



Healthier Washington Medicaid Transformation  
North Sound Accountable Community of Health

*Semi-annual Report 4.0*

*Reporting period:*

*July 1, 2019 – December 31, 2019*

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## Table of contents

ACH Contact information.....	1
Section 1. ACH organizational updates .....	2
Attestations.....	2
Attachments.....	3
Documentation .....	3
Section 2. Project implementation status update .....	6
Attachments.....	6
Documentation .....	7
Narrative Responses.....	16
Attestations.....	41
Section 3. Value-based Payments.....	42
Narrative responses.....	42
Section 4. Pay-for-Reporting (P4R) metrics .....	46
Documentation .....	46

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## ACH Contact information

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## Section 1. ACH organizational updates

### Attestations

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

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

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

## Attachments

### 9) Key staff position changes

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

**Response:**

North Sound ACH added **Attachment A, Updated Organizational Chart**, with staffing changes noted.

### 10) Budget/funds flow

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

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

**Response:**

The North Sound ACH has no additional clarifying comments to add to this question about the report from the Financial Executor portal but is happy to respond to any questions about the North Sound ACH activity as it is reported via the FE Portal report.

## Documentation

The ACH should provide documentation that addresses the following:

### 11) Tribal Collaboration and Communication

Provide two examples that demonstrate how the ACH furthered the relationships with Tribes and Indian Health Care Providers (IHCPs) with whom the ACH shares the region.

**Response:**

North Sound ACH has continued to work and further relationships with the Tribes and Indian Health Care Providers with whom our ACH shares a region. Two examples that demonstrate the continued work include:

- 1) The North Sound ACH October board meeting was hosted by the Didgwálic Wellness

Center, on Swinomish Indian Tribal Community land. The CEO of Didg<sup>w</sup>álič Wellness Center provided a presentation of the work they have provided to the North Sound region. At the end of the meeting, board members from two counties offered potential funds and resources to support the Didg<sup>w</sup>álič Wellness Center, recognizing the center serves patients and families from across the region.

2) North Sound ACH currently has seven of the eight tribal seats filled. We now have a connection to the new clinical director at Stillaguamish, who is working to get a Council appointment to our Board of Directors and the Tribal Alignment Committee. With that Committee’s support the ACH team is working with the tribes, and tribal liaisons from HCA and the five MCOs to mapping how the North Sound tribes could more effectively interact with state partners.

**12. Design Funds**

- a) Provide the ACH’s total Design Fund expenditures to date and an outline of how those funds have been used, by Use Category or other ACH-specific identifiers.
- b) If the ACH has not expended the full amount of earned Design Funds, describe the planned use for these funds. ACHs may identify future expenditures by Use Category, or other ACH-specific identifiers.

**Response:**

North Sound ACH has not expended any dollars from the Design Fund during this reporting period, although the use category balances have been updated since the January 2019 Semi-annual Report, due to funds re-classified during the 2018 Financial Audit. Please see **Attachment B, Design Funds Summary**. The Board of Directors will consider use of the available Design Funds during its annual fund allocation decision making process.

**13. Incentives to support integrated managed care.** Regardless of integrated managed care implementation date, provide the following information regarding ACH incentives to support behavioral health providers transitioning to integrated managed care. Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.

**Response:**

Use of incentives to assist Medicaid behavioral health providers		
Description of Use	Expenditures (\$)	
	Actual	Projected

Consultant (XPIO) who worked with BHAs to identify resource needs for IMC readiness	\$553,320	\$553,320
BHO contract to support \$ for BHAs with IMC readiness assessment and implementation	\$5,936,049	\$5,936,049

## Section 2. Project implementation status update

### Attachments

#### 14. Implementation work plan

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

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

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

provide an orientation to the changes. All required elements of the work plan must be preserved.

***Submit updated implementation work plan that reflects progress made during reporting period.***

Response:

North Sound ACH has added Attachment C, Updated Implementation Plan.

### **15. Partnering provider roster**

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

***Submit updated partnering provider roster.***

Response:

North Sound ACH has added Attachment D, Partnering Provider Roster.

## **Documentation**

### **16. Quality improvement strategy update**

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

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

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

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

For this recurrent reporting requirement, HCA does not require that ACHs report site/provider organization-level quality improvement data. HCA will rely on these updates for evidence of

forward momentum, including evidence that partnering providers have the resources and support required for success.

***Attach or insert quality improvement strategy update.***

**Response:** North Sound ACH is inserting the quality improvement strategy update here.

**Modifications to the North Sound ACH Quality Improvement Strategy:**

There were no structural modifications to the North Sound ACH Quality Improvement Strategy during this reporting period. North Sound ACH continues to use the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles to monitor partner progress and identify delays in implementing transformation approaches or needs for technical assistance. North Sound ACH identifies the following activities in accordance with the regional quality improvement strategy and tests implementation using the PDSA cycles described below:

- **Plan:** Partners planned and committed to transformation approaches as indicated by their scope of work and in the Change Plan.
- **Do:** Partnering providers are currently in the implementation stage of the Medicaid Transformation Project. North Sound ACH has identified the implementation stage as the “Do” cycle of the PDSA model. In order to move to the next PDSA cycle, North Sound ACH staff begin studying or analyzing partner reporting to identify delays in implementation or needs to technical assistance and support. Partners were required to complete reporting for the May 1, 2019 to September 30, 2019 reporting period. Partners completed reporting through the HealthcareCommunities.org portal.
- **Study:** All partners (100%) completed the reporting through the partner portal for the first reporting period. North Sound ACH staff conducted a qualitative analysis of partner reporting, along with conducting site visits in July 2019, to understand what implementation strategies are working well, which partners are experiencing delays, and partners requests for technical assistance/training and support. Partners were directed to select “delayed” while reporting on each implementation strategy in order to indicate to ACH staff that they needed technical support or resources.
- **Act:** Partner reporting provides the information necessary for North Sound ACH staff to help address barriers and delays in implementing transformation strategies. After studying reporting submitted by partners for the first reporting period, North Sound ACH have learned specific needs and requests for support specific to each individual partner. Partners indicated needs and delays while providing requests for assistance from North Sound ACH staff. North Sound ACH staff acted by responding to those needs with a variety of tools, resources, and support.

Based on the premise of continuous quality improvement, the North Sound ACH is using several methods to track progress within Medicaid transformation activities. The activities designed to support partner implementation progress include:

- Partner providers semi-annual reporting
- The North Sound ACH project team conducts a qualitative analysis of reporting data to identify TA requests or delays indicated by partners in the reporting process.
- Designated Project Managers document partner site visits using a qualitative data collection method including note taking/storytelling
- Tracking mechanism to track partner delays, successes, collaboration, similar strategies
- North Sound ACH tracks partner email requests for assistance using a central team@northsoundach.org email to communicate partner needs in a timely manner
- Evaluations of all ACH partners events to track areas for improvement
- Evaluations of ACH weekly webinars using polling questions to improve content
- A third-party evaluator has been contracted to design an evaluation plan intentionally aligned with partner reporting guide and regional CQI framework

### **Summary of Findings, Adjustments, and Lessons Learned**

For the reporting period, North Sound ACH asked partners about their progress on the use of continuous quality improvement strategies to determine a baseline for measuring progress in this area through this and future reporting periods.

North Sound ACH partners were required to complete reporting for the period May 2019 through September 2019 by end of October 2019. Partners completed reporting through the HealthcareCommunities.org portal. All partners (100%) completed reporting with 100% submitting reporting on-time (up from 96% during the last reporting period).

Results:

- Previous SAR: January 1 - March 31, 2019 Reporting Period:
  - Partners committed to a total of 6,496 milestones or transformation approaches
  - Of the 6,496 milestones, 386 or 5.9% were reported to be “delayed” or “not-started”
  - A total number of 47 partners (96%) submitted reporting on-time
- Current SAR: May 1 - September 30, 2019 Reporting Period:
  - Partners committed to a total of 6,693 milestones or transformation approaches

- Of the 6,693 milestones, 187 or 2.8% were reported to be “delayed” or “not-started”
- A total number of 49 partners (100%) submitted reporting on-time

Partners who committed to “Addressing the Opioid Crisis” strategies (North Sound ACH strategies 2.1, 2.2, 2.3, and 2.4) were also required to complete an additional survey for their organization; partners who committed to Bi-Directional Integration strategies (North Sound ACH strategies 3.1 and 3.2) were required to complete one MeHAF SSA Survey for each site working on bi-directional integration.

Reporting in the partner portal consisted of two parts: change status reporting on milestones and selection of tactics for each strategy committed to, and open-ended narrative responses by initiative. As outlined in the Partner Reporting Guide, and in alignment with the PDSA cycles, questions were scored based on completeness. Reporting was considered complete if all requested information was provided in sufficient detail for the North Sound ACH to monitor a partner’s progress toward their committed scope of work.

Reporting of progress is a requirement for all partners committed to Medicaid transformation projects with the North Sound ACH. North Sound ACH’s monitoring includes a combination of partner reporting activities related to:

- Change Plan progress, process and implementation needs
- Regional progress related to addressing the opioid crisis, physical and behavioral health integration, and value-based payments through statewide surveys
- Site visits and assessments to support partner implementation, learning and collaboration.

In addition to monitoring the region’s progress, information reported by partners assists North Sound ACH in developing technical assistance resources, supporting partners’ continuous quality improvement, and identifying needs and barriers as they arise.

A key finding from the first reporting period was that partners requested more opportunities for cross-sector collaboration and a way to learn about which partners are implementing similar transformation approaches. North Sound ACH responded to this request by creating a directory for partners illustrating which partners are committed to and working on strategies and implementation tactics. In addition, North Sound ACH hosted a partner retreat on August 7, 2019 which provided a full-day dedicated to partner collaboration and coalition building. The agenda featured activities to connect partners and provided a platform for partners to share successes and implementation stories. These adjustments allowed partners who are working on the same strategies to be strategically connected to build collaboration groups and focus on practical tools for sustaining those relationships.



## Support Provided to Partnering Providers to Make Adjustments to Transformation Approaches

North Sound ACH staff support partnering providers to make adjustments to transformation approaches by reviewing reporting to identify delays and requests for technical assistance, and conducting site visits to discuss delays and better understand reported barriers. North Sound ACH addresses barriers reported by providing evidence-based resources and technical assistance including:

- Briefs, resources, and toolkits on evidence-based models and best practices on the partner portal.
- Coordinating events for partners that allow for cross-collaboration and networking opportunities
- Hosting a weekly webinar learning series
- Assigning project managers to guide partners through implementation

### Examples of Support:

1. Partner reporting: twice annually, the North Sound ACH requires partners to report on the progress they have made toward implementing strategies they committed to. This includes information on tactics they are using to implement these strategies. In reporting, there are also a wide range of open-ended questions that allow partners to reflect on success, barriers, challenges, and next steps. This information provides ACH staff with information needed to lend extra support to partners, identify areas for collaboration, and identify cross-region technical assistance needs. Partners are required to answer questions around quality improvement readiness and address current progress on implementing quality improvement tactics at the organizational level. Partners were asked to identify if quality improvement tactics were delayed, in-progress, or full implemented as well as identify needs for technical assistance.
2. Data webinars: As a part of a weekly webinar series, the North Sound ACH included a monthly data learning series. This data webinar series was hosted for partners and connected data at the North Sound regional level and the county level with North Sound ACH partner commitments. This allowed us, among other things, to review how data relates to the Medicaid Transformation Project and the accountability framework embedded within it. We were also able to review various data dashboards offered by Healthier Washington, including Analytics, Research, and Measurement dashboards.
3. Site visits: Each contracted ACH partner in the North Sound region is assigned a project manager who supports that partner with implementation initiatives. At least once per year, the assigned project manager does a site visit with their assigned

ACH partners. This visit allows for staff to build relationships with partners, identify areas of strength, and areas where support is needed.

Partners requested training in continuous quality improvement and clarification around requirements of the ACH for partnering providers implementing quality improvement strategies. Partner progress in implementing quality improvement strategies varied across all providers. When asked questions around implementing quality improvement tactics, partners reported the following:

- Tactic: Assess and report the state of the organization's quality improvement capacity, including workforce trained, quality improvement tools and methodologies in use, quality improvement (QI) specific policies and procedures.
  - 69.7% reported that they were in-progress or have fully implemented this tactic.
- Tactic: Staff are trained in quality improvement methodologies.
  - 66.3% reported they were in-progress or fully implemented this tactic.
- Tactic: Utilize direct transformation coaching when appropriate and/or available
  - 57.8% indicated they were in-progress or had fully implemented this tactic.

To respond to varying stages of progress reported by partners, North Sound ACH provided a Quality Improvement training for partners during the partner retreat as well as a two-part webinar series scheduled in September to help partners address CQI for the reporting period ending October 30, 2019.

North Sound ACH partners were required to complete reporting for the May 1, 2019 to September 30, 2019 reporting period. Partners completed reporting through the HealthcareCommunities.org portal. Partners response time increased to 100% with all partners submitting required reporting on-time for the May 1 - September 30, 2019 reporting period. The total number of milestones or transformation approaches increased with the total number of areas marked as "delayed" or "not started" decreased from 5.9% to 2.8%.

#### **Identified Best Practices on Transformation Approaches:**

This section will identify best practices used to support partnering providers and promote achievement of transformation outcomes and objectives.

North Sound ACH uses the Knowledge-to-Action (KTA) model to identify best practices on transformation approaches. According to the model, best practices around implementation strategies are considered to be:

- Evidence-based
- Being implemented as intended

- Being evaluated
- Being sustained

Activities adopted under the KTA model by North ACH are aligned with best practices and evidence informed theory include:

- Cross-sector partnerships across the North Sound ACH region and potentially across all ACH partnering providers.
- Creating learning collaboratives including webinars and opportunities for partnering providers to build and sustain coalitions among those working on similar implementation strategies. Promoting train-the-training opportunities and North Sound ACH and partnering-provider levels.
- Conducting ongoing trainings
- Distributing evidence-based resources and educational materials to inform the workforce on the frontline working to implement transformation approaches.
- Peer mentorship

The KTA model provides a platform for North Sound ACH staff to monitor partner reporting to identify indicated barriers or delays to implementation strategies. Once barriers or delays are identified, partners are provided with evidence-based resources to adjust or change the implementation strategy to optimize transformation approaches so that regional population health determinants reflect goal attainment.

## Narrative Responses

### 17. General implementation update

*Description of training and implementation activities:* Implementation of transformation approaches requires specific training and activities. Across the project portfolio, **provide three examples of each of the following:**

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

#### Response:

The North Sound ACH has provided training and technical assistance to partners on a wide range of topics and in a variety of methods. The following are three examples of technical assistance provided to partners of the North Sound ACH:

- 1) Equity and Tribal Learning Series: All partners are required to attend sessions of the Equity and Tribal Learning Series. The first of these events was May 2019, followed by a half-day in August 2019. The next is scheduled for January 2020. This series helps partners understand the role we all play in making our communities healthier by providing care and services using concepts underscored by Targeted Universalism. The event in May 2019 featured John A. Powell from the Haas Institute at UC Berkeley. His keynote address focused on Othering and Belonging and Targeted Universalism. Children of the Setting Sun Productions also presented at the May 2019 Equity convening and addressed tribal sovereignty, the importance of culturally relevant services for tribal communities, and issues facing tribal communities today.

Several gaps have been identified since launching the learning series. Some partners lack understanding of equity issues and how they manifest in their own organizations, and have requested a very baseline introduction to the topic. Not everyone in the North Sound region shares a common understanding of the terms and vocabulary used in discussing structural racism and social determinants of health. In addition, partners have expressed appreciation for the training **and yet** have stated that they are unclear how to bring the knowledge back to their respective organizations. These gaps will be addressed at future Equity and Tribal Learning series events.

- 2) Six Building Blocks Model: The North Sound ACH hosted Dr. Laura-Mae Baldwin and

Brooke Ike from the University of Washington for a Six Building Blocks (6BB) webinar for partners in August 2019. This webinar helped partners understand the basic mechanisms of the model, and whether or not this model was appropriate for their clinics and their approaches to opioid work. Following the webinar, North Sound ACH co-facilitated a meeting of partners committed to the Six Building Blocks model in December 2019, along with partners who were not committed to the tactic, but for whom the model might be applicable. At this convening, partners discussed different ways that our region may be able to best implement the 6BB Model, including a discussion of barriers and facilitators to implementing the model.

The most pressing gap remaining in the implementation of the 6BB is the training of one or multiple practice facilitators for the North Sound region. The University of Washington has received funding to provide free practice facilitator training, which ACH partners plan to take advantage of in the first quarter of 2020. A practice facilitator is a required component of the 6BB mode; therefore, only a small amount of progress can be made toward implementing the model without trained practice facilitators in the region.

- 3) **LGBTQ Competency:** The North Sound ACH hosted an informational webinar for partners in July 2019 about the Q Card, which is a communication tool designed to empower LBGTO youth and educate healthcare providers. Along with space for users to fill in their sexual orientation, gender identity, and gender pronouns, the Q Card also offers information for providers on how to provide more sensitive care to queer youth, and lists a number of documented health disparities in the LGBTQ community.

Two specific gaps exist in supporting partners in developing LGBTQ competency: 1) gaining consistency in collecting Sexual Orientation/Gender Identity (SOGI) data; and 2) helping partners understand how to put into practice queer competency information to trauma-informed practices, including updating intake forms. The North Sound ACH intends to provide more training for partners on these specific topics in 2020.

In 2020, the North Sound ACH plans to launch a “TA Bank” that will provide partners access to contracted quality improvement and technical assistance consultants on topics like equity, specific evidence-based practices, and Medicaid billing.

Across the project portfolio, **provide three examples of:**

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

**Response:**

- 1) For project 2B, the North Sound ACH is using Care Coordination Systems (CCS) to connect the three Pathways HUB Care Coordination Agencies (CCAs). Referrals into the system from partners are transmitted to the HUB to verify eligibility and assign CCAs and reviewing the community health worker use of pathways, checklists and tools across the platform. While the system allows for communication between the HUB and CCAs and allows for communication back to referring agencies to close the referral loop, it doesn't communicate with other sectors or service providers.

The North Sound ACH is exploring a connection between CCS and Dentist Link (a tool created by the Arcora Foundation) to support oral health referrals by community health workers to start connecting this system to other sectors. The CCS system used in the Pathways HUB allows the North Sound ACH to increase access to care in the region and reach out to underserved and rising risk populations. This system helps the ACH to see different social and clinical needs based on the Pathways and Tools utilized, which will be included in analysis of regional health equity in the future.

- 2) Partnering providers are expanding the use of the Collective Medical platform for getting information on emergency system use and medical hospitalizations. This information is being used for transitions of care (2C) and diversion activities (2D) by partners. While this information is useful, the system could be utilized more in ambulatory care and behavioral health agency clinical environments.

The North Sound ACH is participating in a cross-ACH workgroup to explore the use of the Collective Medical platform as a shared care planning tool between these sectors.

- 3) ACH Health IT Strategy. All ACH Executives are collaborating to develop an ACH Health IT Strategy comprised of a vision for health IT in Washington, goals and recommendations, and near-, mid-, and long-term ACH activities.

The ACHs collectively developed and agreed upon the following vision for health IT in Washington:

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

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



Across the project portfolio, **provide three examples of:**

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

**Response:**

The North Sound ACH has established the following mechanisms for coordinating care management and/or transitional care plans with related community-based services:

- 1) The Community Resource Paramedicine (CRP) program is growing in the North Sound region. Several partners developing and implementing CRP programs have worked to embed themselves within tribal communities. One EMS leader had the opportunity to discuss Community Paramedicine with state officials and described barriers to CRP in existing RCWs and WACs. Work to address barriers in the RCWs and WACs could provide a smoother approach for care coordination initiatives.
- 2) In early development of North Sound Opioid Local Impact Network (LIN) anchor strategies, partners identified 'Transitions after Incarceration and Hospital stays' as one area of focus for the Opioid LIN. Some of this work already exists in the North Sound region through cross-sector care collaboratives focused on high utilizers like GRACE (Ground-Level Response and Coordinated Engagement) in Whatcom County and CHART (Chronic-Utilizer Alternative Response Team) in Snohomish County. The Opioid LIN will convene partners to collaborate on improving care coordination efforts in the North Sound region as it relates to supporting individuals using opioids.
- 3) In December 2019, the North Sound ACH convened partners working on varied care coordination strategies, including those committed to 1) the North Sound care coordination HUB, 2) Acute Care Transitions, 3) Transitional Care After Incarceration, 4) Emergency Department Diversion, and 5) Cross-sector Care Coordination and Diversion Collaboratives. Partners committed to these strategies discussed their successes and challenges, created partnerships to help address those challenges, and identified a need to have a follow-up meeting that included Medicaid managed care plans.

Across the project portfolio, **provide three examples of:**

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

**Response:**

The North Sound ACH has used the following three rapid-cycle quality improvement processes which were developed to monitor performance, provide feedback, implement changes, and track outcomes:

- 1) **Partner reporting:** twice annually, the North Sound ACH requires partners to report on their progress toward implementing the strategies they committed to. This includes information on which tactics they are using to implement these strategies. In reporting, there is a range of open-ended questions that allow partners to reflect on success, barriers, challenges, and next steps. This information provides ACH staff with information needed to lend extra support to partners, identify areas for collaboration, and identify individual and regional technical assistance needs.
- 2) **Data webinars:** As a part of our weekly webinar series, the North Sound ACH included a monthly data learning series. This data webinar series was hosted for partners and connected data at the North Sound regional level and the county level with North Sound ACH partner commitments. This allowed us to review how data relates to the Medicaid Transformation Project and the accountability framework embedded within it.  
  
We were also able to review with partners various data dashboards offered by Healthier Washington, including Analytics, Research, and Measurement dashboards.
- 3) **Site visits:** Each contracted ACH partner in the North Sound region is assigned a project manager who supports that partner with implementation initiatives. In addition to regular contact by email and phone, at least once per year, the assigned project manager does a site visit with their assigned ACH partners. This visit allows for staff to build relationships with partners, and identify areas of strength and areas where support is needed.

**For Project 2A,** provide a summary of financial resources provided to participating providers and organizations to offset the costs of infrastructure necessary to support integrated care activities.

**Response:**

North Sound ACH is using the Pathways model to implement its Care Coordination HUB, and the affiliated software of Care Coordination Systems to track clients and progress. We do not have our Hub branded as a Pathways HUB and will not do so until we are committed to going through the full accreditation process to become certified as a Pathways HUB.

That decision will be made in 2020. North Sound ACH did not issue payments to implementation partners for any specific activities, such as offsetting infrastructure costs. Instead, a pool of funds was made available to implementation partners, and they had discretion as to whether they used the funds for that purpose, to backfill for lost wages, to augmenting staff capacity building, or another purpose that would enhance their ability to help the region reach its performance metrics.

For all partners, including those implementing strategies under Project 2A, the North Sound ACH established a distribution approach that provided consistency in earnings in 2018, 2019 and 2020 for partners. In 2018 it was the priority request for those partners committing to implementation strategies.

In addition to implementation partners, close to \$6 million was distributed to the (then) North Sound Behavioral Health Organization to share with BHAs preparing for the shift to MCO billing. (The BHO had existing contracts that allowed distribution in a more targeted manner.)

**For Project 2B: Provide information related to the following:**

- a. Schedule of initial implementation for each Pathway.
- b. Partnering provider roles and responsibilities to support Pathways implementation.
- c. Inventory of Care Coordination Agencies (CCAs) and the number of referrals to date.
- d. Systems the HUB lead entity is using to track and evaluate performance, providing a list of the related measures.
- e. Success in hiring staff, a listing of open positions and efforts to fill those, including barriers or gaps that exist to retain staff and mechanisms the ACH uses, if any, to address reasons for those barriers or gaps.
- f. Describe the training plan for community health workers, and the number trained. What is the feedback loop for the identification and offering of continuing education training and development? What evaluation and assessment does the ACH conduct, if any, post-training to determine if trained individuals have increased skills, competencies, or performance? How does the ACH use such information or other feedback to determine trainings to provider to either individuals or groups, what trainings to require as mandatory versus individual goals-based, and key partners to include in offering trainings.
- g. Describe technology enabled care coordination tools being used, and how information captured by care coordinators is integrated with clinical information captured through the statewide health information exchange.
- h. Include two examples of checklists or related documents developed for care coordinators.

**Response: overall**

North Sound ACH is using the Pathways model to implement its Care Coordination HUB, and the affiliated software of Care Coordination Systems to track clients and progress. We do not have our Hub branded as a Pathways HUB and will not do so until we are committed to going through the full accreditation process to become certified as a Pathways HUB. That decision will be made in 2020. When questions reference "Pathways" we are responding in reference to the Pathways model and the 20 relevant Pathways that are included.

**Response to: a) Schedule of initial implementation of each Pathway.**

<b>Pathway</b>	<b>Date of implementation (actual or anticipated)</b>	<b>Notes (optional)</b>
<b>Adult education</b>	5/16/2019	successful completion of coursework
<b>Employment</b>	8/06/2019	1 month on the job
<b>Health insurance</b>	5/14/2019	confirmed enrolled
<b>Housing</b>	5/06/2019	1 month secured permanent housing
<b>Medical home</b>	5/16/2019	primary care or ongoing BH provider
<b>Medical referral</b>	5/08/2019	any medical and BH referral
<b>Medication assessment</b>	5/13/2019	provider assessment
<b>Medication management</b>	-	take medications as prescribed
<b>Smoking cessation</b>	5/02/2019	1-month cessation
<b>Social service referral</b>	5/07/2019	linkage to a social service
<b>Behavioral referral</b>	6/14/2019	completion of 3 visits
<b>Developmental screening</b>	-	children
<b>Developmental referral</b>	-	children
<b>Education</b>	5/8/2019	health education; steps in a procedure or process
<b>Family planning</b>	-	30 days use of contraceptive
<b>Immunization referral</b>	-	documented results
<b>Lead screening</b>	-	confirmed results of test
<b>Pregnancy</b>	6/12/2019	confirmed delivery
<b>Postpartum</b>	10/10/2019	2 postpartum visits

**Response to: b) Partnering provider roles and responsibilities to support Pathways implementation.**

**Care coordination agencies (CCAs)** are contracted with the North Sound Community HUB as a partner to deliver care coordination services to the North Sound ACH's focus population for community based care coordination. CCAs also coordinate the delivery of health care and social services.

**Care coordinators** are the service providers in the Pathways model who engage and support clients in their caseload. Care coordinators open and close relevant Pathways with their client, completing all steps to achieve desired outcome of that Pathway, through mediation and connection to identified services

**Supervisors** monitor care coordinator caseload within their agency and assign clients. They also help to prioritize program delivery through documentation integrity and offer staff support.

CCAs provide the initial identification of individuals who would benefit from the HUB care coordination program and direct them to the HUB for participant eligibility determination.

**Referral Partnerships** are agreements with agencies who referral individuals who meet the focus population criteria to the HUB, for eligibility check by HUB staff.

This person-centered evidence based model uses trained community based care coordinators to find opportunities for client engagement and retention, provide initial assessment of risk areas and determine goals of the client using shared decision making tools that support the care coordination model, and continues ongoing support through selection of relevant Pathways to address and follow through with client centered goals.

Care coordinators must successfully complete the relevant Pathways, supportive tools, or checklists for the CCA to receive payment.

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

<b>CCA Name</b>	<b>Total # of Referrals to CCA for any Pathway</b>
Compass Health	427
SeaMar	316
San Juan	113
<b>Total as of 12/31/2019</b>	<b>858</b>

**Response to: d) Systems the HUB lead entity is using to track and evaluate performance, providing a list of the related measures.**

North Sound ACH, as the lead entity, is contracted with Care Coordination Systems (CCS), the online platform housing the Pathways model of care coordination) internal reporting tool. Reports from CCS include:

- Referrals to the HUB (eligible/ineligible)
- Average length of time (in days) for individual Pathways; from opened to closed
- Reason for client discharge
- Types of Pathways opened/closed

Twice a week the North Sound HUB hosts technical assistance call-in times to support care coordinators and their supervisors in three areas:

- Technical assistance of the system
- Navigation of the Pathways model
- Community engagement and retention

Quarterly reports to the CCAs are generated and sent out, outlining areas of procedural concerns and areas of improvement, such as capturing concise notes

QI measures include: Opened/closed Pathways and average time to close, direct care coordinator referrals, client engagement, fidelity to the model, supervision, and professional participation including trainings

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

CCAs are scaling up their workforce levels to fit the caseload for each care coordinator. Challenges in this area include long term care coordinator retention. The ACH is going to host an all-day convening of Community Health Workers (CHWs) mid-year to gain understanding of workforce challenges, assist CCAs with CHW recruitment, and to begin relationship building with paid and non-paid CHWs across the region. Turnover among CHW positions at CCAs has been high, placing a challenge on recruitment and training of place-based and community based care coordinators.

The North Sound HUB itself currently employs 1 HUB Manager and has plans to add a HUB Referral Intake Specialist in 2020. A Community Impact Director will be onboarding in January 2020 to address strategic planning areas of the overall HUB and CCA workforce.

North Sound ACH uses its website ([www.northsoundach.org](http://www.northsoundach.org)) and social media platforms to post HUB related vacancies. Job vacancies are also disseminated among the Community Health Worker networks.

**Response to: f) Describe the training plan for community health workers, and the number trained.**

There are currently 8 community health workers (CHWs) trained to use the Pathways model. The training consists of two sections:

- General Community Health Worker training through the Department of Health (DOH), or through the software vendor, Care Coordination Systems (CCS).
- Training in the Pathways model and accompanying software system, CCS. This is accomplished by either the CCS staff trainers, or the North Sound ACH. We have developed an internal "Activation" training, which educates on the CCS software system and the Pathways model. This training is led by the North Sound ACH HUB Manager.

Ongoing support and instruction are provided to the CHW workforce in the form of twice weekly calls with open question and answer sessions with the HUB manager.

**Response to: What is the feedback loop for the identification and offering of continuing education training and development?**

Opportunities for CHW professional growth and education are discussed at the HUB Advisory Committee and the CHW/Supervisor Subcommittee meetings. Quarterly reports identify areas of training opportunities for the care coordinators, such as engagement or system protocols. These training and education opportunities are discussed and offered based on prioritization aligning with the HUB initiative scope.

**Response to: What evaluation and assessment does the ACH conduct, if any, post-training to determine if trained individuals have increased skills, competencies, or performance?**

Assessments are conducted through the CCS software portal, monitoring the identified QI measures by the reports. Successes and areas of improvement are discussed during individual 1:1 correspondence, in a CCA meeting if the concern is agency wide, or during Subcommittee and Advisory Committee meetings as agenda items. CHWs and Supervisors are encouraged to contact HUB with concerns individually, or express during the meetings.

**Response to: How does the ACH use such information or other feedback to determine trainings to provide either to individuals or groups, what trainings to require as mandatory versus individual goals-based, and key partners to include in offering trainings.**

In the HUB policy and Procedure manual, mandatory and optional trainings are identified and listed with a check for completion by the due date listed (varies). Mandatory and optional trainings are provided to each CCA as they are onboarded and listed as an appendix in the policy and procedure manual. Group trainings are scheduled based on availability of the course, trainers and the participants. Some trainings can be accommodated during Subcommittee Meetings, added as an agenda item.

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

A secure information exchange exists within the CCS platform, CHWs are able to obtain and share health information by using the secured CCS software platform folders.

**Response to: Include two examples of checklists or related documents developed for care coordinators.**

Two documents are attached to demonstrate checklists or related documents developed for care coordinators.

- North Sound ACH has added **Attachment E, Pathways CHW Software Protocols**
- North Sound ACH has added **Attachment F, Focus population**

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

**Response:**

The North Sound ACH surveyed partners in regard to their use of Advance Directives and POLST forms. This survey also asked partners what technical assistance would be useful in supporting partners in implementing POLST forms. 66% of respondents said they do not have a formal policy on how to complete and follow the Advance Directive and POLST forms, and 51% of respondents said that their organization would benefit from assistance in the use of Advance Directives and POLST forms. To support partners with this, the ACH will be hosting an informational and technical assistance webinar for partners on the topic of Advance Directives and POLST forms in February, 2020.

**For Project 3A: Provide two examples of the following:**

- a. Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recovery supports.
- b. Methods the ACH is using to monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan.
- c. A description of existing local partnerships the ACH has convened or leveraged to implement strategies under this project, including a summary of the structure, frequency of meeting, and confirmation that the partnership includes all required individuals and entities (e.g., consumer representatives, community-based service providers, and law enforcement). Describe any successes and challenges with identification of partnership leaders and champions.
- d. Describe gaps in access and availability of providers offering recovery support services, and provide an overview of the ACH's planned approach to address gaps. Describe whether the approach will impact the number, or location of current providers.

**Response to: a) Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recovery supports.**

The North Sound ACH, working with the North Sound Behavioral Health Administrative Services Organization (BHASO), will be implementing a Local Impact Network (LIN) to address opioid strategies. The LIN model promotes collaboration and will allow the North Sound ACH to address the four core components of opioid work concurrently. To date, the North Sound partners have made progress on the following strategies and approaches:

- 1) Prevention: North Sound ACH staff hosted Dr. Laura-Mae Baldwin and Brooke Ike from the University of Washington for an informational webinar for partners on the Six Building Blocks Model in August 2019. This developed into a Six Building Blocks partner convening that occurred on December 20, 2019.
- 2) Treatment: The North Sound BHASO is hosting a buprenorphine waiver training available for free to all North Sound ACH partners, including CME credits. The training will be held on January 10, 2020.
- 3) Overdose Prevention: ACH staff worked with partners to understand practices around distributing Narcan. Partners identified that despite universal prescriptions, the cost of Narcan could be prohibitive for some clients. To help address this challenge, the ACH explored the potential for Naloxone leave-behind programs. Partners have discussed the potential for collaboratively applying for grant funding to serve the North Sound region with access to Narcan for those not prescribed with opioids, but who may be at risk of witnessing an overdose.
- 4) Recovery Supports: The Opioid Workgroup Leadership Team in Skagit County includes members from eight ACH partners. Through this workgroup, Skagit County has made progress on implementing community recovery supports. The team is working on the development of a hub for community-based recovery supports.



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

The North Sound ACH is working with the BHASO to monitor state-level modifications to the Washington State Interagency Opioid Plan. The work of the Opioid Local Impact Network (LIN) closely follows the goals and strategies outlined in the plan.

ACH staff participate in monthly calls with Kris Shera, the Health Care Authority's Opioid Coordinator. This call is used to provide high-level updates from the State Opioid Response Plan workgroup leads, share ideas about innovative programming, discuss problems and possible solutions.

**Response to: c) A description of existing local partnerships the ACH has convened or leveraged to implement strategies under this project, including a summary of the structure, frequency of meeting, and confirmation that the partnership includes all required individuals and entities (e.g., consumer representatives, community-based service providers, and law enforcement). Describe any successes and challenges with identification of partnership leaders and champions.**

The North Sound ACH will be convening a Local Impact Network to address the opioid crisis. An advisory committee half-day retreat will be held on January 14, 2020 to plan the structure of the Local Impact Network. Participants included law enforcement, community-based service providers, individuals with lived experience (consumer representatives), county health departments, and healthcare providers. A set of anchor strategies has been drafted in consultation with the Opioid Workgroup Leadership Team in Skagit County and in conjunction with the BHASO.

There are some challenges related to launching the Opioid Local Impact Network. Leadership for the regional opioid response plan was largely held by the BHASO. As the ACH joined the network, with specific responsibility to address the opioid crisis, an emphasis on building strong, trusting relationships, has been needed to ensure that leaders not see duplication of work or "reinventing the wheel". We have worked to address this challenge by partnering with the BHASO for the launch of the opioid network, and ensuring participants that the work of the LIN will build off of work already outlined and accomplished.

A specific success for the development of the Opioid LIN is progress toward the identification of the LIN's anchor strategies. These have been drafted with input from partners across the North Sound region. They will be refined further once the Steering Committee is established for the Opioid LIN. The current list of anchor strategies is: Community Education; Access to Care and Treatment; Prevention; Prescriber and Clinic Education; Diversion; Advocacy; and Transitional Care.

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

The gaps in access and availability of providers offering recovery support services have yet to be formally analyzed. This analysis will fall under the purview of the Access to Care and Treatment workgroup within the Opioid LIN. The planned approach to address the gaps will use Targeted Universalism and Results Based Accountability frameworks. These approaches ensure equitable approaches and strategies to improving access and availability of providers offering recovery support services.

Though the totality of the gaps in access and availability have not yet been fully analyzed, one FQHC partner reported:

“The most significant adoption has been the requirement of all non-Pediatric Physicians to be trained in MAT-assisted therapy and achieve a waiver to prescribe Suboxone. By the beginning of 2019, 40 providers [had been] trained and waived to provide MAT-assisted therapy throughout all 7 of our medical clinics. Clinical staff [have also been trained] on the use of Narcan and purchased a significant number of “Narcan kits” to provide to families and friends of patients suffering from SUDs.”

This change will clearly have a positive impact on the number of prescribers available.

**For Project 3C: Provide the following:**

- a) A summary of mechanisms established for coordinating care with related community-based services and supports, as well as referral relationships that have been established with dentists and other specialists, such as ENTs and periodontists.
- b) Two examples of workflows developed to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed.
- c) A summary of methods used to engage with payers in discussion of payment approaches to support access to oral health services. If applicable, indicate payment approaches that have been agreed upon.

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

One mechanism for coordinating care with related community-based services and supports is the Oral Health Local Impact Network. There are two anchor strategies of the Oral Health

LIN that support coordinating care: 1) Care Coordination and Access to Care and 2) Mobile Dental and School-Based Sealants. Through the Mobile Dental work group, multiple relationships have been built to coordinate school-based sealant services to underserved schools in the North Sound region. One of those relationships is between San Juan County, Dental Hygiene Mobile Services (DHMS), and Island County. Dental Hygiene Mobile Services is an independent dental hygienist who coordinated with the county ABCD coordinators and school districts to provide school-based oral health screenings and sealants to children.

Another mechanism established for dental care coordination is the training on and use of DentistLink. The North Sound ACH provided training and education for partners in using DentistLink, which is a free service provided by the Arcora Foundation. In 2019, DentistLink has connected over 20,000 individuals to essential dental care. The service is provided at no cost to users, dentists or community partners. Further, DentistLink assists everyone regardless of insurance coverage, but the majority of users have Medicaid coverage. More than 25 organizations across the state currently refer their clients and patients to DentistLink. These referral partners include small organizations such as community-based non-profits and emergency rooms in large hospital systems.

Individual referral relationships with dentists and other specialists are in process and will be further established in 2020 as part of the Access to Care and Care Coordination anchor strategy of the LIN. The LIN model is uniquely suited to support providers and referrers in developing these relationships.

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

One partner engaging in school-based mobile dental sealant work reported:

*"On my sheets that have reports, I have a blanket statement for a referral. I usually talk to the patient (or their caregiver) and find out where they can/are willing to go for help and give them a referral accordingly. [The local] ABCD program gave us a referral sheet with provider names on it and we handed them out. Referrals are done at the time of smile checks or treatment."*

Another partner within an FQHC who conducts mobile dental school-based sealant care reported:

*"Any dentist in the dental clinic are able to go on mobile visits, but try to take [dentist from preferred list]. Either dental hygienist can go on mobiles, but hygienist JC is most experienced."*

Regarding workflows partners reported:

- Dentists are scheduled on the Initial Visit to all schools and first visit to all Head Starts and Daycares.
  - Dr. S is scheduled on all Thursday mobiles if available.
  - If a dentist has 3 columns on the Dentrix schedule, they are working with a dental hygienist that day.
  - They can only go on a mobile visit if the hygienist is going on a separate one as well. (Dr. H on Wednesdays, Dr. S on Mondays)
  - Dr. A will not work with the Portable Sealant Machine.
- Hygienists JC and HD are the hygienists that can go on MDP Sealant or 3rd visits or second or third visits to daycares. They should not be scheduled for any first visits at schools or daycares.
  - If a hygienist is needed on a Monday or Wednesday, they are assigned to the middle column of the 3-column visit (Dr. H on Wednesdays, Dr. S on Mondays). Schedule them by blocking out the middle column only. They can go on an MDP visit, leaving the dentist with 2 columns, but the dentist cannot go an MDP visit, leaving column 1.

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

Engaging payers in discussion of payment approaches to support access to oral health services is within the role of the Oral Health LIN Steering Committee. While specific payment approaches have yet to be determined, the Oral Health LIN Steering Committee has identified advocacy with MCOs on behalf of providers in the North Sound region as a priority. Further, the staff of North Sound ACH are connecting to a statewide Local Impact Network Learning Collaborative, where the five Oral Health LINs across the state can organize and plan for statewide initiatives. Through this statewide collaborative, strategic efforts can be made to engage payers in discussion of payment approaches to support access to oral health services.

**For Project 3D: Provide the following:**

- a) Description of status of activities that have been conducted based on the Chronic Care Implementation Plan, including a summary of how the ACH is ensuring integration of clinical and community-based strategies through communication, referral, and data sharing strategies.
- b) Description and two examples for how the Chronic Condition/Transition Management plans align with and partner with Pathways or other community-based care coordination strategies or programs to address social needs interventions (e.g., referrals to program/communication and data sharing for shared care planning).



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

North Sound ACH has implemented Project 3D across multiple strategies, one of which is '2.10: Clinical Transformation for Prevention and Management of Chronic Disease.' The North Sound ACH has collected semi-annual reporting from partners regarding their progress on strategies to ensure integration of clinical and community-based strategies. In April of 2019, reporting for Strategy 2.10 showed 47% of partners not yet started on implementation of this work. In the reporting for October 2019, 71% (12 out of 17) of partners were in progress or had fully implemented this strategy. One community-based organization reported that "connecting with clinical partners for referrals" was part of how they are accomplishing this work.

**Response to: b) Description and two examples for how the Chronic Condition/Transition Management plans align with and partner with Pathways or other community-based care coordination strategies or programs to address social needs interventions (e.g., referrals to program/communication and data sharing for shared care planning).**

In partner reporting for the North Sound ACH Strategy 2.11: Community Linkages for Chronic Disease Prevention and Management Programs, 97.5% of partners report that they have implemented the tactic of "patients/clients are referred to chronic disease education and support services such as Diabetes Prevention Program (DPP), Chronic Disease Self-Management (CDSM), and exercise programs."

For example, chronic disease partners in Snohomish County are working together to find client referrals and trainer availability for CDSM groups. In April 2019, one partner reported that they had "been unable to proceed with CDSME classes due to lack of leader training in our area." In October, however, the same partner reported "We have reached out to partnering agencies such as Kaiser Permanente and Comagine for leader training," and "we [have been able to] offer leader trainings and support classes for leaders. We provided leaders with scripted manuals to support the CDMSE program...we currently have 19 active leaders in Snohomish County."

The North Sound ACH's Community HUB initiative supports the identification, assessment, and treatment of eligible persons based on the established population of focus, which includes chronic conditions. In the HUB, referral partnerships are made with a variety of agencies, from hospital systems to grassroots agencies, who receive login credentials for the secured software system CCS (Care Coordination Systems) to submit referrals to the HUB for processing and assignment to a CCA (Care Coordination Agency). Community Health Workers (CHWs) are assigned clients after an eligibility check. During the initial

intake meeting, an assessment is conducted, identifying prominent areas of client concern. This is done in two ways:

- the intake form captures data on chronic conditions through a questionnaire, and CCS codes the selected entries to connect and open relevant “pathways”, based on client responses.
- CHWs can manually select and open a Pathway (such as the Social Service Pathway or Medical Referral Pathway) to help the client navigate through necessary systems and receive a personalized care plan.

Once the appropriate areas of concern are identified, the CHW will assist the client at the level of their comfort, using person-centered care:

- The CHW will provide an up to date referral list of services and agencies if the client feels confidence in navigating appropriate services themselves.
- The CHW will work with the client to select and make appointments with the appropriate services and agencies, and follow up with the client post visit to discuss successes and next steps.
- The CHW will make the appointment, meet the client at the appointment, provide more direct services to accomplish goals of appointment.

The CHW is in regular contact with their preferred partner agencies and services. The software system CCS also allows for HIPAA compliant transmission and sharing of relevant documents, such as prescription files or medical chart notes. This is used by the CHW to support holistic client care.

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

The main risk identified in completing Medicaid transformation work is the timeline within which progress is measured and when the ACHs have accurate baseline data. It is that baseline data that would provide clarity of where changes needed to occur, and what levers could be used regionally or locally. That baseline data was not specifically available until after partners were selected and their change plans were approved. That makes course correction challenging for small and large organizations.

We feel confident that we have many partners working on the right initiatives, but there are also partners who see large numbers of Medicaid patients who are not engaged yet. To mitigate this challenge, we completed a gap analysis of partner commitments, model sector requirements, and population of focus commitments. Following the analysis, North Sound ACH developed a strategy to recruit additional partners. We hosted a webinar and conducted targeted recruitment for partners who could fill those gaps. We will be adding

strategically selected partners in 2020.

A risk to making change in the region on key metrics is insufficient/delayed reporting. To mitigate this risk, the ACH incentivized partner reporting. Additionally, each partnering provider has been assigned a project manager to help answer questions that arise as they complete their implementation work and reporting.

Two challenges across projects have been identified. Partners identified data sharing and working across EHRs and other HIE systems as a barrier to collaboration. To reduce this barrier, the North Sound ACH is continuing to assess appropriate Community Information Exchange (CIE) platforms and middleware solutions that could be implemented. To that end, staff and board members attended the Live Well Advance conference in San Diego to learn more about their approach to CIE and data sharing.

The second challenge across projects is addressing issues in equity and trying to ensure that the strategies partners are implementing do not reinforce existing inequitable structures. To address this challenge, the North Sound ACH has begun a required equity and tribal learning series for implementation partners, and will continue to share equity resources as appropriate.

A project specific challenge exists in project 2B, Community-based Care Coordination. North Sound elected to implement this project because effective care coordination and sharing of information is key to many of the other project areas, including addressing the opioid crisis and integrating physical and behavioral health. The Health Care Authority agrees that people on Medicaid are entitled to community based care coordination, but we are not in agreement as to how that is delivered or how it is paid for. Until we determine what community-based means collectively we will build a model that is difficult to grow or sustain.

A second project specific challenge exists in project 3A, Addressing the Opioid Crisis. The Regional Opioid Work Group was previously housed within the North South BHO. With the 2019 transition from the BHO to the BHASO, there was a potential for momentum to be lost in this work. To address this challenge, ACH staff have had multiple meetings with BHASO staff to understand the ways in which we can keep this work moving forward. The North Sound ACH staff has also worked with the BHASO to develop an Opioid Local Impact Network and a communication plan to effectively share news of this change with appropriate partners as it relates to opioid work in the region.

## **18. Pre- and post-project implementation example**

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



**Response:**

WhidbeyHealth, which operates the WhidbeyHealth Medical Center and clinics in Island County, reported in their October 2019 reporting to the North Sound ACH that many of their successes were made possible due to DSRIP investments. They specifically highlighted the “major population health transformational work that has been integrated into the fabric of the community” that was funded by the DSRIP investments. This included the adoption of a community-wide screening and needs assessment which allows them to better target patients and families who are experiencing needs related to depression, suicidality, substance use disorder, domestic violence and abuse, and food, housing, utility, electricity, and transportation insecurities. One of the barriers to implementing such a large task prior to DSRIP funding had been collaboration between community agencies and sites across Island county. WhidbeyHealth used DSRIP funding to reach out to potential partner agencies to collaborate and learn about best practices that were currently underway.

During this period WhidbeyHealth also launched MyWhidbeyHealth, an improved patient portal that serves all patients of the hospital, clinics, and ancillary services. This new and improved portal was built to address disparities in accessibility, such as lack of internet or phone services, limited transportation access, and other disparities patients may face when accessing their health information and health care team. The electronic health record systems were also updated to be more inclusive of gender identity and sexual orientation to allow for better data collection. Additionally, WhidbeyHealth trained staff and released a statement about gender inclusivity. Through this work they hope to better serve the needs of the LGBTQ+ population in the region.

As the North Sound ACH moves forward in the Medicaid Transportation Project, the ACH will continue to encourage collaboration and information sharing among partners across the region, much like the extensive work WhidbeyHealth has championed in Island County. In 2020, the ACH will focus further on partner collaboration, identifying where collaborations are already existing and thriving and where there are gaps. Through a partner collaboration survey, the North Sound ACH will better understand how partners are connecting and what barriers the ACH can help address through DSRIP investments to ensure regional success.

## 19. Regional integrated managed care implementation update

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

### Response:

Challenges related to the 2019 transition to integrated managed care:

- After the transition to MCO payers, the crisis response line and crisis dispatch, managed regionally by the Volunteers of America, lost its ability to view service history of Behavioral Health Agencies (BHAs). This information was previously centralized in the BHO system. The ACH is participating in a cross-ACH workgroup with Collective Medical to identify data elements and use cases for their platform to resolve this issue. (The Interlocal Leadership Structure's Joint Operating Committee is also discussing the use of the Collective Medical Platform to distribute this information.)
- Decrease in non-Medicaid funding for crisis triage. The BHASO had to decrease non-Medicaid funding to crisis triage in order to maintain crisis outreach teams and other services. The ACH is participating in the Interlocal Leadership Structure, which is discussing this funding gap and the use of state non-Medicaid fund allocation to address the issue. Coding changes in the way the BHASO delivers crisis services may increase Medicaid crisis funding in the future.
- Decreased availability of non-Medicaid funds to support people on Medicare in spend down. The BHASO needed to decrease the use of non-Medicaid funding to BHAs that was previously used to cover spend downs. This has created an increase in referrals to agencies that accept Medicare for behavioral health services, including FQHCs, who are feeling the impact. The ACH has participated in several provider meetings to discuss the increase and the best routes for advocacy regarding non-Medicaid funding needs for the region.
- High claims denial rates reported in the early warning system for 2-3 MCOs. Some ACH partners are reporting issues with provider payment. The ACH has distributed the regional provider survey to partners, participated in the Early Warning System webinars, and connected providers to the HCA and MCOs to address payment challenges.

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

Response: Not Applicable

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

Response: Not Applicable

## Attestations

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

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

## Section 3. Value-based Payments

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

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

### Narrative responses

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

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

#### Response to: Methods North Sound ACH uses to identify providers struggling to move towards value-based care

- Reporting: Partners committed to Capacity Building section 4.5: Examine and report barriers of successful adoption of Value Based Purchasing. All are required to report on their progress towards implementing Value-Based Care. Partners reported on their progress through the completion of the statewide Value-Based Payment Survey.
- Annual Paying for Value Survey: Partners committed to moving to Value-Based Care are required to complete the annual Paying for Value Survey. Partners committed to this strategy area will be scored during the next reporting period based on the completion of this survey in 2019. This year, 100% of partners required to complete this survey completed the survey.

#### General Overview of ACH Activities Used to Support Providers Struggling to Implement Practice Transformation and Move Toward Value-Based Care

- Technical Assistance: North Sound ACH provided a Value-Based Care webinar in September 2019. Partners were encouraged and required to complete the Value-Based Payment survey and instructions on how to do this were covered during the webinar.
- Resources: VBC resources are posted on the partner portal where partners can discuss VBC via a message board on the portal. Partners were encouraged and

required to complete the Paying for Value Survey and instructions on how to do this were covered during the webinar.

- Advocacy: North Sound ACH made the annual Paying for Value Survey a requirement. All partners required to complete this survey successfully met the requirement.

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

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

### **Response:**

The following three examples were derived from site visits and partner reporting. These examples demonstrate how the ACH has supported providers to implement strategies to move toward value-based care, including provider type, provider needs, supportive activities, description of action plan, and key milestones that have been achieved:

Provider Type: Provider with Low-VBP Knowledge

- a) A community based organization (CBO) expressed a need for more education around VBP and how to provide Value-Based Care with contracted clinical staff. North Sound ACH supported this request by conducting a VBP Webinar, adding resources on the Partner Portal, and offering one-to-one support from Project Managers. A key milestone for this partner was the VBP Webinar.
- b) This provider shared the following action plan in their October 31, 2019 reporting: "We are also working with a consultant to sketch out our options to pursue a value-based payment model specific to reproductive health -- although we have had initial conversations with our payors about small VBP pay-for-performance contracts based on a handful of metrics, it is not appropriate to tie payment to performance related to the majority of our services (e.g. contraceptive use and LARC access), so we are looking at ways to think more broadly and creatively to completely overhaul a reproductive payment model. We believe the state's goals related to VBP are a great opportunity for us to develop something innovative that makes Washington a leader around alternative payment models for sexual and reproductive health."

Provider Type: Small Providers (25 FTES or fewer)

- a) A small provider with 25 FTEs or fewer reported a need to engage MCOs in VBP contracting. This provider shared that one of the biggest barriers has been

communicating and engaging MCOs on this topic. North Sound ACH supported this request by advocating for the provider to the HCA and determining a contact at the HCA for the provider to reach out to as another method to engage MCOs. North Sound ACH continues to advocate for providers seeking to engage MCOs around VBP. A key milestone will be a convening planned in January to bring MCOs to the North Sound region to connect with partners seeking their participation in discussion. North Sound ACH continues to connect providers with MCOs, other organizations, and state resources on VBP and VBP contracting.

- b) Another provider shared the following in the reporting narrative submitted on October 31, 2019: "The Health Care Authority's changing approach to Value Based Purchasing measures for 2020 poses a significant challenge. Each year, we attempt to align our internal QI measures and department-level initiatives with the P4P measures included in our Medicaid Managed Care contracts (along with other commitments including North Sound ACH, and HRSA's Uniform Data System measures). We balance new external measures with a desire to limit the number of new measures visible to staff with a finite capacity to implement new workflows each year. This year, we benefited from substantial alignment of our quality measures with our two Medicaid MCOs: CHPW and Molina. We are challenged in planning for 2020, with the HCA having just released the suite of VBP measures, and the MCOs not yet having communicated how they will factor these into their 2020 quality payments."

Provider Type: Behavioral Health Provider

- a) A large behavioral health provider in the North Sound Region expressed a need for more education around VBP contracting as well as MCO cooperation with efforts to move to Value-Based Care. This provider's action plan was to attend the VBP Academy in King County to learn more about the payment structure. This provider reported that attending the VBP Academy was a milestone and provided valuable education around the topic. The provider reports continued challenges engaging MCOs and when they are engaged, MCOs are not as cooperative as they need to be to address the challenges in moving to Value-Based Care.
- b) Another provider shared the following action plan in their October 31, 2019 reporting: "We have been attending the VBP Academy in King County in order to prepare for VBP. We have started to build log frames associated with future work."

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

- a) **Provide three examples** of the ACH's efforts to support completion of the state's 2019 provider Paying for Value Survey. The ACH should indicate new tactics, if any, compared to tactics employed in prior years. The response should also specify if incentives were offered, and if so, include a description of the incentives.
- b) Describe how the ACH utilized individual responses and/or aggregate data, provided by HCA to the ACH from previous state-issued provider Paying for Value Surveys, to inform communications and/or identify providers in need of technical support.

**Response to: a) Provide three examples of the ACH's efforts to support completion of the state's 2019 provider Paying for Value Survey.**

- 1) North Sound ACH incorporated findings from the 2018 Paying for Value Survey results as part of 2019 Current State Assessment report and subsequently required all relevant partners to complete the 2019 Paying for Value Survey when distributing this report.
- 2) North Sound ACH promoted the 2019 Paying for Value Survey as part of the monthly July newsletter sent to all ACH partners. This newsletter included a link to HCA VBP webpage and the 2018 survey results.
- 3) In April 2019, North Sound ACH leadership shared 2018 Paying for Value Survey results with newly hired project management staff to prepare them to work with partners who have expressed VBP contracting needs.

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

North Sound ACH received 2019 Paying for Value Survey results on December 4, 2019. Next steps for this data include: analysis and aggregation of data for the North Sound region, an internal dissemination of partner specific responses to the assigned ACH project manager responsible for tracking and responding to partner technical assistance needs, and an external dissemination of analysis and findings to the public in early 2020.

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

### Documentation

#### 24. P4R Metrics

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

#### *Instructions:*

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

#### ***Submit P4R metric information.***

#### **Response:**

North Sound ACH has added **Attachment G, Pay for Reporting Metric information.**

## North Sound (NSACH)

*July 1, 2019- December 31, 2019*

**Table 1: Incentives earned**

	Q3	Q4	Total
Project 2A	\$ -	\$ 1,122,965.00	\$ 1,122,965.00
Project 2B	\$ -	\$ 772,038.00	\$ 772,038.00
Project 2C	\$ -	\$ 456,205.00	\$ 456,205.00
Project 2D	\$ -	\$ 456,205.00	\$ 456,205.00
Project 3A	\$ -	\$ 140,371.00	\$ 140,371.00
Project 3B	\$ -	\$ 175,463.00	\$ 175,463.00
Project 3C	\$ -	\$ 105,277.00	\$ 105,277.00
Project 3D	\$ -	\$ 280,741.00	\$ 280,741.00
Integration	\$ 6,498,653.00	\$ -	\$ 6,498,653.00
VBP	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 6,498,653.00</b>	<b>\$ 3,509,265.00</b>	<b>\$ 10,007,918.00</b>

**Table 2: Interest accrued for funds in FE portal**

	Q3	Q4	Total
Interest accrued	\$ 25,027.56	\$ 35,742.84	\$ 60,770.40

**Table 3: distribution of funds for shared domain 1 partners**

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

**Table 4: incentive funds distributed, by use category**

	Q3	Q4	Total
Administration	\$ 15,978.00	\$ 15,592.60	\$ 31,570.60
Community health fund	\$ -	\$ 36,303.51	\$ 36,303.51
Health systems and community capacity building	\$ 1,336,768.00	\$ 476,775.50	\$ 1,813,543.50
Integration incentives	\$ -	\$ -	\$ -
Project management	\$ 566,514.00	\$ 444,103.73	\$ 1,010,617.73
Provider engagement, participation, and implementation	\$ 54,975.00	\$ 1,522,662.72	\$ 1,577,637.72
Provider performance and quality incentives	\$ -	\$ -	\$ -
reserve/contingency fund	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 1,974,235.00</b>	<b>\$ 2,495,438.06</b>	<b>\$ 4,469,673.06</b>

**Source:** Financial Executor Portal

**Prepared by:** Washington State Health Care Authority