in this area (especially around pediatric behavioral health care providers), there is a robust existing clinical, and nonclinical workforce across the North Sound region, including:

- OB/Gyns
- Family Practice providers
- ARNPs
- Pediatricians
- Nurses
- PAs
- Home-visiting Nurses
- Community Health Workers
- Social Workers and Case Managers

- Public Health professionals
- Regional Experts on LARC, ACEs, early childhood health, etc.
- Reproductive Health advocates

Financial Resources

The North Sound ACH intends to establish a braided funding model to support strategies to address reproductive, maternal and child health in the North Sound ACH region, supplemented by Medicaid Transformation project funding and including the following sources:

- Managed Care Organizations
- Philanthropic support from "angel investors"
- Kaiser Permanente (LARC project)
- Upstream USA, The Bixby Center at UCSF (in-kind support)
- Potential city, county, state, and federal funding

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Anticipated Challenges	Proposed Solutions
Project has difficulty meeting performance metric targets	• The ACH will engage implementation planning teams in embedding tracking mechanisms in their implementation plans, including surveys, regular automated or manual reports of metrics, and other means for tracking success. Quality Improvement Plans will be integrated into the implementation strategy using rapid-cycle process improvement strategies to identify points of failure and improvement early for quick response. Quality Improvement teams will also convene, based either in the implementation planning teams or the data and learning team, to regularly review metrics and assess areas of change or improvement. • The ACH Data and Learning team will support the strategy through the development of a suite of monitoring and evaluation measures that provide an ongoing, actionable dashboard for project progress. Included in this will be ongoing survey-based assessments of training effectiveness and project implementation to partnering providers, regular review of clinical quality measures aligned with toolkit pay for performance measures, HCA reports on performance measure benchmarks, and other heuristic metrics for assessing project implementation success. Clinical quality measures will be pulled for tracking and quality improvement

	purposes, based on reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform or cloud-based registries. • Modifications to project plans will occur after the data and learning teams or implementation planning teams identify and report gaps or areas of improvement to the Program Council. ACH staff and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Managed Care Organizations could be engaged in this component, to assist ACH staff and partners in workflow redesign and lean process improvement activities. • The ACH will identify potential sources of outside technical assistance to support this process, including Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations. • Work with project partners to identify and understand barriers or limitations that contribute to the inability to meet these metrics • Actively engage with partner providers to support additional training (with financial support) to adopt new practices (i.e. One Key Question, HealthySteps) • Outreach to other ACHs, as well as state and national experts, to learn successful strategies to address performance issues
Geographic barriers, resulting in limited capacity in more remote/rural areas and transportation barriers for Medicaid enrollees in these areas.	• The North Sound ACH will prioritize flexibility when developing implementation plans, and ensure that mobile services (such as mobile dentistry, mobile needle exchange/substance use disorder treatment, etc.), telehealth, and home visiting services are possibilities for populations in particularly rural or remote areas (such as the San Juan Islands or east Whatcom, Skagit, and Snohomish counties). • Allocate ACH resources to improve access to, use of, and reimbursement for Medicaid Transport services. • Utilize monitoring and continuous improvement processes to quickly identify when geographic barriers are impacting access to services.
Lack of affordable, available housing in the North Sound region resulting in inability of Medicaid enrollees to pursue preventive care;	• Outreach to other ACHs, as well as state and national experts on reducing homelessness, to learn successful strategies to address performance issues

unstable housing limits improvement in health outcomes (especially for children and families)	• Consider investing ACH resources (including staff time) in more upstream efforts to reduce homelessness rates (investing in housing, advocacy at the city, county, and state levels, etc.)
Challenges with reimbursement for services by Apple Health (services not covered/reimbursement rate is insufficient/lack of provider understanding around billing procedures)	• Exploring sustainability with the local Managed Care Organizations will be needed to continue integrated services. • Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services and prevention services • Work together with the HCA to ensure that reimbursement rates for services are sufficient for providers to cover their costs and continue to provide services for Medicaid patients. • Leveraging expertise from the UW-AIMS center and cross sector workgroup support can provide information on proper billing and coding.
Challenges identifying long-term funding outside the Medicaid Transformation	• Utilizing monitoring and continuous improvement processes, regularly evaluate project performance to be able to clearly communicate project impact to potential outside funders, as well as demonstrate a commitment to effectiveness. • Collaborate with MCOs to identify opportunities that align long-term objectives and achieve total cost of care savings in line with needed investments • Dedicate ACH resources to Identify additional funding sources, including in-kind support, local community development foundations, philanthropic foundations, other state and federal programs and "angel investors". • Partner with other ACHs to achieve economies of scale • Facilitate site visits for stakeholders and decision makers with ability to provide needed funds, so that the value of the models can be experienced first-hand. • Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to transitional care planning. • Advocate for city, county, state, and federal-level allocation of funds to promote access to reproductive health care services, as well as maternal and child health services • Work together with the HCA to increase the number of covered services that will support movement of

	performance metrics, including community-based services
Community stigma and or political issues around sexual and reproductive health (e.g., religious opposition to contraception and abortion care, concerns about historical reproductive coercion in communities of color) limit progress of project strategies	• Adoption of a life course perspective at the North Sound ACH leadership level, recognizing and prioritizing investments in critical periods of development (i.e., prenatal, early childhood, pre-conception) • Implement strong communication strategies with health systems (particularly faith-based health care systems and community organizations) demonstrating the evidence base for LARC/highly effective contraceptive methods • Early engagement and dialogue with community members including communities of color around concerns about historic reproductive coercion to ensure that these concerns are addressed and project strategies are culturally appropriate and are not reinforcing institutional racism
Limited partner capacity (for training, implementing new programs, willingness to take on new projects)	• Design distribution of project incentive funds to incent partner participation based on specific activities, adoption, and accomplishments; revise distribution as needed throughout the duration of the project to support ongoing partner engagement • Coordinate with front-line staff to address barriers and correct the project implementation plan as needed • Engage partnering providers in leading the project design and implementation as a way to activate their participation • Subsidize training fees for partners, and/or reimburse providers for lost revenue due to clinic shut down for training. • Work with clinical providers to revise internal work flow to eliminate steps causing excessive strain on workflows • Provide technical assistance from the ACH and other external partners

3B: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and

continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform,

syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.

As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

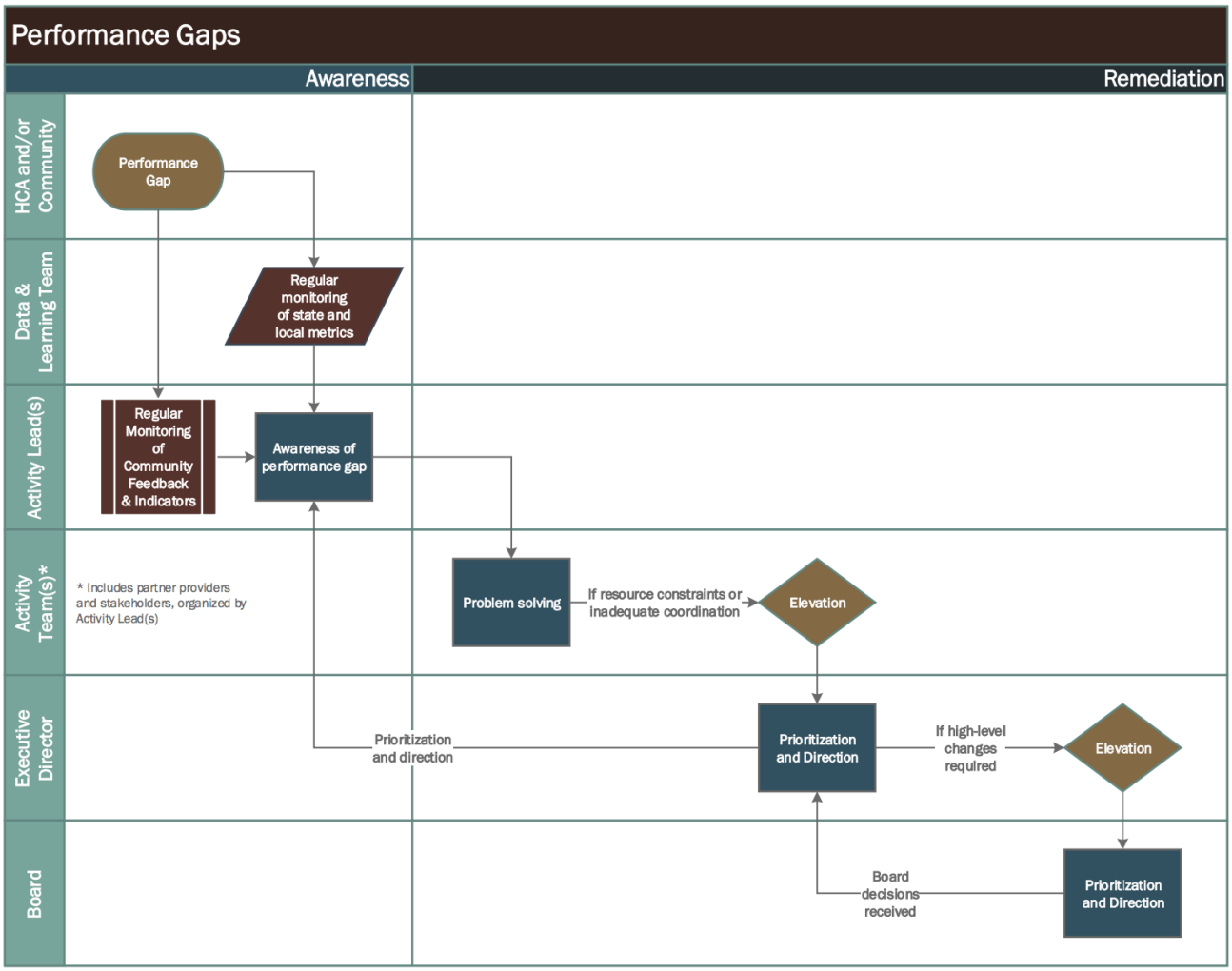

Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and

improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

3B: Project Metrics and Reporting Requirements

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

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

YES	NO
XX	

3B: Relationships with Other Initiatives

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

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

YES	NO
XX	

3B: Project Sustainability

The North Sound ACH is committed to working with partners in our region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation period. A virtuous cycle results when clinical transformation improves provider performance on clinical quality measures in value based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community, and community-based organizations to address upstream, social determinants of health. To ensure lasting impact, we will optimize project strategies that hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster relationships among partnering providers, so implementation is realized on the regional level and when Medicaid Transformation funds are no longer available, the relationships and transformative changes will continue.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to braid together DSRIP earnings with other sources, including Managed Care Organization partners. Additionally, philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged wherever possible.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements, both current and future as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between clinical settings and

community based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, childcare, employment, food access, environmental pollutants, etc. Additionally, the ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to assure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building capacity for these providers in the long-term. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long term, likewise driving increases in reimbursements for value based contractual agreements.

Specific to Maternal and Child Health, the Washington State Department of Health is committed to supporting provider training across the state focused on best practices around reproductive, maternal and child health. Training costs can also potentially be supported by non-profit organizations like Upstream USA (which has already given a 6-year commitment to training key providers in One Key Question and LARC best practices), the Bixby Center for Reproductive Health at the University of California San Francisco (which has committed to offering no-cost trainings to providers in addition to precepting), and others. The Family Planning portion of this project area (LARC training for providers) is partially supported by a grant from Kaiser Permanente Community Benefit confirmed through 2018, with the strong likelihood to continue. One of our key partners in this work (Mt. Baker Planned Parenthood) has relationships with private philanthropists who are committed to providing substantial financial support to expand reproductive health access in our region. Strategies in this project area focus heavily on prevention with a true “upstream” focus or “long lens” by focusing on preventing unintended pregnancies and reducing adverse childhood experiences by supporting families throughout the life cycle.

3C: Transformation Project Description: Access to Oral Health

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

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

3C: Project Selection & Expected Outcomes

Introduction- Current State

The North Sound region has poor access to oral health services stemming from a lack of provider capacity and a lack of organized systems and processes to link Medicaid enrollees with care sources. Rates of Medicaid service utilization in the North Sound region are currently 7% below statewide averages and two counties, (Island and San Juan) rank 37th and 39th respectively among Washington's 39 counties.[1] Additionally, the 2009-2014 Dental Care Provider Survey found that only 11.3%-28.6% of dental care providers in the North Sound region accepted new Medicaid patients.[2] Insufficient access to dental services has been identified as a high priority in Community Health Assessments and Community Needs Assessments across all five counties. Barriers to accessing care include insufficient capacity to see adult patients, transportation, location, and cost of care. Residents living in poverty in all five counties stated, "not enough preventative dental care" as a barrier to accessing care in County Health Needs Assessments and in County Low Income Needs Assessments. According to the 2015 Snohomish County Low Income Needs Assessment, 11% of low income households listed the location of dental services as prohibitive to oral health.

The highest priority in the region for oral health is expanding access to and utilization of dental services by Medicaid enrolled adults. In the North Sound, 32% of adults overall reported that they had not been to a dentist in the last year and 35% reported not having a dentist.[3] Despite being eligible for dental services, North Sound residents with Medicaid coverage have lower rates (34.6%) of receiving dental services compared to the state average (38.2%).[4] These rates vary by county from 22.5% (San Juan) to 35.6% (Skagit, Snohomish) and only 19.7% of eligible adults (21+) received dental services, while 51.7% of children (20

[1] RHNI Starter Kit, HCA, released May 8, 2017.
[2] Health Professional Shortage Areas (HPSA) Designations, WADOH, 2017.
[3] Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016
[4] RHNI Starter Kit, HCA, released May 8, 2017

and under) received care.[5] Among the 9 ACH regions, North Sound ACH ranks third best for overall access, but 9th for adults and 5 of 9 for children.[6]

While oral disease is largely preventable, the current state of Medicaid dental service delivery has led to elevated costs for treatment and care. For example, while the region shows the lowest adult utilization rates, it has a $555 cost per user annually.[7] This is the highest per-user Medicaid cost for adult dental care in Washington State, indicating that adult patients require more complex, expensive care when treated.

Target Population

The strategies described for Access to Oral Health Services has the potential to impact all North Sound Medicaid enrollees, particularly those not receiving any dental care or sufficient recommended dental preventative services. Specifically, the North Sound project will target key sub-populations at higher risk due to underutilization of services and oral-systemic links between oral diseases (such as caries and periodontitis) and health outcomes. These populations include:

- Children ages 6 to 14 at elevated risk of caries and not already receiving sealants
- Adults with chronic periodontitis not already receiving treatment
- Adults and children in primary care medical practices who are not accessing dental services
- Pregnant women
- Individuals with diabetes

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

Targeted Universalism[8] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

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[5] RHNI Starter Kit, HCA, released May 8, 2017
[6] RHNI Starter Kit, HCA, released May 8, 2017
[7] RHNI Starter Kit, HCA, released May 8, 2017
[8] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

North Sound Project Area Reach & Impact Project Area 3C: Access to Oral Health Services	

Potential Target Population Reach:
• 325,566 total Medicaid enrollees who are eligible for dental services*
  ○ 174,185 Adults (21 and over) with Medicaid who are eligible for dental services
  ○ 151,386 Children (20 and under) with Medicaid who are eligible for dental services
  ○ 50,646 Children (6 and under) with Medicaid who are eligible for dental services
• 22,421 Children (1-17) with Medicaid with dental decay or cavities
• 22,390 diagnosed with Type 1 or 2 diabetes
  ○ 5,868 Disabled, 1,501 Non-Disabled Adults, 8,080 Newly Eligible Adults, 608 Non-Disabled Children, 6330 Elders
• 5,981 pregnant women with Medicaid coverage	

Project Area Impact:	
Performance Measures • 34.6% of eligible Medicaid enrollees received dental services • 19.3% of Medicaid adults used dental care--lowest ACH rate in the state • 51.7% of enrollees below the age of 20 used dental services • 39.1% of children 6-9 with elevated caries risk received sealants. • 45.7% of children under 6 received preventive dental care • .1% of children received primary caries prevention intervention as part of Well/Ill Child Care provided by Primary Care Medical Providers (PCMP)	**Geographic Disparities** • 37% of adults in Skagit County had not visited a dentist in the last year, compared to the regional rate of 32%. • 68% of adults in San Juan county do not have dental insurance, compared to regional rate of 35%. • All counties except Snohomish are lower than statewide averages for adult Medicaid dental utilization. San Juan shows the lowest adult utilization rate, with 7.6% of eligible adults receiving dental care. • Snohomish County has the highest number of fluoridated water systems in the region, while the remaining counties are limited to 1-2 systems. • 11.3% of Skagit county dental providers accept new Medicaid patients, which is the lowest in the region, though 50% of dental providers currently treat Medicaid patients.
Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) ACH Toolkit Historical Data, HCA, released August 17, 2017. 3) Healthier Washington Dental Reports, Washington Dental Services, released April 5, 2017. 4) Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. 5) Chronic Disease Profiles (North Sound) WADOH, April 2016. 6) Public Water Systems that Deliver Fluoridated Water, WADOH, 2017. * Note: Medicaid eligibility counts for dental services varies from the North Sounds total Medicaid population (286,760), this issue has been raised to HCA and a remedy is pending, in general regional counts can vary due time frame of data collection and the reporting agency's definition of Medicaid populations.	

Current State

Existing efforts to expand oral health provider capacity in the North Sound region have been primarily fostered by Federally Qualified Health Centers (FQHCs), in order to meet the need of newly eligible adults included in the Medicaid Expansion. FQHCs accounted for approximately 40% of Medicaid claims for dental

care in 2016, with 60% provided by private practice or other dental services.[9] These services were primarily delivered to children age 20 and under, who account for 69.5% of dental services billed to Medicaid in 2016.[10]

The North Sound's three FQHCs are currently engaged in expansion activities that will increase regional FQHC operatory capacity by 15%, dentist staffing by 11% and hygienist staffing by 29%, all through existing funding mechanisms outside of Medicaid Transformation projects. By adding this capacity regionally, the FQHC dentist/Medicaid population ratio drops from 1: 15,431 to 1: 10,287. However, with HRSA Designated Dental Professional Shortage Area rates classifying any regions with a dentist to population ratio of 1: 5,000 as underserved – it is clear this ratio will need to be supplemented with engagement from private practice dentistry.[11]

In order to not duplicate this existing capacity expansion and practice transformation work, the North Sound ACH's strategies are designed to be complementary. These strategies will include initiatives to connect patients with the newly expanded capacity at FQHCs through patient outreach and engagement, to coordinate service delivery across the region, and implement innovative population health management methodologies in dental clinics.

Relation to other project areas

Additionally, the region's oral health strategies, in combination with several other project areas such as Care Coordination and Diversion Interventions will address ED utilization linking dental patients with emergent care needs with more appropriate sites of care. Overlapping planning and implementation will need to occur with the Chronic Disease and Bi-Directional project areas due to the oral-systemic links between periodontitis and chronic diseases such as diabetes and heart disease, as well as the connections between oral disease and chronic oral pain on mental health status and substance abuse disorders.

Strategies to Improve Access

North Sound ACH oral health capacity building strategies (I, below) aim to expand access to and utilization of dental care by addressing barriers to care due to lack of capacity and location of care. These strategies include expansion of existing clinic capacity, implementation of new provider models, integration of dental screening and referral into primary care practices, and mobile dental services in community settings. A second set of regional strategies (II, below) are designed to introduce and inculcate population management approaches which are now only in rudimentary form in the oral health delivery system. The ACH and partner organizations will also work to include more diverse partners in this work, and conduct outreach to private dentists to increase participation and collaboration in serving Medicaid patients.

I. Capacity Building: Workforce Strategies

These strategies build capacity by adding to the oral health workforce or use that workforce in different ways. Strategies coordinate with and enhance existing projects currently underway without duplicating the work these partners are engaged in. Each strategy is built off of pilot projects with demonstrated success in the region and demonstrate opportunity for enhancement and expansion.

1) **Pilot New Dental Workforce Models in Tribal Settings**
   a) **What:** North Sound ACH will engage with each Tribal nation in the region to assess interest in workforce expansion using the DHAT (Dental Health Aide Therapist) program. To date, several Tribes in the region have expressed an interest in exploring this opportunity. North

[9] Preliminary Medicaid Provider Files Dental Tables, HCA released June 27, 2017
[10] Utilization of Dental Services by Users' Region & Age FY 2016, HCA released April 5, 2017
[11] Health Professional Shortage Areas (HPSA) Designations, WADOH, 2017.

Sound ACH will leverage work with the Swinomish Tribe and Skagit Community College, and partner with Northwest Indian Health Board and Olympic Community of Health, to bring DHAT training to Washington State. If Tribes opt to leverage the DHAT training opportunity, North Sound ACH will partner with Arcora Foundation to strategize capital expansion opportunities for those Tribal clinics, so that there is infrastructure to support this new workforce.

b) **Who**: Swinomish Tribe with possible expansion to additional Tribal dental clinics and training centers, including Lummi and Tulalip Tribal Health Centers.

c) **Implementation Steps**:
   i) Establish DHAT Training Program.
   ii) Recruit students/secure scholarship funds.
   iii) Hire to work in Tribal settings.

2) **Mobile Dental Hygiene in Community Settings**

a) **What:** Recruit currently underutilized dental hygienists to provide a range of Medicaid-billable dental services in community settings using mobile dental equipment, focusing on the most underserved areas in the region. This model leverages mobile care strategies as described in the Medicaid Transformation Project Toolkit by combining a workforce currently underutilized to meet the needs of the region and equipment that can provide billable oral hygiene services outside the walls of a dental clinic, and bring dental hygiene services to where people are in community settings including hospitals, schools, and community centers. Additionally, this strategy will also support referral of patients into dental clinics for care that cannot be delivered through mobile equipment.

b) **Potential Partners**: A new regional network of approximately 30 hygienists to be recruited and trained for this purpose. Registered dental hygienists throughout the region are already practicing independently and this strategy seeks to build on and connect with this existing workforce.

c) **Implementation Steps**:
   i) Assess workforce needs and hygienist supply regionally.
   ii) Recruit hygienists to form network.
   iii) Secure Medicaid provider numbers.
   iv) Train new workforce and assist in establishing practices across the region.
   v) Determine and execute outreach strategy to consumers.

3) **Implementing the Oral Health Delivery Framework**

a) **What:** Several large medical groups will expand integration of dental services into medical primary care, using the Oral Health Delivery Framework as an evidence-based model. This toolkit strategy trains medical assistants and other existing personnel in medical practices to screen and refer patients with specific oral health conditions while also directly providing certain preventive services.

b) **Potential Partners:**
   i) Providence Medical group, which has already piloted integration in a single clinic and plans to expand the practice to additional clinics.
   ii) Federally Qualified Health Centers with co-located and integrated medical/dental clinic sites.
   iii) Additional hospital associated and independent primary care clinics will be solicited to participate.

c) **Implementation Steps**:

i) Secure final commitments from specific sites, emphasizing underserved geographic areas.
ii) Provide training (via existing Arcora Foundation Program) to providers and clinic staff.
iii) Finalize which preventive services will be offered.
iv) Finalize referral pathways from primary care to dental clinics.

II. Implement Population Health Management Tools in Dental Settings

These tools are used primarily within provider organizations in order to more effectively organize services so the provider system produces improved results for patients. Since most of these tools are not typically yet in place, the work involves setting up new internal business procedures and then using them to reorganize care processes.

a) **What**: Develop internal procedures within provider organizations which will allow for improved care outcomes. These procedures will include:
   i) Increased use of registries to monitor performance in priority populations with these registries including:
      (1) Adults with chronic periodontitis
      (2) People with diabetes
      (3) Pregnant women
      (4) Sealant status
      (5) High-risk adults (for dental issues)
      (6) High-risk children (for dental issues)
   ii) Create linkages between registry populations and practice call back systems.
   iii) Develop use of care management personnel within dental practices (see also B.3) and between medical practices and dental practices in order to improve patient navigation to services.
   iv) Institute use of ICD-10 coding at the practice level in order to allow disease severity measurement and improve efficiency of benchmarking.
   v) Increase use of silver diamine fluoride.
   vi) Improve organization-level dental analytics capability as a way to focus efforts on improved outcomes.
b) **Who**: Initially this strategy will focus on the three regional FQHC systems and then expand to independent private practice dentists and dental hygienists.
c) **Implementation Steps**:
   i) Provide technical assistance to clinical partners for setting up these new internal systems.
   ii) Monitor implementation progress.
   iii) Track progress on metrics.
   iv) Make adjustments in processes as needed.

Impact on Metrics

Through expansion of capacity to serve Medicaid eligible patients in existing clinics, the development and expansion of dental provider workforce throughout the region, expanded patient outreach and engagement practices, and the implementation of population health management methodologies, we expect to see movement across the following performance metrics in the Medicaid Transformation project toolkit:

- Dental Sealants for Children at Elevated Caries Risk
- Ongoing Care in Adults with Chronic Periodontitis
- Outpatient Emergency Department Visits per 1000 member months
- Periodontal Evaluation in Adults with Chronic Periodontitis
- Primary Caries Prevention Intervention as Part of Well/Ill Child Care as Offered by

- Primary Care Medical Providers
- Utilization of Dental Services by Medicaid Enrollees

Health Equity

The North Sound ACH will use health equity as a lens for all our project areas. In order to be truly transformational and meet the needs of our community, disparities by race/ethnicity, socioeconomic status, geographic area, and other categories must be brought to the forefront. In the Oral Health project area, strategies will be adapted when possible to each community to ensure that clinical and community interventions are both culturally appropriate and accessible (for example, hiring bilingual community health workers and clinic staff; hiring staff from the communities they will serve; requiring training on cultural humility, undoing institutional racism, implicit bias, and more).

During the planning phase of 2018, the North Sound ACH and regional partners will gather and analyze oral health outcome data to identify geographic and demographic disparities that can be addressed through application of these strategies and the lens of Targeted Universalism. Rural areas such as Island and San Juan counties and the eastern areas of Snohomish, Skagit, and Whatcom counties are particularly lacking access—it will be necessary to address this lack of access through targeted support with mobile dental services, transportation services, and expansion of dental services for people eligible for Medicaid.

Lasting Impact

Much of the activities in the Oral Health project area are low-cost, self-sustaining, and require only an upfront investment to implement. Oral health integration activities (integrating oral health into primary care) involve primarily technical assistance and up-front training costs. Implementation of new population health management tools and coding systems, like ICD-10 coding, use of advanced analytics, and linking registries to call-back systems, are all one-time, up front investments, and once these tools and systems are up and running, require only maintenance and training for new staff and provide long-term sustainability. Through the use of value-based contracting associated with the expansion of managed care to Medicaid dental services, both providers and clinic leadership will have strong incentives to improve their health systems performance and their patients' health outcomes. Transitioning to value-based payment in combination with these other strategies reinforces HCA's mid-ranged payment policy objectives while fostering a sustainable approach, not dependent upon the Medicaid Transformation funding long-term.

3C: Partnering Providers

In the Oral Health project area, the North Sound ACH has high levels of engagement from regional providers of oral health services essential to the project success. These include FQHCs, Tribal Nation partners, foundations, and oral hygienists. Project Leads in this area include representatives from Arcora, a regional dental foundation, and a local expert in regional health services including oral health.

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

Most key providers are already engaged with North Sound ACH on these strategies. These include CHC Snohomish, Sea Mar, Unity Care which together represent 100% of regional FQHC capacity. The two hygienist societies and key leaders within the region's dental hygiene professional community will also be key participants. Others include the Swinomish Tribe and key advocacy and coordinative groups such as health departments and the Whatcom Alliance for Health Advancement. Additionally, partnerships will be

needed with educational institutions to train and develop a new and expanded workforce for providing dental care to the Medicaid population.

Upon news of a successful agreement for the Medicaid Transformation, the North Sound ACH began a process of moving from broader stakeholder engagement into targeting partnering providers based on those currently serving or interested in serving a greater proportion of the Medicaid population. This engagement began with the formation of eight workgroups in each of the Toolkit project areas. An open invitation was extended to providers and stakeholders with interest in specific project areas. These included behavioral health and SUD providers community-based organizations, county governments, primary care providers, health systems, Managed Care Organizations and health departments. Two or more volunteer subject matter experts from the community were invited to serve alongside staff in a lead role for each workgroup. As more information on the Medicaid Transformation Project became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to craft draft "Statements of Interest" highlighting their individual interest and ideas for project frameworks. Staff and leads then gathered these submissions and reflected back a compilation of content to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas during dialogue at monthly face-to-face meetings with remote access capability. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking a strategy capable of incorporating participation from partnering providers across the region, while also aiming to move their respective pay-for-performance metrics. This dialogue on target populations, partnering providers already serving and committed to serve the Medicaid population and effective strategies honed the focus of the workgroups onto Medicaid enrollees, including the subpopulations indicated by the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum of partnering providers are represented and remain a value for future engagement.

Concurrently, a coalition of health system primary care providers formed and eventually agreed to become an advisory body to staff, wherein staff facilitate regular meetings, assist with scheduling, agendas and note-taking. The Health System Advisory Coalition includes members from the largest hospital systems providing primary care in the region, all the regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. Collectively, the group has self-reported coverage of approximately 194,940 Medicaid primary care assignees in the region. Staff are continuing with further outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to ensure inclusion of those serving a significant majority of the Medicaid population. Plans to similarly convene partnering providers working in behavioral health and SUD settings will ensure a broad spectrum is represented for the purposes of bi-directional integration.

While Medicaid dental services are currently provided on a fee-for-service basis outside the managed care system, this statewide dental service payment system is expected to transition to managed care during the five years of the transformation project. As such, the North Sound ACH recognizes the importance of Managed Care Organizations to the success of the Medicaid Transformation Project and efforts at systems transformation in our region, including the projects in the Oral Health Project Area. Managed Care Organization partners are engaged on the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication.

3C: Regional Assets, Anticipated Challenges and Proposed Solutions

Regional Assets

Oral health providers and advocates in the North Sound ACH area have been involved in developing regional strategies through a region-wide workgroup convened by North Sound ACH staff. Participation has been strong and enthusiasm high. The oral health community in the region has viewed Medicaid transformation as an opportunity for improving care delivery and patient health outcomes as shown below in Table 1. Planning for the strategies described in the project selection section above required regional stakeholders from Federally Qualified Health Centers (FQHC) and other dental care settings to convene, identify priorities, and ultimately collaborate in bringing their plan to the larger group.

Table 1. Capacity and Future Plans of FQHC Partners in North Sound ACH region

FQHCs	What Involvement	Current Dental Clinic Sites	Future Expansion
Community Health Center of Snohomish County	• Population outreach • Population health management systems • Care management • Pay for Performance	6 locations • Snohomish • Arlington • Everett N. • Everett S. • Lynnwood • Edmonds	
Sea Mar Community Health Centers	• Population outreach • Population health management systems • Care management • Pay for Performance	7 Locations • Bellingham • Oak Harbor • Mt. Vernon • Everett • Marysville • Monroe • Burlington	• New site in Lynnwood • Expansion of Oak Harbor site
Unity Care NW	• Population outreach • Population health management systems • Care management • Pay for Performance	3 locations • Bellingham pediatrics • Bellingham adults • Ferndale	• Major expansion in Ferndale
Data Source: Self-report from FQHC leadership.			

The table below (Table 2) summarizes key community sectors and the anticipated contributions of each. Because they are a large sub-segment within the project's strategies, the FQHC providers are detailed below separately.

Table 2. North Sound ACH FQHCs Capacity, Enrollees

County	FQHCs in County	Operatory Supply	Dentist FTE	Hygienist FTE	Future Supply	Medicaid Enrolled Population (Sep 2017)	FQHC Dentists/ Per Medicaid Eligibles
Snohomish	6 locations	70	10	33.75	+ 10 Operatories + 2 Dentists + 1 Hygienist	166,794	1: 16,679
Skagit	1 location	10	1	3	0	36,739	1: 36,739
Whatcom	2 locations	39	6	17	+ 8 Operatories + 6 Operatories + 3 Hygienists	55,850	1: 9308
Island	1 location	2	1	0	+ 1 Dentist + 1 Hygienist	14,942	1:14,942
San Juan	None	N.A.			N.A.	3,437	- 0 -
North Sound	11 locations	121	18	53.75	+ 18 Operatories + 9 Dentists + 5 Hygienists	277,762	1: 15,431
Data Source: Self-report from FQHC leadership, Preliminary Medicaid Provider Files Dental Tables, HCA released June 27, 2017. RHNI Starter Kit, HCA, released May 8, 2017.							

Workforce Assets

The participation of private dental providers will be needed to meet the goals for the region. We have had active participation from oral hygienists, who provide many of the types of services which relate to toolkit metrics, (e.g., sealant applications, periodontal treatment). Independent, private hygienists will organize a network of an estimated 30 providers to serve Medicaid patients with an emphasis on unserved and underserved geographic areas and populations which can be reached on a mobile basis, such as children in school, persons in senior centers and facilities, as well as rural sites identified as underserved.

Table 3 below describes other providers and advocates and the assets they will bring to the project.

Table 3. Assets of North Sound ACH's Regional Providers and Oral Health Advocates

Type of provider or other organization involved with North Sound ACH oral health strategies	Assets brought to the region's project
Oral Health Coalitions and outreach/coordinating groups • Snohomish Oral Health Coalition • Whatcom Oral Health Coalition • Whatcom Alliance for Healthcare Access • ABCD providers (4 of 5 are Health Departments)	• History of engagement and activity with outreach, planning, and coordinating oral health • In several cases, ability to do outreach and engagement of unserved eligible enrollees
Medicaid Health Plan: The region's five health plans as well as Delta Dental may ultimately help to reorganize and better manage the delivery system. They have been engaged with North Sound ACH on oral health.	• Expertise with population health management • Care management and other infrastructure • Advanced analytics capability/ data management • Incentives to better integrate dental care with medical
Tribal Nations: Swinomish Tribe will be engaged with Arcora Foundation and others to train and bring up a new type of mid-level provider--DHATs	• Recent legislation supports this • Opportunity to pilot new roles for this provider type
Private Dentists: Regional coalition will engage private dentists through their Societies- Snohomish Dental Society and Mt. Baker Dental Society - strategy is to test readiness as later adopters	• Way to connect with fragmented community of small dental practices
Private Philanthropy: • Arcora Foundation • Verdant Foundation Both foundations have been very engaged and committed to oral health	• **Arcora**: Expertise, financial resources, willingness to devote staff time, knowledge of innovation across the state • **Verdant**: Strong interest in oral health, history of supporting South Snohomish efforts
Hospitals or Health Systems: • Providence (existing integration pilot) • Island Hospital (considering Oral Health integration/engaged in ACH work) • Peace Health (engaged in ACH work)	• Large numbers of medical primary care providers who may adapt to oral health integration pilots • Potential for scale and infrastructure to adopt population management tools

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

CHALLENGE	STRATEGY TO ADDRESS CHALLENGE
Implementation of project area strategies not successfully improving performance measures toward goals.	• Convene Data & Learning Team to review gaps in performance measures • Explore reasons for performance gaps and consider revisions or enhancements to improve rate for target population • Use population health management technologies to identify key target populations that are not responding to intervention. • Implement needed mid-course corrections, including integration of new partners or new strategies.
Limited partner capacity (for training, implementing new programs, willingness to take on new projects)	• Support the dedication of provider time to oral health delivery framework trainings and workflow modification activities • Identify financial opportunity for participation in demonstration project through improved efficiency and outcomes that supports organizational budgets beyond funding incentives. • Integrate and support front-line providers in planning and implementation process, so that projects are appropriate to provider needs and capacity.
HIT/HIE systems not compatible with EHRs used by delivery systems or not functional for oral health population management purposes.	• Coordinate with vendors and systems to troubleshoot issues with interoperability/compatibility/functionality, including software updates and custom programming if no other solution available. • Explore contracts with other vendors who are able to provide more interoperable or functional solutions. • Train providers and clinical staff in use of HIT systems to improve functionality and engagement with population health management technologies. • Provide more technical assistance from Arcora Foundation and other sources.
Inability to obtain funding for expanding/spreading successful strategies across regional partners.	• Facilitate site visits for stakeholders and decision makers with ability to provide needed funds, so that the value of the models can be experienced first-hand. • Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to oral disease prevention activities
Clinic expansion and workforce development activities not utilized by target patient population.	• Retool patient outreach and engagement processes; use analytics to identify promising demographic areas for patient engagement.

	• Devote more resource to outreach, analyze what is working and shift in that direction.
Unable to recruit sufficient workforce to build capacity (including hygienists, dentists, or DHAT trainees).	• Promote employment opportunities through avenues of communication and marketing to relevant professional categories. • Explore incentive opportunities to attract sufficient workforce through funding, education waivers, or other solutions. • Investigate opportunities to engage existing regional dental professional workforce to build capacity.

3C: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.

As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

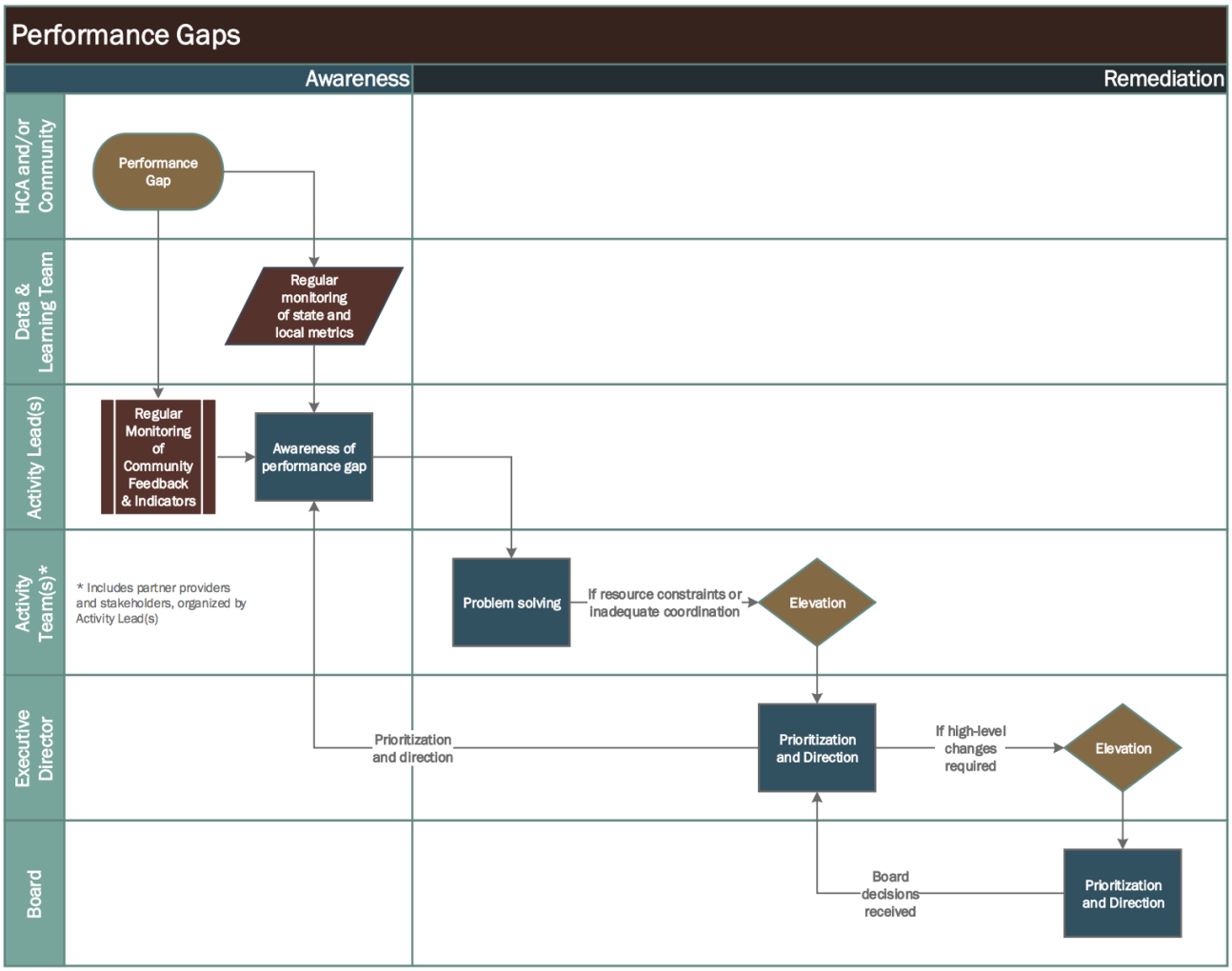


Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and

improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

3C: Project Metrics and Reporting Requirements

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

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

YES	NO
XX	

3C: Relationships with Other Initiatives

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

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

YES	NO
XX	

3C: Project Sustainability

The North Sound ACH is committed to working with partners in our region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation Project period. A virtuous cycle results when clinical transformation improves provider performance on clinical quality measures in value-based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community, and community-based organizations to address upstream, social determinants of health. To ensure lasting impact, we will optimize project strategies that hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster relationships among partnering providers, so implementation is realized on the regional level and when Medicaid Transformation funds are no longer available, the relationships and transformative changes will continue.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to braid together DSRIP earnings with other sources, including Managed Care Organization partners. Additionally, philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged wherever possible.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other interventions. Finally, establishing improved linkages and care coordination between clinical settings and community based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure

performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, child care, employment, food access, environmental pollutants, etc. Additionally, the ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to ensure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building capacity for these providers in the long-term. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long term, likewise driving increases in reimbursements for value based contractual agreements.

Specific to Oral Health, the ACH and partner organizations will also work to include more diverse partners in this work, and conduct outreach to private dentists to increase participation and collaboration in serving Medicaid patients. Much of the activities in the Oral Health project area are low-cost, self-sustaining, and require only an upfront investment to implement. Oral health integration activities (integrating oral health into primary care) involve primarily technical assistance and up-front training costs. Community outreach to identify new or hard-to-reach patients is primarily an initial one to three-year activity. Finally, implementing new population health management tools and coding systems, like ICD-10 coding, use of advanced analytics, and linking registries to call-back systems, are all one-time, up front investments, and once these tools and systems are up and running, require only maintenance and training for new staff and provide long-term sustainability. Increased provider capacity and patient outreach to fill this capacity are targeted efforts which result in more demand to fill the new capacity created. In contrast, the operational shifts in the delivery system to population management tools and techniques will require ongoing infrastructure. A value-based payment approach linked to the project metrics is proposed as the financial tool to maintain this infrastructure over time.

These strategies are sustainable and will have lasting impacts. Funding to support activities in this project area will primarily be drawn from outside the Medicaid Transformation, through private foundations, existing delivery system budgets, and established Medicaid claims sources--allowing project activities to achieve built-in sustainability after the Medicaid Transformation project is concluded.

3D: Transformation Project Description: Chronic Disease Prevention and Control

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

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

3D: Project Selection & Expected Outcomes

Introduction- Why the Project is Needed

In the North Sound region, asthma, diabetes, and hypertension are among the most common chronic diseases experienced by Medicaid enrollees, and are tied to high rates of admission to hospitals and emergency departments. The presence of chronic diseases such as pulmonary or cardiovascular disease were associated with a two to four times higher likelihood of three or more ED visits per year compared to the general Medicaid population.[1] While largely preventable—with early, identifiable disease precursor states such as prediabetes and prehypertension—if not diagnosed early and not managed effectively through medical and lifestyle interventions, they can lead to severe health challenges and high health care costs. For example, Type II Diabetes is a national epidemic, fastest growing in the pre-teen and adolescent population. Hypertension is a precursor to cardiovascular and cerebrovascular diseases and can impact or exacerbate existing chronic conditions like diabetes, congestive heart failure, or coronary artery disease.

Health is most impacted by factors that occur outside of the clinical setting, by where we live, work, learn and play. Environmental conditions that many Medicaid enrollees in our region experience have been shown to influence health outcomes negatively. For example, homes that low-income residents in Western Washington can afford tend to be older, with deferred maintenance issues, including water intrusion, mold growth, air leakage, and old carpets that can all exacerbate asthma symptoms. Living in non-walkable or unsafe neighborhoods can limit ability to exercise, and a lack of access to healthy, fresh food (because grocery stores are not available in a convenient location, or because fresh and healthy food tends to be more expensive) contributes to increased obesity and diabetes rates.

For low-income adults (incomes less than $25,000/year) in the North Sound region, 13.6% had an asthma diagnosis, and 12.8% had a diabetes diagnosis.[2] There is variability of chronic disease burden and risk for local populations in the North Sound. Overall, health disparities in chronic disease risk factors and disease

[1] Measure Decomposition Data, RDA/DSHS, released July 7, 2017.
[2] RHNI Starter Kit, HCA, released May 8, 2017.

burden were present in population segments by gender, race/ethnicity, age, education and income. Further, necessary chronic disease screening, prevention, and management processes show opportunity for improvement—with only 31% of qualified diabetics having received eye screening for diabetic retinal disease, 20% of adults with diagnosed cardiovascular disease prescribed a statin, and 27% of Medicaid enrollees (5-64 years) remaining on asthma medication[3]. Finally, four of the 9 leading causes of death for Medicaid enrollees in the North Sound region are directly associated with chronic disease, accounting for 28.5% of mortality among enrollees:[4]

- Major Cardiovascular Disease (15.1%)
- Chronic Liver Disease & Cirrhosis (7.1%)
- Diabetes (3.6%)
- Chronic Lower Respiratory Diseases (2.8%)

Table 1: Chronic Diseases, Risk Factors, & Health Disparities, North Sound & WA

Measure	WA	North Sound	Health Disparities by Population Segments				
			Gender	Race & Ethnicity	Age	Education	Income
Poor Mental Health Status- Adults	11%	10%	Female	AI/AN Hispanic White	18-24 25-34	HS or Less Some College	Less Than $25,000 $25,000 to $49.999
Asthma- Adults	10%	9%	Female	AI/AN White	18-24 45-54 55-64	HS or Less Some College	Less Than $25,000 $25,000 to $49.999
Diabetes- Adults	8%	8%	Male	Hispanic Asian	45-54 55-64 65+	HS or Less	Less than $25,000
Personal Health Care Provider- Adults	74%	75%	Male	AI/AN Native* Black* Hispanic	18-24 25-34 35-44	HS or Less	Less Than $25,000 $25,000 to $49.999
Obesity- Adults	27%	26%	Female	AI/AN Black* Hispanic White*	35+	HS or Less Some College	Less Than $25,000 $25,000 to $49.999
Smoking- Adults	16%	16%	Male	AI/AN White	18-24 25-34 35-44 45-54	HS or Less Some College	Less than $25,000 $25,000-$49,000
Washington State Department of Health, BRFSS. 2013-2015. CHAT, 2015.							

Actual chronic disease diagnosis rates among Medicaid enrollees are relatively low as reflected in claims data, with 3% showing billing codes for with diabetes diagnosis, 3% with billing for asthma diagnosis and 10% with billing for major depression diagnosis.[5] However, diagnosis rates may not be the strongest measure to indicate the disease burden of chronic conditions, including behavioral health and substance abuse. Analyzing claims data through the lens of the UCSD Chronic Illness & Disability Payment system,[6] burden

[3] RHNI Starter Kit, HCA, released May 8, 2017
[4] RHNI Starter Kit, HCA, released May 8, 2017
[5] Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. Chronic Disease Profiles (North Sound) WADOH, April 2016
[6] Improving Health-Based Payment for Medicaid Beneficiaries: Chronic Illness & Disability Payment System, University of California- San Diego, 2000.

of chronic illness and/or disease can be seen in the association of claims and disease categories. Based on this, the top five chronic illness diagnoses in North Sound were:[7]

1. Depression
2. Pulmonary conditions like asthma, COPD
3. Hypertension
4. Gastro conditions like intestinal infections, ulcers and hernias.
5. Osteoporosis, musculoskeletal anomalies

Lastly, chronic conditions, mental illness and substance abuse can exacerbate one another, which is why it is a fundamental North Sound ACH priority to identify co-occurring illnesses while further defining target populations for this project area. In 2016, 40,626 of Medicaid enrollees were diagnosed with a Mental Illness and one or more chronic conditions, while 20,135 of Medicaid enrollees were diagnosed with a Substance Use Disorder (SUD) and one or more chronic conditions. Several other North Sound project areas will be implementing strategies designed to address the relationship between mental illness, SUD, and chronic disease, including Bidirectional Integration of Physical and Behavioral Health, Diversion Interventions, Transitional Care, Addressing the Opioids Crisis, and Care Coordination.

Target Population

The target population for Chronic Disease Prevention and Control strategies are Medicaid enrollees (adult and children) with, or at-risk for, chronic respiratory disease (asthma), diabetes, and hypertension, with a focus on those populations experiencing the greatest burden of chronic disease in the North Sound region. These three categories of disease were selected by the Chronic Disease project area workgroup due to the associated opportunities for primary and secondary prevention of disease development, their prevalence in the Medicaid population, the cost to treat these conditions if unmanaged, and their association with the pay for performance metrics identified in the Medicaid Transformation Project Toolkit.

During the 2018 planning period, the North Sound ACH will review the best data available for the region and identify the population segment with the most need, in which a strategic investment in system reform can likely move the performance metrics during the Medicaid Transformation Project period. A focused target population for this project area will be selected from this population segment. The North Sound ACH will use Targeted Universalism[8] as an approach for selecting target populations to ensure that health equity features strongly in this process. Targeted Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted interventions.

As required during the 2018 planning period, North Sound ACH staff will conduct further statistical analysis and facilitate planning processes necessary for final target population selection due in June 2018. The North Sound ACH will work with implementation planning teams, Community Leadership Council and the Data and Learning Team to use the best available research, regional data, and community input to identify a final high-need target population, with consideration for how strategic investments can impact performance metrics during the Medicaid Transformation Project period.

Targeted Universalism[9] will be used throughout the planning phase as an approach and analysis framework for selecting target populations to ensure that health equity features strongly in this process. Targeted

[7] ACH Profiles Future, DSHS/RDA, released April 11, 2017

[8] John A. Powell, Haas Institute. Targeted Universalism. 2017. Retrieved from http://haasinstitute.berkeley.edu/targeteduniversalism

[9] Targeted Universalism is a different way—a powerful way—to make the transformational changes we need. Changes we need to improve life chances, promote inclusion, and enhance and sustain equitable policies and programs. Means setting

Universalism will be applied when measuring regional needs, identifying population segments experiencing health disparities, understanding root causes within population segments and selecting appropriately targeted strategies.

North Sound ACH staff will continue to collaborate with ACH's across the state and the Health Care Authority's AIM Team to identify shared data-driven processes and target population selection methodology. To maximize the reach and impact of the demonstration projects and increase the likelihood of region-wide success in moving the metrics, the North Sound ACH aims to align target populations across the project portfolio.

The North Sound ACH used a common format for each project area to summarize the anticipated reach of target population(s) and identify performance metrics and health disparities project strategies aim to impact, as follows below.

<table>
<tr><th colspan="2">North Sound Project Area Reach & Impact
Project Area 3D: Chronic Disease Prevention and Control</th></tr>
<tr><td colspan="2">Potential Target Population Reach:
• 37,279 diagnosed with asthma, COPD (Pulmonary, low)
  ○ 5,997 Disabled, 3,280 Non-Disabled Adults, 11,406 Newly Eligible Adults, 13,159 Non-Disabled Children, 3,437 Elders
• 32,100 diagnosed with hypertension (Cardiovascular, extra low)
  ○ 6,727 Disabled, 2,620 Non-Disabled Adults, 11,406 Newly Eligible Adults, 461 Non-Disabled Children, 7,688 Elders
• 22,390 diagnosed with Type 1 or 2 diabetes
  ○ 5,868 Disabled, 1,501 Non-Disabled Adults, 8,080 Newly Eligible Adults, 608 Non-Disabled Children, 6330 Elders
• 40,626 diagnosed with a Mental Illness and one or more chronic condition
  ○ 14,651 diagnosed MI and any cardiovascular condition
  ○ 14,238 diagnosed MI and any pulmonary condition
  ○ 4,330 diagnosed MI and Type 1 or Type 2 Diabetes
• 20,135 diagnosed with a Substance Use Disorder and one or more chronic condition
  ○ 8,335 diagnosed SUD and any cardiovascular condition
  ○ 7,410 diagnosed SUD and any pulmonary condition
  ○ 2,001 diagnosed SUD and Type 1 or Type 2 Diabetes</td></tr>
<tr><td>Project Area Impact:</td><td></td></tr>
<tr><td>Performance Measures
• 20% of Medicaid adults with cardiovascular disease were prescribed statins
• 27% of Medicaid enrollees (5-64 years) with asthma and medication managed
• 86% of Medicaid children ages 2-6 years who went to a PCP in the last year</td><td>Geographic Disparities
• All counties in the North Sound (39%-43%) have higher rates of adults with high cholesterol compared to the state.
• Snohomish County has the highest smoking rate among adults at 17%</td></tr>
</table>

universal goals that can be achieved through targeted approaches. Ultimately, this approach shows how a universal goal can be a good thing, but a one size fits all approach is not always the solution. John Powell, Haas Institute, 2017

• 31% of Medicaid enrollees with a diagnosis for diabetes received an eye exam screening for diabetic retinal disease.	• Snohomish County has the highest rate (6%) of enrollees with SUD and more than one chronic condition. • In Whatcom and Island counties, 12% of enrollees with a mental illness have more than one chronic condition **Demographic Disparities** • Adult females are more likely to have poor mental health and asthma • Adult males are more likely to have diabetes and smoke • Adults with incomes under $25,000/year are more likely to experience higher rates of chronic conditions and risk factors. • Whites and American Indian/Alaskan Natives were more likely to have poor mental health, asthma, not have a personal health care provider and smoke. **Co-morbid Disparities** • Patients with chronic pulmonary or cardiovascular diseases or diabetes were between 2 and 4 times more likely to have 3 or more outpatient ED visits. • 40,626 diagnosed with a Mental Illness and one or more chronic condition • 20,135 diagnosed with a Substance Use Disorder and one or more chronic condition
Data Sources: 1) RHNI Starter Kit, HCA, released May 8, 2017. 2) Measure Decomposition Data, RDA/DSHS, released July 7, 2017. 3) ACH Toolkit Historical Data, HCA, released August 17, 2017. 4) ACH Profiles: ESA Profiles Program Participants, RDA/DSHS, released September 22, 2017. 5) BH and Co-Occurring Disorders, RDA/DSHS, released October 10, 2017. 6) Chronic Disease Profiles (Island, San Juan, Skagit, Snohomish, Whatcom) WADOH, February 2015. 7) Chronic Disease Profiles (North Sound) WADOH, April 2016.	

In the North Sound ACH region, many challenges exist to effectively address chronic diseases in our current systems, and many Medicaid enrollees in our communities face significant barriers to health that put them at a higher risk for developing chronic diseases like asthma, diabetes, and hypertension. Many people and families lack funds to afford insurance or co-pays, medication, transportation, or healthy foods. Distance from clinics and services are a significant barrier to accessing care, and can lead to isolation in rural or remote areas (such as east Whatcom, Skagit, and Snohomish counties, or throughout Island or San Juan counties). The elevated costs of living in city centers where services and clinics are often located can prevent low-income families from having easy access to health care providers.

Many community members have complex care needs, and have a need for integrated services such as primary care and diabetic retinopathy screenings. Managing chronic diseases often requires environmental support, which many people do not have at home, at work, or at school. Knowledge and education is also essential to effective self-management of chronic diseases, such as the ability to use an inhaler, blood pressure cuff, insulin pen, as well as healthy lifestyle practices such as regular exercise and healthy cooking.

Primary care providers can vary considerably in the use and implementation of national clinical guidelines to guide their clinical practice. Opportunities for clinical improvement in this area include:

- regularly prescribe controller medications for asthma when warranted;
- help ensure patients use an inhaler correctly;
- inform their patients why they are prescribing medications like Metformin (used to control diabetes) and/or how best to take it in order to minimize side effects;
- counsel patients about the risks of being overweight or obese
- provide suggestions healthy eating and lifestyle changes.

Embedding evidence-based practices and prescribing policies around chronic disease prevention and management through practice transformation and population health management techniques as elements of the Chronic Care Model will be essential to address these clinical performance gaps.

Alignment with Regional Priorities

This project area aligns with regional priorities as identified in the most recent Community Health Needs Assessments, Community Health Improvement Plans, and Community Health Assessments conducted by counties, hospital systems, and community-based organizations in our region - specifically around addressing food insecurity (especially for people with chronic diseases), nutrition, child and adult obesity, and promoting exercise. Asthma, diabetes, and hypertension are specifically called out in recent needs assessments and improvement plans as priorities that need to be addressed in our region to promote better health, especially for low-income communities.

Recommended Strategies

PROJECT OBJECTIVE: Integrate health system and evidenced-based community approaches to improve chronic disease management and control.

Enhancement and Expansion of the Chronic Care Model in Primary Care Practices

The Chronic Care Model (CCM) of chronic disease prevention and management is an evidence-based and patient-centered methodology for reducing chronic disease burden through clinician-patient teams and community-based resource referral links.[10] Developed at the MacColl Center for Healthcare Innovation by Ed Wagner in 2004, the Chronic Care Model has been tested and expanded throughout the nation over the course of the last decade. The model has demonstrated success in clinical prevention and management for a range of chronic diseases, including:[11]

- Arthritis[12]
- Asthma[13]
- Depression[14]

[10] Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998

[11] Battersby MW. Health reform through coordinated care: SA HealthPlus. BMJ 2005; 330(7492):662-5.

[12] MacLean CH, Louie R, Leake B, McCaffrey DF, Paulus HE, Brook RH, Shekelle PG. Quality of Care for Patients with Rheumatoid Arthritis. JAMA 2000; 284(8): 948-992.

[13] Lozano P, Finkelstein JA, Carey VJ et al. A multisite randomized trial of the effects of physician education and organizational change in chronic-asthma care: health outcomes of the Pediatric Asthma Care Patient Outcomes Research Team II Study. Arch Pediatr Adolesc Med 2004; 158.(9):875-83

[14] Simon G, VonKorff M, Rutter C, Wagner E. Randomised trial of monitoring, feedback, and management of care by telephone to improve depression treatment in primary care. BMJ. 2000; 320:550-4.

- Diabetes[15]
- Hypertension[16]

Most clinical organizations in the region report successful implementation of the Chronic Care Model, in using clinician/medical assistant teams to identify, prevent, and manage chronic disease. Indeed, a regional primary care system, Family Care Network, was an initial pilot site of the CCM and counts national subject-matter experts on chronic disease management in their provider staff. Collaborating with partners on the Health Systems Advisory Coalition (primary care and hospital systems), this project will continue to build on existing chronic disease prevention and management systems in:

- training providers in the most current clinical guidelines on screening, diagnosing, and intervening to prevent and manage the chronic diseases in the scope of this project;
- educating providers on local community-based chronic disease prevention and management programs;
- implementing population health management techniques, including Health Information Technology (HIT) tools, to identify patients who are at risk of or diagnosed for the chronic diseases;
- recalling identified at-risk or diagnosed patients for prevention, intervention, and potential to community-based programs;
- use of available billing options and processes for referring or prescribing patients to home-based chronic disease management (such as at home blood pressure management) or community-based chronic disease prevention and management programs.

In addition, specific work will be done to implement practice improvement and provider education activities around asthma, diabetes, and hypertension:

1. *Asthma*: Ensure clinics implement national clinical guidelines on diagnosis and treatment for asthma with home-based assessments and remediation, through trainings in:
    - effective asthma diagnosis through spirometry;
    - Stepwise approach to medication management;
    - patient education on use of inhalers with spacers;
    - asthma action plans.
2. *Diabetes*: Ensure clinics implement national clinical guidelines for diagnosing and treating both prediabetes and diabetes; and linking with other community-based programs like Chronic Disease Self-Management Education (CDSME) and other community- and school-based programs that will help promote healthy lifestyles (increase activity, healthy eating/portion control, etc.).
3. *Hypertension*: Implementing national clinical guidelines on diagnosis and treatment for hypertension through application of tools and protocols the Million Hearts initiative; refer patients to community-based programs that focus on healthy lifestyle, smoking cessation, etc.; prescriptions for home blood pressure monitoring equipment.

Expand Regional Capacity for Community-based Chronic Disease Prevention and Management

A key part of this work will be to expand regional capacity to provide evidence-based, community-based chronic disease prevention and management programs. A critical element of the Chronic Care Model is referral to community-based resources, which requires strong, available community programs where patients can receive support in self-management and lifestyle modification. Several evidence-based environmental, patient education, and self-management programs will be implemented where appropriate to address asthma, diabetes, and hypertension.

[15] Piatt GA, Orchard TJ, Emerson S et al. Translating the chronic care model into the community: results from a randomized controlled trial of a multifaceted diabetes care intervention. Diabetes Care 2006; 29(4):811-7.
[16] Battersby MW. Health reform through coordinated care: SA HealthPlus. BMJ 2005; 330(7492):662-5.

This work will build on current programs that exist in communities to prevent and manage chronic diseases, and look to examples of successful programs that are accessible and effective at improving health outcomes. A significant part of the 2018 planning phase will be identifying these community-based programs to ensure that all partners are engaged and that duplication of programs does not happen. Projects in this area will take care to not "reinvent the wheel" but build on or scale up the work that is already happening in communities.

During this planning phase, the North Sound ACH will collect and analyze sufficient data to identify target populations through review of existing chronic disease burden on communities, disparities in disease prevention and management, and existing chronic disease prevention and management resources. Implementation partners will collaborate with the North Sound ACH in a financial analysis of intervention cost compared to the impact on health outcomes and performance measures. Existing regional programs that are strong candidates for enhancement or expansion include:

1. *Asthma Home-Based Multi-trigger, Multicomponent Environmental Intervention (Healthy Homes)*: Healthy Homes targets persons with asthma or COPD and provides a holistic housing assessment coupled with environmental health education that includes: a home education visit to help families take action to create a healthier home; inventory to support households in improving indoor air quality; comprehensive home assessment to identify indoor air health and safety hazards; referral to weatherization and home repair programs to improve indoor air quality, reduce asthma triggers and increase energy efficiency; one year of follow up service, both in-home and via phone. Community health workers can become certified to conduct environmental assessments and refer to Healthy Homes.
2. *National Diabetes Prevention Programs (NDPP)*: The goals of NDPP are to increase healthy eating and activity and promote healthy weight loss. NDPP are based in community organizations like the YMCA (one-year program is comprised of 25 small group one-hour sessions), Washington State University (WSU Extension DPP consists of 16 weekly Core classes and followed by 6 monthly Post Core classes).
3. *Chronic Disease Self-Management Programs (CDSMP)* is an effective small group self-management education program for people with chronic health problems to help them control their symptoms and better manage their health problems. The program specifically addresses arthritis, diabetes, lung and heart disease, but teaches skills useful for managing a variety of chronic diseases.
4. *"Eating Smart, Being Active"*, an 8-week food and nutrition series;
5. *"ACT!"*, a partnership between Seattle Children's Hospital and the YMCA of Greater Seattle, that coaches overweight kids (8-11), and teens (12-14), and their families to lead healthy lifestyles.
6. *Fruit and Vegetable Prescription Program* - a partnership between local food banks and primary care providers, to prevent and treat food insecurity and chronic diet-related diseases (type 2 diabetes, hypertension). Participants are enrolled by a healthcare provider, screened for food insecurity, and work with a counselor to discuss nutrition goals and strategies each month. Participants are referred to WIC/SNAP if appropriate, and receive a Fruit and Vegetable Rx voucher that is redeemable at farmers' markets, mainstream grocers and corner stores.

Toolkit Model Used

The strategies in this project area are based in the Chronic Care Model, and implement several different evidence-based change strategies, such as Self-Management support, Delivery System design, Decision Support, Clinical Information Systems, Community-Based Resources and Policy, and Health Care Organization strategies.

ACH Role and Supports for Partners

The North Sound ACH will improve health in the region by supporting the strengthening of clinical and community-based prevention, treatment, and management of chronic diseases for Medicaid enrollees who are at-risk or have been diagnosed with asthma, hypertension, or diabetes. Partner organizations directly serving Medicaid enrollees who are at-risk or diagnosed with chronic diseases (including primary care providers, specialty providers, social service organizations, and community-based prevention and management programs) will implement the strategies selected for this project area, and the North Sound ACH's role will be to support them in doing so successfully and with maximum impact in the target populations (which will be finalized in 2018).

Examples of roles the ACH will play in strengthening the prevention and management of chronic diseases in the North Sound Region include:

- Working with partners to identify and address challenges in engaging the target populations;
- Acting as convener for regular cross-sector collaboration meetings during the planning and implementation phases;
- Working with leadership of partner organizations to:
    - increase protected time for trainings (including trainings in best practices for screenings and referrals to community-based programs, which the ACH would likely not lead, but can assist in connecting providers with trainers and potentially provide financial support)
    - identify opportunities for partners to see organizational budget savings based on improved efficiency
    - achieve buy-in to transformative change of front-line staff;
- Developing and brokering relationships between clinical providers and community-based services to expand the resources available to Medicaid enrollees;
- Collaborating with MCOs and delivery system leadership to develop funding mechanisms that solve reimbursement challenges;
- Facilitating the use of interoperable HIT and Release of Information agreements across partners;
- Demonstrating the financial value of these interventions to funders, health systems, and other stakeholders who can potentially provide additional, sustainable financial support;
- Considering the needs of the entire North Sound Region to ensure that strategies are implemented which promote access to services for Medicaid enrollees in rural and remote areas as well as urban areas;
- Sharing learnings from other ACH regions with planning partners when developing implementation plans.

Metrics

In order to be successful in meeting the reporting and performance metrics this area, a strong partnership and active collaboration between primary care providers and community-based programs is essential. The strategies in this project area are expected to improve the following measures of success:

I. Reporting or attestation measures:
    - Number of providers trained in appropriate blood pressure assessment practices;
    - Number of patients with automated blood pressure monitoring equipment;
    - Number of new or expanding community self-managed support programs, such as CDSMP and NDPP;
    - Number of home visits for asthma services and hypertension;
    - Number of completed, documented, and up to date Asthma Action Plans
    - Number of Medicaid enrollees in the North Sound region participating in chronic disease prevention or management programs.

II. Performance, HEDIS or clinical quality measures:

- Percent of Medicaid enrollees with a diabetes diagnosis who have received comprehensive diabetes care including retinal exams, hemoglobin A1c testing, and medical attention for nephropathy;
- percentage of Medicaid enrollees 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.
- Percent of Medicaid enrollees with three or more ED visits
- Percent of Medicaid enrollees with inpatient hospital utilization
- Access to Primary Care for Adults and Adolescents,
- Percent of Medicaid enrollees with a diagnosis of hypertension and whose blood pressure was adequately controlled
- Percent of Medicaid enrollees with diagnosed cardiovascular disease who were proscribed statin therapy.

Health Equity

The North Sound ACH will use health equity as a lens for all our project areas. In order to be truly transformational and meet the needs of our community, disparities by race/ethnicity, socioeconomic status, geographic area, and other categories must be brought to the forefront. In the Chronic Disease project area, strategies will be adapted when possible to each community to ensure that clinical and community interventions are both culturally appropriate and accessible (for example, hiring bilingual community health workers and clinic staff; hiring staff from the communities they will serve; requiring training on cultural humility, undoing institutional racism, implicit bias, and more).

Lasting Impacts

Historically, healthcare has been clinically driven, with limited links to outside-the-clinic, evidence-based interventions and resources that are proven to reduce risks or assist in managing chronic diseases. Clinical transformation can play a big part in preventing and managing chronic disease. However, true transformation will require a shift in relationships along the healthcare continuum to create strong, sustainable pathways and links for integrated care from clinic to community, and investment in building up both clinical interventions to prevent and manage chronic disease, and community-based programs to also help prevent and manage chronic disease.

Chronic Disease project strategies will benefit the Medicaid population as a whole beyond those diagnosed or at-risk for asthma, diabetes, and cardiovascular disease. Strengthening clinical and community-based systems that help prevent and manage chronic conditions and address the behaviors and environmental factors that can contribute to them, will benefit the entire community by reducing the burden of disease and cost of care while improving quality of life.

3D: Partnering Providers

The organizations and stakeholders listed in the Partnering Providers Tab of the Supplemental Workbook represent partners who have been substantively engaged in the project planning workgroups to date or that we expect will be engaged in the planning phase in 2018. Some, but not necessarily all of these partners will eventually be entered into the financial executor portal to receive payment.

In the Chronic Disease project area, the North Sound ACH has been fortunate to receive high-levels of engagement from both community-based and clinical partnering providers whose participation will be essential to the project's success. Serving in the role of workgroup leads are representatives from a local

community-based organization (Opportunity Council), a regional health system (Skagit Regional Medical Centers), and a Managed Care Organization partner (Molina Healthcare).

Upon news of a successful agreement for the Medicaid Transformation, the North Sound ACH began a process of moving from broader stakeholder engagement to targeting partnering providers based on those currently serving or interested in serving a greater proportion of the Medicaid population. This engagement began with the formation of eight workgroups in each of the Toolkit project areas. An open invitation was extended to providers and stakeholders with interest or focus in certain project areas. These included behavioral health and SUD providers, community-based organizations, county governments, primary care providers, health systems, Managed Care Organizations and health departments. Two or more volunteer subject matter experts from the community were invited to serve alongside staff in a lead role for each workgroup. As more information on the Medicaid Transformation project became available, the focus and process for workgroups evolved accordingly. An initial inquiry was made for workgroup members and coalitions to craft draft "Statements of Interest" highlighting their individual and organizational interest and ideas for project frameworks. Staff and leads then gathered these submissions and reflected back a compilation of content to produce the outlines of a regional approach in each area.

Workgroups further honed these ideas during dialogue at monthly face-to-face meetings with remote access capability. North Sound ACH staff encouraged workgroups to focus on guidance from the Project Toolkit, including indicated target populations and seeking a strategy capable of incorporating participation from partnering providers across the region, while also aiming to move their respective pay-for-performance metrics. This dialogue on target populations, partnering providers already serving and committed to serve the Medicaid population and effective strategies honed the focus of the workgroups onto Medicaid enrollees, including the subpopulations indicated by the toolkit and the partnering providers necessary to reach them. Due to the open and inclusive nature of stakeholder engagement in the workgroups, a broad spectrum of partnering providers are represented and remain a value for future engagement.

Concurrently, a coalition of health system primary care providers formed an advisory body to staff, wherein staff facilitate regular meetings, assist with scheduling, agendas and note-taking. The Health System Advisory Coalition includes members from the largest hospital systems providing primary care in the region, all the regional Federally Qualified Health Centers, a large independent physician practice and a smaller pediatric practice. Collectively, the group has self-reported coverage of over 205,000 Medicaid primary care assignees in the region. Staff are continuing outreach to other partnering providers, including those located in more rural settings and smaller in size. These efforts form the foundation of the strategy to ensure inclusion of those serving a significant majority of the Medicaid population. Plans to similarly convene partnering providers working in behavioral health and SUD settings will ensure a broad spectrum is represented for the purposes of Chronic Disease Prevention and Management.

The North Sound ACH recognizes the importance of Managed Care Organizations to the success of the Medicaid Transformation Project and efforts at systems transformation in our region. Managed Care Organization partners are engaged on the Board of Directors, the Program Council and represented in each of the workgroups, including serving as leads in the areas of Care Transitions and Chronic Disease. MCO partners have thus provided significant expertise and guidance to the project planning to date and will continue to do so throughout. Through existing channels of governance and the workgroup format, the North Sound ACH will consult and leverage MCO expertise in project planning and eventual implementation, while simultaneously avoiding duplication.

3D: Regional Assets, Anticipated Challenges and Proposed Solutions

Assets

The foundation of the regional assets that will support this project is the collaborative nature of the diverse partners working to improve health in the North Sound region. Since the inception of the ACH, organizations that have traditionally competed with each other have come together to collaboratively plan the transformation of our regional health system. Strategies in this project area will build on the many assets in our region, including strong commitments from diverse partners to improve environmental quality in homes, food access, healthy eating, physical activity, and other conditions that help prevent chronic disease, as well as effectively manage chronic diseases to help reduce health care costs and improve patient outcomes. Key assets include:

Clinical Service Delivery and Expertise

Our region has many health care providers who are an asset to this work, including:

- Federally Qualified Health Centers (Sea Mar, Unity Care NW, Community Health Center of Snohomish County)
- Community Health Workers (Home health programs)
- Community Paramedics (Whatcom and Snohomish)
- Pediatricians and pediatric practices (such as Skagit Pediatrics)
- School based health (school nurses, and school based health centers under development)
- Military medical services (U.S. Naval Air Station Whidbey Island)
- Behavioral health providers (North Sound BHO, Compass Health, Sunrise Services, etc.)
- Hospital Systems (such as PeaceHealth, Skagit Regional, Providence, Island Hospital, etc.)
- Emergency Departments
- Managed Care Organizations
- Pharmacies

Nonclinical Service Delivery and Expertise

In the North Sound region there are many nonclinical, government or community-based organizations focused on preventing and managing chronic diseases like asthma, diabetes, and heart disease, including:

- Community Action Agencies (e.g., Opportunity Council, Skagit Community Action, etc.)
- Local Health Jurisdictions
- Population Health Trust (Skagit County)
- Community Wellness Programs (YMCA, WSU Extension, etc.)
- Food systems, hunger relief and coalitions (Food Banks, etc.)
- Gyms and health clubs
- Grocery stores and Farmers Markets
- City and County-supported wellness and recreation programs
- Transportation partners (public transit, biking advocates, etc.)
- Tribal governments
- Faith communities
- K-12 schools
- Area Agency on Aging (NW Regional Council)
- Housing and social service providers (Lydia Place, YWCA, Catholic Community Services, Lutheran Community Services, etc.)
- Health promotion organizations (Verdant Health Commission, etc.)

Workforce and Human Capital Assets

While there is opportunity for workforce expansion in this area, there is a robust existing clinical, and nonclinical workforce across the North Sound region, including:

- Community Health Workers
- Primary Care Providers
- Emergency Department providers
- Specialists (pulmonologists, nutritionists/dietitians, cardiologists, etc.)
- Pediatricians
- Nurses
- Home-visiting nurses
- Community wellness program leaders
- Social Workers and Case Managers
- Public Health Professionals

Financial Resources

The ACH and implementation partners in the Chronic Disease project area intend to draw on existing funding sources external to Medicaid Transformation funds to cover all the costs for the recommended strategies, many of which are currently operating in some capacity. Funds will be leveraged from federal and state funding, philanthropy and other existing funding mechanisms to expand the limited scope, limited capacity, and pilot projects, with DSRIP funds used to build out capacity to unserved areas and to additional targeted populations. The North Sound ACH intends to establish a braided funding model to support the prevention and management of chronic disease, supplemented by Medicaid Transformation funding and including the following sources:

- Managed Care Organizations
- Philanthropic support from "angel investors"
- Potential city, county, state, and federal funding
- Community organizations

CHALLENGES AND STRATEGIES TO OVERCOME THEM

Below are several of the challenges inherent in these strategies and an early assessment of ways to mitigate issues arising. All of these will depend on continuous performance monitoring and application of quality improvement techniques to resolve problems.

Anticipated Challenges	Proposed Solutions
Project has difficulty meeting performance metric targets	• The ACH will engage implementation planning teams in embedding tracking mechanisms in their implementation plans, including surveys, regular automated or manual reports of metrics, and other means for tracking success. Quality Improvement Plans will be integrated into the implementation strategy using rapid-cycle process improvement strategies to identify points of failure and improvement early for quick response. Data & Learning Teams will also convene, based either in the implementation planning teams or the data and learning team, to regularly review metrics and assess areas of change or improvement. • The ACH Data and Learning team will support the strategy through the development of a suite of monitoring and evaluation measures that provide an ongoing, actionable dashboard for project progress. Included in this will be

	ongoing survey-based assessments of training effectiveness and project implementation to partnering providers, regular review of clinical quality measures aligned with toolkit pay for performance measures, HCA reports on performance measure benchmarks, and other heuristic metrics for assessing project implementation success. Clinical quality measures will be pulled for tracking and quality improvement purposes, based on reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform or cloud-based registries. • Modifications to project plans will occur after the data and learning teams or implementation planning teams identify and report gaps or areas of improvement to the Program Council. ACH staff and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Managed Care Organizations could be engaged in this component, to assist ACH staff and partners in workflow redesign and lean process improvement activities. • The ACH will identify potential sources of outside technical assistance to support this process, including Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations. • Work with project partners to identify and understand barriers or limitations that contribute to the inability to meet these metrics • Actively engage with partner providers to support additional training (with financial support) to adopt new practices (i.e. appropriate chronic disease screenings, referral to community programs, etc.) • Outreach to other ACHs, as well as state and national experts, to learn successful strategies to address performance issues
Geographic barriers, resulting in limited provider capacity in more remote/rural areas, transportation barriers for Medicaid enrollees in these areas, as well as limited food access and access to safe places to exercise	• The North Sound ACH will prioritize flexibility when developing implementation plans, and ensure that mobile services (such as mobile dentistry, mobile needle exchange/substance use disorder treatment, etc.), telehealth, and home visiting services are possibilities for populations in particularly rural or remote areas (such as the San Juan Islands or east Whatcom, Skagit, and Snohomish counties). • Allocate ACH resources to improve access to, use of, and reimbursement for Medicaid Transport services. • Work closely with existing resources in these areas (not necessarily within the realm of health care) to think of non-traditional methods to promote access to food and exercise

	• Utilize monitoring and continuous improvement processes to quickly identify when geographic barriers are impacting access to services.
Lack of affordable, available housing in the North Sound region resulting in inability to reduce homelessness, and unstable housing limits improvement in health outcomes	• Outreach to other ACHs, as well as state and national experts on reducing homelessness, to learn successful strategies to address performance issues • Consider investing ACH resources (including staff time) in more upstream efforts to reduce homelessness rates (investing in housing, advocacy at the city, county, and state levels, etc.)
Challenges with reimbursement for services by Apple Health (services not covered/reimbursement rate is insufficient/lack of provider understanding around billing procedures)	• Exploring sustainability with the local Managed Care Organizations will be needed to continue integrated services. • Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services and prevention services • Work together with the HCA to ensure that reimbursement rates for services are sufficient for providers to cover their costs and continue to provide services for Medicaid patients. • Leveraging expertise from the UW-AIMS center and cross sector workgroup support can provide information on proper billing and coding.
Health Information Technology/Exchange (HIT/HIE) challenges, including interoperability of multiple systems, implementation challenges with new systems (such as Pathways), barriers to data sharing between providers/systems (including protected health information), concerns around public disclosure and liability issues	• Utilize a mutually agreed-upon Release of Information (ROI) that can be used by partner providers in this project area, to ensure that patients' Protected Health Information (PHI) can be shared across agencies and agencies remain HIPAA-compliant. • Set up regular data/HIT round tables with partner providers to identify concerns around HIE, data sharing, and challenges around implementing new systems. • The ACH will work with partners to identify any legal or regulatory barriers to sharing data and health information across providers or systems (laws around Public Disclosure; criminal history sharing; 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records, for example), and advocate where possible to remove these barriers. • Engagement with partner providers for evaluation of current capacity and needs around Medicaid reimbursement and billing. Connect partner providers with the Healthier Washington Practice Transformation Support Hub and resources through the project plan could mitigate this barrier. • In late 2017 and 2018, North Sound ACH (as the Pathways HUB) and the MCOs will design a data-sharing system that facilitates eligibility determinations and protects privacy, and the North Sound ACH will describe this arrangement in

	contracts with the MCOs. The ACH can draw on the experience and expertise of other Pathways HUBs and Pathways experts in doing so. • Work with leaders of the Pathways Community HUB to ensure that Pathways technology is able to integrate with existing HIT in use by partner providers. • Potentially leverage ACH resources to pay for data migration costs and set up of new systems, as well as staff training on the new system.
Challenges identifying long-term funding outside the Medicaid Transformation Project	• Utilizing monitoring and continuous improvement processes, regularly evaluate project performance to be able to clearly communicate project impact to potential outside funders, as well as demonstrate a commitment to effectiveness. • Collaborate with MCOs to identify opportunities that align long-term objectives and achieve total cost of care savings in line with needed investments • Dedicate ACH resources to identify additional funding sources, including in-kind support, local community development foundations, philanthropic foundations, other state and federal programs and "angel investors." • Partner with other ACHs to achieve economies of scale • Facilitate site visits for stakeholders and decision makers with ability to provide needed funds, so that the value of the models can be experienced first-hand. • Perform cost effectiveness calculations that demonstrate short and long-term savings for care settings due to transitional care planning. • Advocate for city, county, state, and federal-level allocation of funds to promote access to chronic disease prevention and management • Work together with the HCA to increase the number of covered services that will support movement of performance metrics, including community-based services
Limited partner capacity (for training, implementing new programs, willingness to take on new projects)	• Design distribution of project incentive funds to incent partner participation based on specific activities, adoption, and accomplishments; revise distribution as needed throughout the duration of the project to support ongoing partner engagement • Coordinate with front-line staff to address barriers and correct the project implementation plan as needed • Engage partnering providers in leading the project design and implementation as a way to activate their participation • Subsidize training fees for partners, and/or reimburse providers for lost revenue due to clinic shut down for training.

	• Work with clinical providers to revise internal work flow to eliminate steps causing excessive strain on workflows • Provide technical assistance from the ACH and other external partners
Challenges reaching/recruiting patients to fill new/expanded programs	• Consider additional consumer and stakeholder engagement tactics to identify barriers to adoption and expand buy-in, including, but not limited to: o Targeted focus groups o Engage the North Sound ACH's Community Leadership Council to clarify community needs and understand challenges to adoption o Leverage CHWs, social workers, care managers, patient navigators, and allied health professionals that can engage hard-to-reach consumers o Leverage trusted community organization partners that can help expand buy-in • Outreach to other ACHs to learn successful strategies to stimulate project adoption in early implementation • Devote more resources to outreach, analyze what is working & shift in that direction • Retool out-reach and in-reach processes; use analytics to identify promising demographics • Incorporate marketing tools into referral mechanism; offer incentives when appropriate • Use Motivational Interviewing techniques to overcome ambivalence

3D: Monitoring and Continuous Improvement

Summary

The North Sound ACH will implement a monitoring and continuous improvement plan, which will include quality improvement processes, that leverages existing infrastructure, such as internal clinical quality improvement (QI) teams at partner organizations, regional experts in QI, clinical quality measure dashboards, and health information exchange data, as well as identifying gaps in information and explore opportunities for data collection systems with multiple ACH's. The identification and use of measures for monitoring and continuous improvement will emphasize pragmatic, real-time measurement data sources that track progress through automated systems without requiring a heavy burden of manual measurement and tracking. Methodologies used will include embedded evaluation tools and continuous quality improvement techniques such as logic models, key driver diagrams, Plan-Do-Study-Act (PDSA) cycles, and run charts to track project success and address any gaps or areas of improvement. The North Sound ACH staff and the ACH Data and Learning team will supply the implementation planning teams for each project area with QI plan measure dashboards on an ongoing basis in order to determine success of evidence-based approaches. When projects or approaches are identified as in need of improvement or modification by stakeholders through a deliberative process, ACH will consult with Program council and implementation planning teams to provide assistance and explore solutions before engaging with the Health Care Authority (HCA) engage in a project plan modification.

Information Management & Data Sources

Tracking measures for monitoring and continuous improvement will include data from ongoing survey-based assessments of training effectiveness and implementation milestones to partnering providers, regular review of clinical quality measures aligned with toolkit pay-for-performance measures, HCA reports on performance measure benchmarks, and other proxy metrics for assessing implementation success. While some measures will require manual tracking, such as training enrollment forms, tally sheets for workflow revisions, and manual chart review, special consideration will be given to measures that can provide real-time, automated tracking of progress that have a low-impact on partner organizations' staff time.

Project Managers will serve as liaisons and primary contacts with implementation partners, ensuring that monitoring and continuous improvement measures are submitted or collected on a monthly or quarterly basis for review by the data and learning team. As stated in Section I, Sub-section Governance, Project Managers will be assigned specific projects and groups of providers to monitor. Functions performed by Project Managers will include site visits, meetings with providers to identify successes and challenges, and periodic surveys to measure progress toward contractual goals.

The North Sound ACH will collaborate with partners to identify and capture clinical quality measures and related proxy measures for tracking and quality improvement purposes, based on automated or custom-built reports from partnering organizations or third-party data aggregators such as CMT's PreManage platform, syndromic surveillance systems, or cloud-based registries. Because these measures use data directly managed from HIT systems they provide a nearly real-time (within 24 hours) view of performance, the ACH Data and Learning team will be able to quickly identify and respond to delays in implementation or gaps in performance. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems. A full inventory of available data sources for monitoring of implementation progress will be developed as part of the ACH current state assessment process. Selection of measures within these data sources will be informed by the planning processes among the Implementation Teams and the North Sound ACH Current State Assessment.

As illustrated in Figure 1, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the Project Managers in their capacity as Activity Leads. In the latter case, surfacing performance gaps will be a primary function of the Activity Teams. Independently and in cooperation with the team, Leads will routinely probe for indicators of lagging achievement, employing site visits, meetings with providers, and periodic surveys. When a performance gap is identified through either signal path, the Lead (i.e. the responsible project manager) will lead the Activity Team to develop a remediation plan.

In some cases, adequate remediation may be inhibited by resource constraints or sub-optimal coordination within the ACH or the community. If Leads are unable to resolve these impediments themselves (e.g. through cross-team problem solving), they will elevate unresolved issues to the Executive Director (ED). The ED will then make prioritization decisions and provide direction as necessary. When high-level or systemic obstacles are at play, the ED will request Board assistance to resolve them and then translate Board decisions into instructions for Leads to implement.

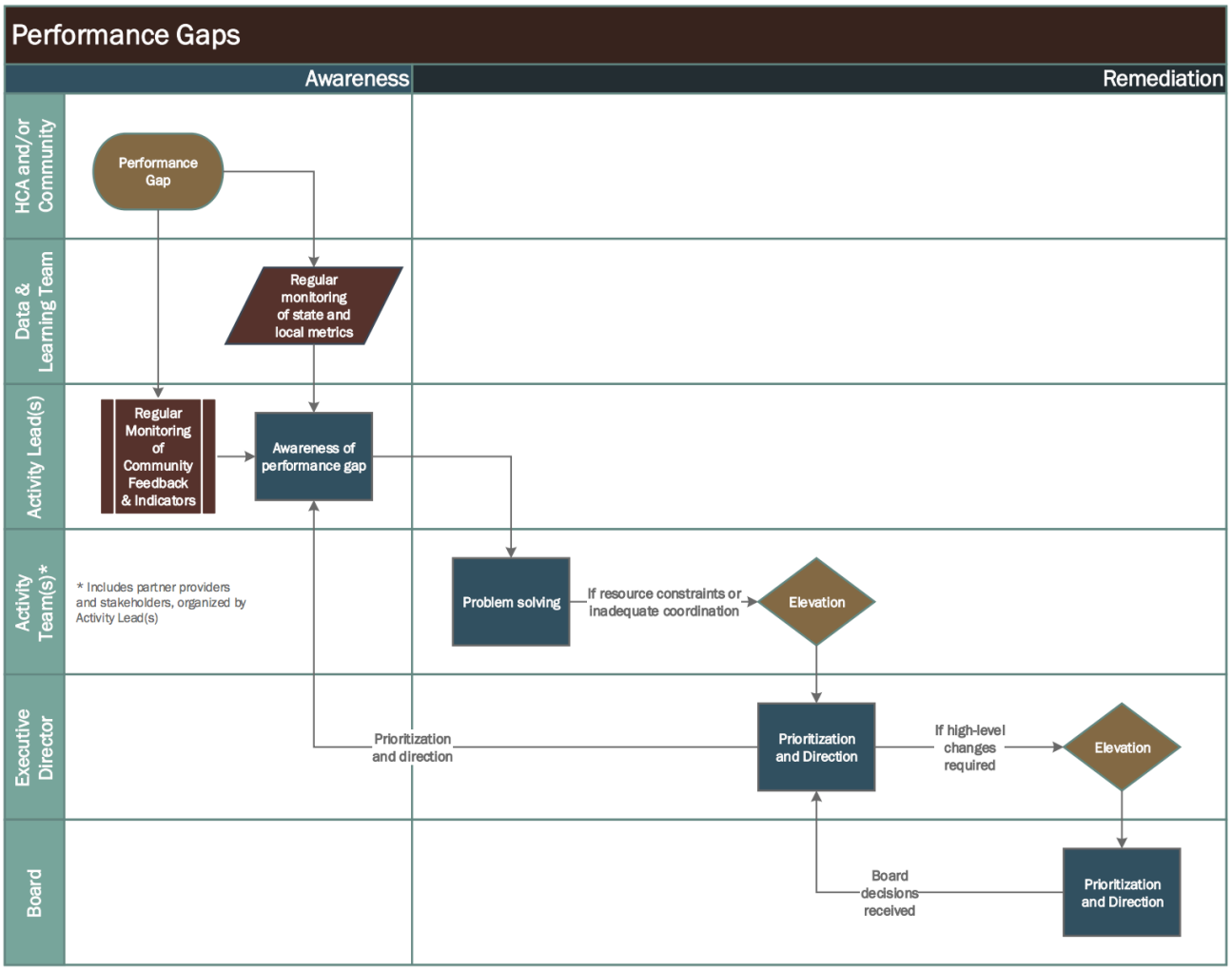


Figure 1: Performance Gaps Process Map

Quality Improvement Planning Process

Internal or embedded implementation teams will work with the most immediate data, based on quality improvement plans, internal quality improvement tracking mechanisms such as clinical quality measures, provider dashboards, and tally sheets. These will be reported to Project Managers and shared with the data and learning team for oversight. Additionally, the data and learning team will continuously identify and use HIT and HIE systems for tracking performance data such as hospital admission, ED utilization, and immunization status based on population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours. When these systems identify performance gaps, the data and learning team will collaborate with implementation teams via the Project Managers to solve the challenges. This is an area where the North Sound ACH will explore partnerships with other ACHs to combine resources and develop shared reporting and data analytic systems, such as a performance management portal.

The North Sound ACH implementation planning teams will embed continuous tracking mechanisms in their implementation plans as part of their quality improvement planning process, to include surveys, regular automated or manual reports of metrics, and other means for tracking success. This quality improvement planning will emphasize rapid-cycle process improvement strategies that will identify points of failure and

improvement for quick response through PDSAs or workflow redesign. The ACH will engage existing quality improvement teams at clinical or community-based implementation partners to provide expertise and support ongoing, real-time review and improvement of evidence-based approach implementation. Where possible, implementation partners will be encouraged to use these internal quality improvement teams to track their performance and PDSA improvements as needed.

The North Sound ACH Data and Learning team will support this strategy through the development of a suite of monitoring and evaluation measures for each evidence-based approach that provide an ongoing, actionable dashboard for tracking progress. The Data and Learning team will convene to regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements.

Process Improvement and Project Plan Modification

Implementation delays will be identified through regular monitoring and oversight of performance and tracking measures by internal implementation teams at partner organizations. When implementation is delayed or encounters a barrier, these teams will first attempt rapid cycle improvement processes including Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to Project Managers. If this method does not lead to improvement, Project Managers will collaborate with implementation partners, the data and learning team, program council, and technical assistance consultants to address implementation delays.

When changes or improvements are identified as necessary by the ACH Data and Learning Team, the North Sound ACH staff will first work to support project implementation teams through internal QI activities, workflow redesign, PDSA cycles, resource allocation, staff training, collaborative conversations across sectors and ACHs, and other forms of assistance to improve performance (Figure 2). Technical assistance, trainings, and other resources will be supplied as needed to partner organizations and individual providers for these additional supports based on data and a deliberative process between North Sound ACH staff, the Data and Learning team, and implementation partners, as well as with feedback from the program council.

Modifications to project plans will occur after the North Sound ACH staff and implementation planning team leads report to the Program Council that a project has gaps, delays, or areas of improvement that could not be solved through other forms of assistance, as described above. North Sound ACH staff, project partners, key stakeholders, and members of the Program Council will deliberate on potential changes to improve project performance and determine whether a program can be adapted or needs to be discontinued. Prior to applying for a project plan modification in these instances, the North Sound ACH will coordinate with the Health Care Authority to identify potential alternative solutions.

Technical Assistance

Potential sources of technical assistance in developing our quality improvement plans, training our teams in continuous improvement, and identifying tracking measures include Qualis Health, Providence CORE, Kaiser Permanente Washington Health Research Institute, the Northwest Center for Public Health Practice, and Managed Care Organizations.

3D: Project Metrics and Reporting Requirements

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

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

YES	NO
XX	

3D: Relationships with Other Initiatives

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

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

YES	NO
XX	

3D: Project Sustainability

The North Sound ACH is committed to working with partners in our region to develop strategies and initiatives that will move the metrics outlined in the Project Toolkit, and achieve long-term sustainability while impacting Washington's health system transformation beyond the Medicaid Transformation Project period. A virtuous cycle results when clinical transformation improves provider performance on clinical quality measures in value based contracts, payers such as Managed Care Organizations reap savings, and reinvestments can be made back into the community, and community-based organizations to address upstream, social determinants of health. To ensure lasting impact, we will optimize project strategies that hold promise for additional financial earnings and substantial buy-in from both clinical and community-based partners. The implementation of projects will foster relationships among partnering providers, so implementation is realized on the regional level and when Medicaid Transformation project funds are no longer available, the relationships and transformative changes will continue.

The North Sound ACH plans to leverage its unique position as a regional convener and facilitator to identify additional long-term supports for transformative changes to our health systems. Whenever possible, the North Sound ACH will seek to braid together DSRIP earnings with other sources, including Managed Care Organization partners. Additionally, philanthropic support and investment from foundations and community development organizations at the local, state, and federal level will be pursued and leveraged wherever possible.

Within the clinical environment, the North Sound ACH will work with partnering providers to foster systems transformation, evidence-based practices, and team-based workflows to drive performance on clinical quality measures and thereby increase reimbursements for value-based contractual agreements, both current and future as the state moves toward HCA goals for increased VBP adoption. Improving utilization of non-clinical staff in the clinical environment can increase the ability to pursue payments for additional services billable to Medicaid, such as those supporting behavioral health practitioners performing assessments or other

interventions. Finally, establishing improved linkages and care coordination between clinical settings and community-based resources can improve patient engagement and satisfaction, also bolstering clinical quality measure performance and subsequent reimbursements. Through the Pathways and other models incentivizing value-based or population health models over fee-for-service models ensures a more holistic approach to achieving health equity in the region.

The North Sound ACH plans to advocate at city, county, and state level for policies that will support this work, and reduce regulatory barriers to successful project implementation. This includes advocacy for policies that impact bi-directional integration and clinical transformation, social determinants of health, such as housing, access to transportation, child care, employment, food access, environmental pollutants, etc. Additionally, the ACH will advocate for changes in programs and policies within partner organizations and systems, to support the implementation of services that support Medicaid Transformation and address health disparities.

Domain 1 areas of Workforce and Population Health Management offer substantial opportunities to assure long-term sustainability and transformation. Training new members of the health workforce (or retraining current members) is an upfront and self-sustaining investment, particularly if partners are able to train staff in-house, building capacity for these providers in the long-term. Supporting implementation of systems for Health Information Technology or Exchange (HIT/HIE), is an up-front investment and will help defray costs over the long term. Additionally, improved interoperability, communication and patient service resulting from improved technology and systems will reduce costs and improve patient satisfaction in the long-term, likewise driving increases in reimbursements for value based contractual agreements.

Specific to Chronic Disease, successful implementation of the Chronic Care Model will yield multiple opportunities for long-term project sustainability. By focusing on team-based care, patient engagement, connection with community-based resources and clinical training on evidence-based practice, clinical partners will improve performance on clinical quality measures for chronic conditions such as diabetes or asthma. This improved performance will generate revenues for these clinical partners and cost savings for Managed Care Organization partners and create opportunities for investment in community based organizations and services to address the social determinants of health.

NORTH SOUND ACH COMPONENTS OF CHANGE

1 Collaboration

Clinical and community providers working together to improve whole person care

2 Evaluation

Growing what works, changing or eliminating what doesn't

3 Innovation

Supporting new and emerging best practices, or making fundamental improvements to current strategies

4 Learning

Collaborative region-wide teams in data, health equity and leadership development

5 Increased Capacity

Strengthen and grow numbers and quality of workforce and data infrastructure to meet needs of regionally diverse populations

6 Policy and Practice Change

Advocacy to change rules and regulations that get in the way of innovation and transformation

7 Community Health Planning

Expand ability to plan and act regionally with health improvement strategies

8 Sustainability

Meet needs downstream, midstream and upstream that result in savings, and deeper partner commitments.

NORTH SOUND ACH COMPONENTS OF SYSTEM TRANSFORMATION

Upstream/Wellness Prevention Strategies

Community-based services that support community members where they live, learn, work and play.

Person Centered Care Coordination

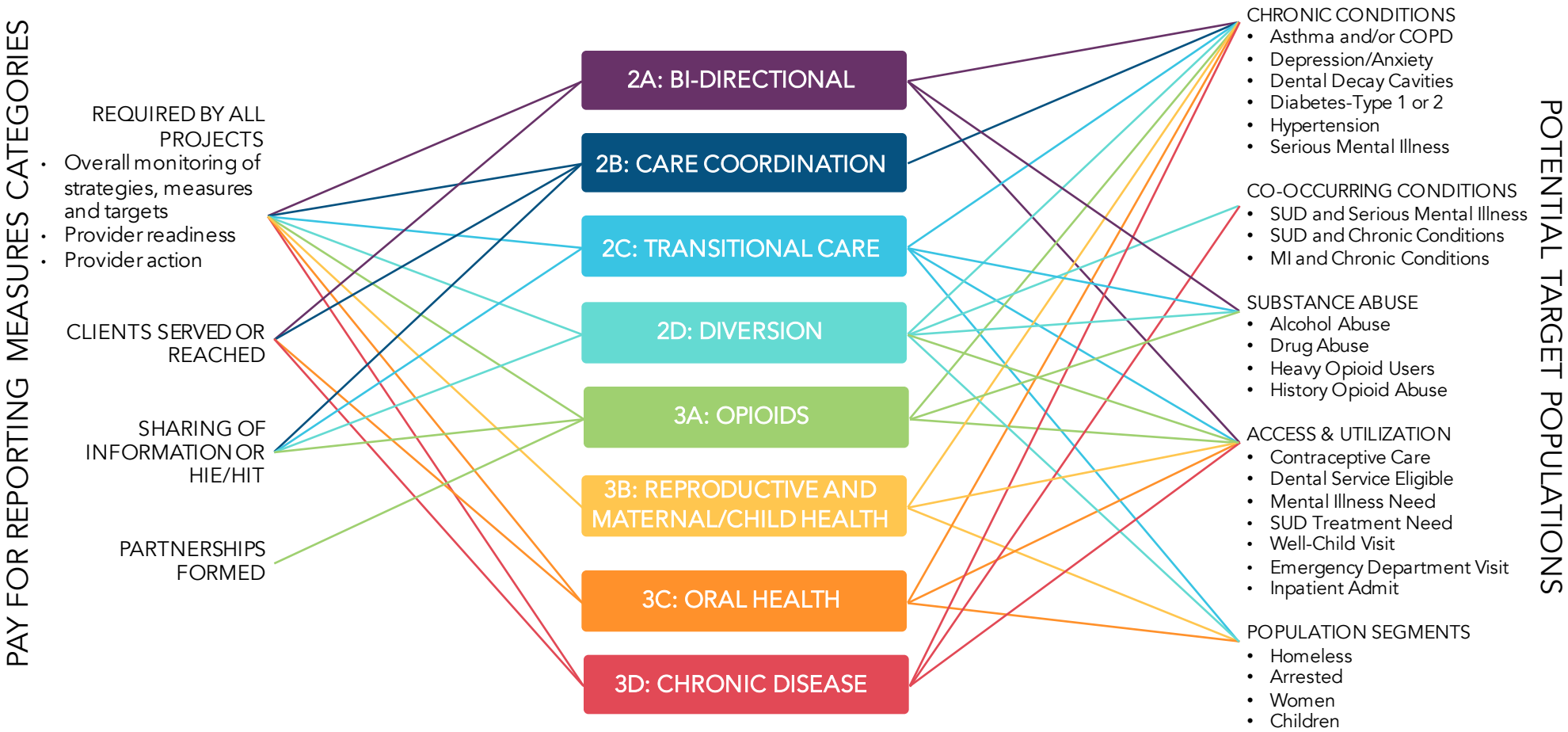
Clinical and community based organizations and services are connected to enhance coordination of care and services around the person and family.

Whole Person Care Delivery

High quality physical, behavioral and oral health care services are available, in the right place at the right time.

NORTH SOUND ACH: CONNECTING THE STRATEGIES TO TRANSFORM CARE AND SERVICES

NORTH SOUND ACH
PROJECT PORTFOLIO ALIGNMENT



NORTH SOUND ACH PROJECT STRATEGY AREAS AND PERFORMANCE METRICS

Person-centered Care Coordination

2B: Pathways Community HUB

2B: PreManage Integration

2B: Health Home Coordination

2C: Enhanced Care Transitions Interventions (CTI) Model

2C: Jail Transitions

2C: Inpatient Mental Health Transitions

2D: Community Paramedicine

2D: Care Coordination Collaboratives for Complex Cross-System Cases

3C: Dental Case Finding and Navigation

Whole Person Care Delivery

2A: Screening (BH/chronic disease)

2A: Brief counseling interventions (BH/chronic disease)

2A: Medication Assisted Therapy (MAT) for depression and opioids

2A: Registry Development

2A: Treat-to-Target

2A: Consultation (medical/psychiatric)

2A: Referral to specialty providers

3A: Screening, Brief Intervention, and Referral to Treatment (SBIRT)

3A: Enhance/expand community recovery services

3A: Mobile treatment and outreach

3A: Improve opioid prescribing practices

3A: Scale up Medication Assisted Therapy (MAT)

3B: One Key Question

3B: Increasing Long-Acting Reversible Contraception (LARC) access

3B: HealthySteps specialists in pediatric practices

3C: Integrating Oral Health in primary care

3C: Dental Health Aide Therapists (DHAT) in Tribal Clinics

3C: ICD-10 coding in oral health

3C: Mobile Hygienists in Community Settings

3C: Silver Diamine Fluoride

3D: Clinical transformation around chronic disease best practices (training, screening, treatment, etc.)

Upstream Wellness /Prevention Strategies

3A: Social marketing and public awareness

3A: Safe medication storage and disposal

3A: Improve opioid prescribing practices

3A: Prevention education for youth

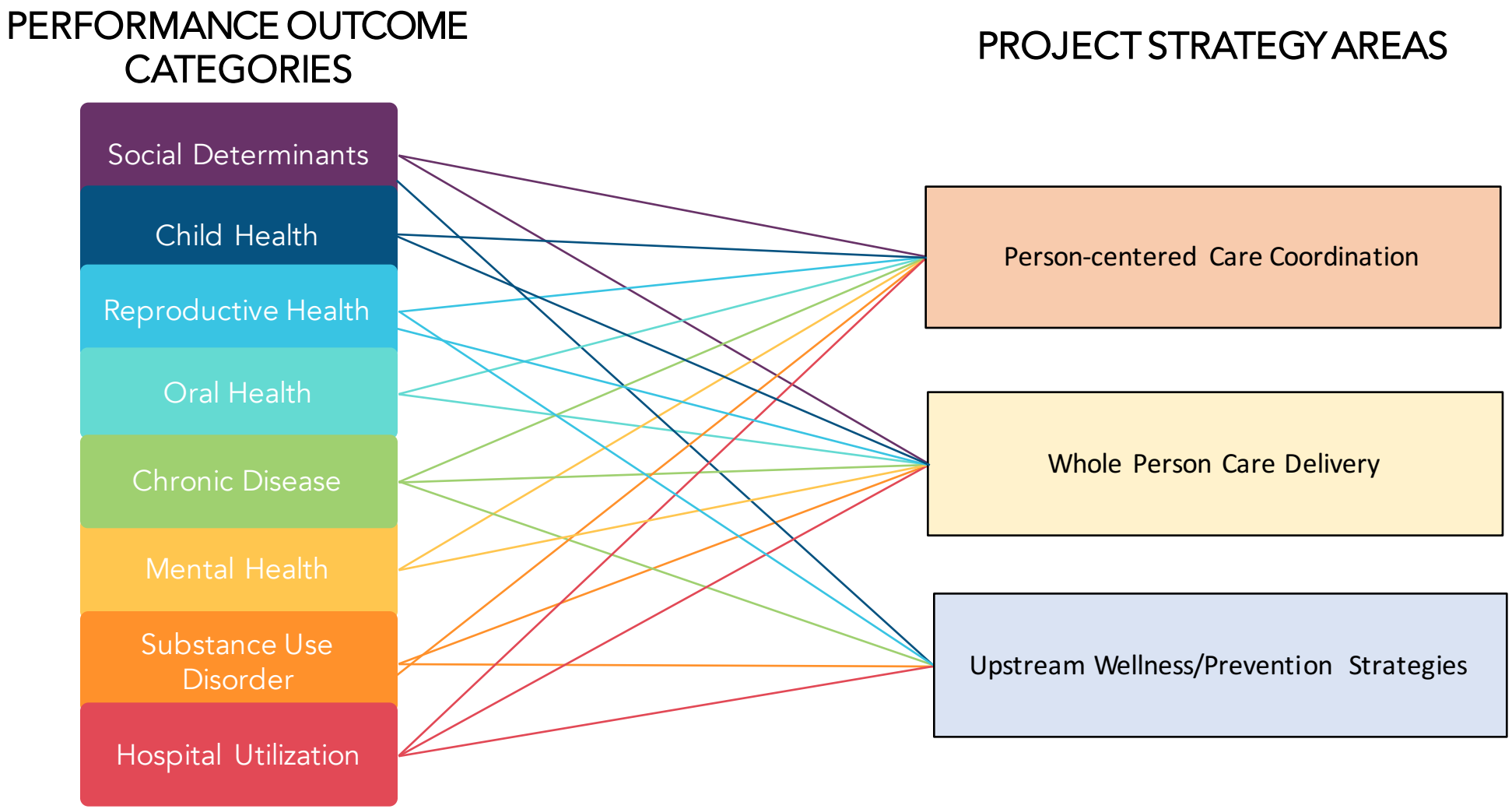
3A: Increase availability and use of Naloxone

3B: One Key Question

3B: Increasing Long-Acting Reversible Contraception (LARC) access

3D: Asthma home-based environmental intervention

3D: Community-based chronic disease prevention and management programs


PERFORMANCE OUTCOME CATEGORIES
Social Determinants
Child Health
Reproductive Health
Oral Health
Chronic Disease
Mental Health
Substance Use Disorder
Hospital Utilization
PROJECT STRATEGY AREAS
Person-centered Care Coordination
Whole Person Care Delivery
Upstream Wellness/Prevention Strategies

NORTH SOUND ACH DOMAIN 1 & PROJECT AREAS: PLANNING PHASE ALIGNMENT

Value-Based Payment

- VBP practice readiness assessment
- Preparing for Fully Integrated Managed Care
- Preparing for Dental Managed Care, i.e. ICD-10 coding in oral health
- Readiness for value-based payments for Care Coordination
- Regional VBP Transition Plan alignment with Project Area Implementation Plans
- MVP Action Team participation and information sharing

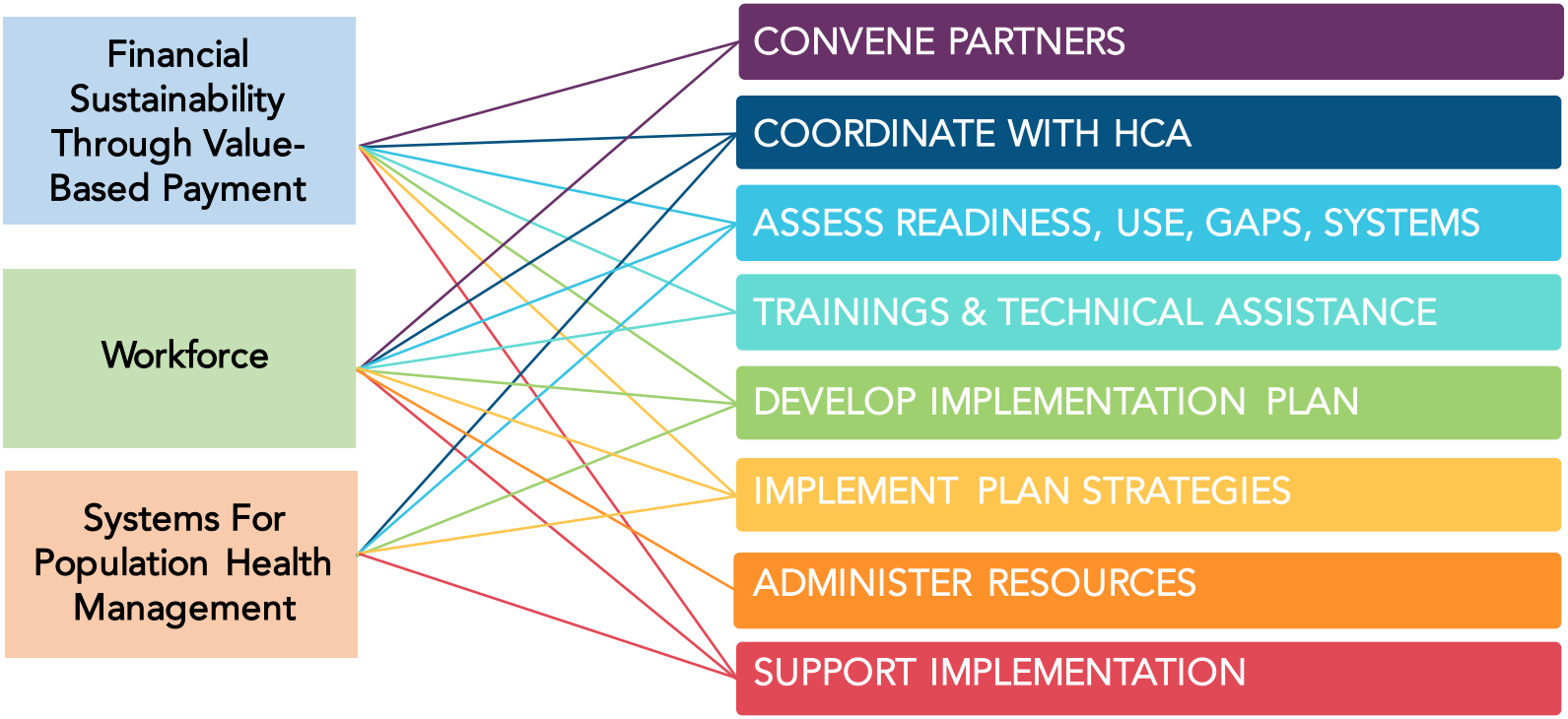
Workforce Development

- Trainings for Community-based care coordinators, Transitions Coaches, Chemical Dependency Professionals, others as identified
- Cultural competency and health literacy trainings
- Workforce gap analysis with regional partners
- Project Implementation Plans include workforce strategies
- Explore telehealth readiness and current state
- Dental Health Aide Therapists (DHAT) workforce pilot with Tribal partners

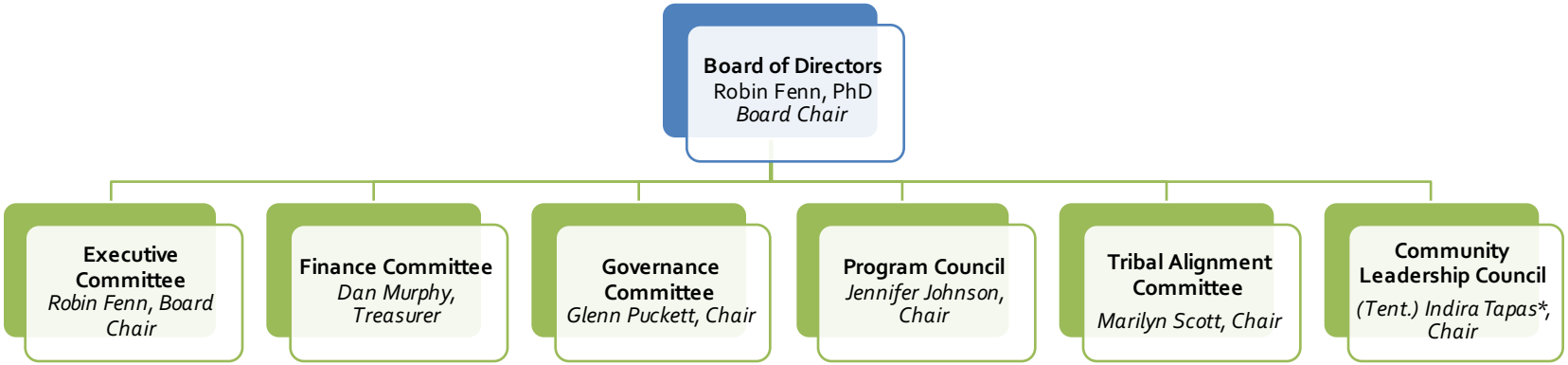
Population Health Management

- Assess provider EHR use and HIE readiness expansion, i.e. PreManage
- Explore state HIE/HIT current use and increase regional adoption, i.e. PMP, WAIIS, EDIE
- Preparing for Registry implementation
- Adopt usage of ICD-10 codes in dental care
- Project Implementation Plans include population health management strategies

NORTH SOUND ACH
DOMAIN 1 ACTIVITY ALIGNMENT



North Sound ACH Board Structure



North Sound ACH

* To be voted on at Dec 2017 Board of Directors Meeting

North Sound ACH

Public ACH-related Engagements or forums May 1 – Aug 31

May 1st	North Sound BHO Advisory Board
May 4th	North Sound ACH Program Council
May 9th	San Juan County CHIC Meeting
May 25th	North Sound ACH Board Meeting
May 25th	North Sound ACH Primary Care Providers
June 1st	North Sound ACH Program Council
June 8th	North Sound ACH Primary Care Providers
June 15th	North Sound ACH Program Council
June 23rd	North Sound ACH Board Meeting
June 23rd	Interlocal Leadership Structure Meeting
July 6th	North Sound ACH Primary Care Providers
July 8th	Island County Community Health Advisory Board
July 20th	North Sound ACH Program Council
July 26th	San Juan Community Network Meeting
July 26th	San Juan Board of Health
July 26th	San Juan Provider / Public Outreach Meeting
July 26th	San Juan Island Hospital District Board Meetings
July 28th	North Sound ACH Board Meeting
August 1st	Behavioral Health Advisory Committee
August 2nd	North Sound ACH Primary Care Coalition
August 3rd	North Sound ACH Program Council
August 3rd	Whatcom County Health Department Community Café
August 9th	Interlocal Leadership Structure Meeting
August 15th	Snohomish County Community Advisory Council
August 15th	Chasing Heroin Film Screening
August 16th	Whatcom County Health Department Community Cafe
August 21st	Women's Advocacy Group
August 25th	North Sound ACH Board Meeting
August 25th	Project Homeless Connect
August 29th	Interlocal Leadership Structure Meeting

North Sound ACH

Public-facing North Sound ACH Community Engagement since Sept 1

Date	Event	Purpose
9/5/17	BHO advisory committee presentation	Public education and communication and integration of community feedback especially those advisory council members on Medicaid
9/7/17	Whatcom Prevention Coalition Meeting	Develop and foster relationships with partners and stakeholders
9/7/17	Kendall-Maple Falls Community Council	Develop and foster relationships with partners and stakeholders
9/8/17	Health & Transportation Workshop	Develop and foster relationships with partners and stakeholders
9/11/17	Radio interview	Public education and communication and integration of community feedback
9/13/17	Columbia Valley Community Association	Public Education and develop and foster relationships with partners and stakeholders
9/13/17	South Forks Valley Community Meeting	Public Education and develop and foster relationships with partners and stakeholders
9/14/17	Latino Advisory Council-Mt Vernon	Public Education and develop and foster relationships with partners and stakeholders
9/14/17	Island County Community Resource Network	Public Education and develop and foster relationships with partners and stakeholders
9/15/17	Northwest Youth Services Housing: Groundbreaking ceremony	Develop and foster relationships with partners and stakeholders
9/18/17	North Sound ACH Community Leadership Council	Community participation in governance & Program Oversight
9/21/17	Community Resouce Network-Whatcom County	Public Education and develop and foster relationships with partners and stakeholders
9/21/17	Opioid Forum	Public education and communication and integration of community feedback
9/25/17	Practice Transformation Hub Conference: Western WA: Steering Toward Success: Achieving Value in Whole-Person Care	Identify stakeholders
9/26/17	Early Learning Leadership Brunch	Public Education and develop and foster relationships with partners and stakeholders
10/2/17	EDIE/Premanage Learning Collaborative	Identify stakeholders
10/3/17	Lummi Nation Salish Sea Series	Develop and foster relationships with partners and stakeholders
10/7/17	NAMI Stigma Stomp	Public education and communication and integration of community feedback
10/9/17	Indigenous Peoples Day Celebration-Lummi Nation	Develop and foster relationships with partners and stakeholders
10/10/17	YMCA - Collaborating for Community & Clinical Linkages	Develop and foster relationships with partners and stakeholders and public education and communication
10/12/17	Latino Health Forum	Develop and foster relationships with partners and stakeholders and public education and communication
10/12/17	Island County Community Resource Network	Develop and foster relationships with partners and stakeholders and public education and communication
10/15/17	Unity Care NW Gala	Foster relationships with partners
10/16/17	Washington State Public Health Association Conference	Develop and foster relationships with partners and stakeholders and public education and communication
10/16/17	North Sound ACH Community Leadership Council	Community participation in governance & Program Oversight
10/17/17	Washington State Public Health Association Conference	Develop and foster relationships with partners and stakeholders and public education and communication
10/18/17	Latino Advisory Council-Mt Vernon	Develop and foster relationships with partners and stakeholders and public education and communication
10/25/17	2017 Regional Opioid Summit	Develop and foster relationships with partners and stakeholders and public education and communication
10/28/17	National Drug Take Back Day	Develop and foster relationships with partners and stakeholders and public education and communication
11/1/17	NW Senior Services Advisory Board Presentation	Develop and foster relationships with partners and stakeholders and public education and communication

Behavioral Health - HC integration

1. yes! SeaMar worked, positive
   - agency vs. provider (indiv) - distinction
   - who does provider/agency see the most?
   - team approach to be effective
   - primary care provider as care coordinator
   - concern about primary care provider (person) helping w/ BH needs (training)

Opioids

1. Barrier - lack of Beds - Spokane for treatment - how do we address
2. Co-occuring disorders - underlying behavioral he issues → why they are using.
   - probation officers - partner
3. waitlists. weak links - transitional/counseling, bed
4. get to core of issue. $: fill gaps first, communitu ACTION

Care Coordination

1. $ for workforce? training, capacity
2. HIT - Epic?
3. community Health workers - need to be from communities - neutral, bias

Notes from North Sound ACH Community Engagement Session

Authentic Community Engagement as North Sound ACH

People

+: consumers,

-: missing voices,
Rural vs. urban
Being only PoC
· singled out
Hidden networks
· Comm. trust

· Documentation

· Trauma: yes
· pop/indiv.

· Different views of this engagement/ experiences w/ engagement

Place

· safety of communities represented authentically
· lead w/work on standards of emotional, physical safety
· Work w/comm. partners who know this already
· Geographic isolation
· Env. impact on CoC living rurally
↳ but resources concentrated urban

Process

·

Power

· No one talks about race
· Who leads the conversation?
↳ trust
· Emotional impact of systematic process
· Need to get buy-in (barrier) for inst. change
→ implies people aren't already bought in
· Benefit: comms feel empowered, ownership
· Burden: repping whole comm.
· Accountability: ?
· Decision-making: CLC? BOD?

North Sound ACH Community Leadership Council
Minutes of meeting of October 16, 2017
Burlington Library - Rotary Community Room
Google Maps link: https://goo.gl/maps/iAMRLi8C2FG2
12:00pm-2:00pm

12:00-12:15	Food/Socializing/ Networking Guests: Harriett Markell-retired from public mental health system in WA and California Pat O'Maley-Lanphaer- NSBHO Advisory Board
12:15-12:25	Welcome and Meeting Agenda
12:25-01:15	The Community Leadership Council Charter ● Background -With a few small changes to the wording, team accepted background statement as written ● Purpose -It was decided the purpose needs to be more specific. Perspectives instead of perspective. Bullets instead of paragraph format. CLC members agreed to create a separate workgroup to flush out the details of the purpose and scope section. ● Responsibilities -Very well detailed, the group suggested adding examples for further clarification ● Charter -In general the CLC seemed to agree with the content of composition and responsibilities ● What's next?

-Send a call out to all CLC workgroup members to discuss the details of the Purpose and Scope to bring to the CLC.
-Bio or background as attachment with this CLC charter submission. 200 word max bio added to that survey.
-Send list of program council and board of directors
-Invite Liz to speak on her vision for the Council within the governing structure of the CLC
-Get an organizational chart that includes the CLC
-Connect Natasha and Jim Bloss
-Add Official voting mechanism and norms (equity) lens to the next agenda

01:15-01:55 The Medicaid Demonstration

- Review Project Areas and suggested demonstration projects

- Reviewed basic project area descriptions
- Review project approaches
-The CLC coordinator will create a survey for all CLC members
-The survey should include project: areas of interest, area of experience, possible idea(s) for additional partners, training needs (as they relate to project area content), and a brief bio (200 words or less)

01:55-02:00	Public Comment ● Meeting Date/Time -In 2018 the CLC will experiment with traveling meeting dates and times throughout the North Sound to allow for more public input opportunities

NORTH SOUND ACCOUNTABLE COMMUNITY OF HEALTH

PLAN FOR COMMUNITY ENGAGEMENT

Introduction

The Board of the North Sound Accountable Community of Health (North Sound ACH) approved development of a plan to actively involve those enrolled in Medicaid in the North Sound ACH activities.

Definitions

For purposes of this Community Engagement plan, the term "community member" is intended to include those individuals who are, have been, or based on their history may become eligible for health coverage under Medicaid, CHIP, or Medicare. While the range of community members included in this plan is broader than the Medicaid Transformation Project period, it is also valuable to include those who have received Medicaid health coverage in the past, those who have or have had difficulty navigating the healthcare system, those who have experienced qualifying life experiences including: homelessness, victims of violence, substance use, mental illness and those from populations inequitably served by the healthcare system.

Similarly, the term "community engagement" used in this plan is inclusive of stakeholders but should not in it's entirety include only "*stakeholder* engagement," which tends to result in the involvement of intermediary stakeholders who themselves interact with the actual consumers of health care services. This plan recognizes the considerable value of community stakeholders' participation in North Sound ACH activities and even in helping to articulate certain consumer needs, but holds that stakeholder representation by itself is not an adequate conduit for the kind of consumer engagement that North Sound ACH needs or wants.

Elements of Community Engagement

The North Sound ACH commits to undertake the following strategies to involve people with Medicaid coverage in its governance, planning, programs, and services. Further planning with the Community Leadership Council will determine the sequence, timing, scope, and organizational resources appropriate to these steps.

Community Member Participation in Governance and Program Oversight
Based on the identification and recruitment of community members, the North Sound ACH will approve the formal participation of one or more community members as members of the Board of Directors. North Sound ACH will also explore the feasibility of

maintaining additional layers of consumer participation, including but not limited to the Program Council and Community Leadership Council.

Training, Support, and Accommodations
The North Sound ACH will plan and implement training sessions that prepare community members who become (or express interest in becoming) involved in governance activities. The North Sound ACH will provide appropriate accommodations to participating community members. Such accommodations may, for example, require changes in schedule of North Sound ACH meeting times, provide stipends for travel or childcare, have interpreter services available for North Sound ACH activities, and/or arrange for on-site childcare during meetings.

Public Education and Communication
The North Sound ACH recognizes the continuing need to inform and update the public about the North Sound ACH itself and its work. The elements of this commitment will include, but are not limited to, presentations to community-based organizations and groups who directly interact with people enrolled in Medicaid; North Sound ACH sponsorship of community forums inviting dialog with community members; communication strategies to provide updates, survey community members, and request community input. The Community Leadership Council will be active in planning and conducting education, communication, and media initiatives, and these efforts will be conducted so that additional potential participants can be identified and involved in the future as appropriate.

Integration of Community Feedback
The North Sound ACH is committed to using community feedback throughout its programs, operations, and decision-making. Community related feedback includes aggregated data available to the public, personal accounts and opinions offered by individuals or groups, and other input that reflects consumer viewpoints on matters relevant to activities. The North Sound ACH accepts a responsibility to seek out and develop community feedback if such information is not already available.

Periodic Evaluation and Improvement
The North Sound ACH accepts community involvement as a central value for the organization, therefore the North Sound ACH obligates itself to evaluate its engagement activities at least every 12 months and to make changes in this plan and/or its implementation on an ongoing basis that are necessary to ensure meaningful engagement.