



*Produced by Myers and Stauffer on behalf of the Washington Health Care Authority*

# **Healthier Washington Medicaid Transformation Accountable Communities of Health Semi-annual Reporting Guidance**

***SAR 4.0***

***Reporting Period:***

***July 1, 2019 – December 31, 2019***

***Template Release Date: August 7, 2019***

## Table of contents

Table of contents.....	2
Semi-annual report information and submission instructions.....	3
ACH contact information.....	7
Section 1. ACH organizational updates.....	8
Attestations.....	8
Attachments.....	9
Documentation.....	10
Section 2. Project implementation status update.....	13
Attachments.....	13
Documentation.....	19
Narrative responses.....	23
Attestations.....	38
Section 3. Value-based Payment.....	40
Narrative responses.....	40
Section 4. Pay-for-Reporting (P4R) metrics.....	44
Documentation.....	44

## Semi-annual report information and submission instructions

### *Purpose and objectives of ACH semi-annual reporting*

As required by the Healthier Washington Medicaid Transformation’s Special Terms and Conditions, Accountable Communities of Health (ACHs) must submit semi-annual reports on project implementation and progress milestones. ACHs submit documentation per the requirements of the reporting guidance. The guidance will evolve over time to capture relevant information and to focus on required milestones for each reporting period. ACHs must submit reports as follows each year of the Medicaid Transformation:

1. **July 31** for the reporting period January 1 through June 30
2. **January 31** for the reporting period July 1 through December 31

The purpose of the semi-annual reporting is to collect necessary information to evaluate ACH project progress against milestones, based on approved project plans and corresponding implementation plans. The Washington State Health Care Authority (HCA) and the state’s contracted Independent Assessor (IA) will review semi-annual report submissions.

The ACH may be called upon to share additional information that supports the responses submitted for the purposes of monitoring and auditing, or for general follow-up and learning discussions with HCA, the IA and/or the Independent External Evaluator (IEE).

### *Reporting requirements*

The semi-annual report for this period (July 1, 2019 to December 31, 2019) includes four sections as outlined in the table below.

Semi-annual reporting requirements (July 1, 2019 – December 31, 2019)		
Section	Item num	Sub-section components
<b>Section 1. ACH organizational updates</b>	1-8	Attestations
	9-13	Attachments/documentation <ol style="list-style-type: none"> <li>1. Key staff position changes</li> <li>2. Budget/funds flow update</li> </ol>
<b>Section 2. Project implementation status update</b>	14-16	Attachments/documentation <ol style="list-style-type: none"> <li>3. Implementation work plan</li> <li>4. Partnering provider roster</li> <li>5. Quality improvement strategy update</li> </ol>
	17-19	Narrative responses <ol style="list-style-type: none"> <li>6. General implementation update</li> <li>7. Regional integrated managed care implementation update</li> </ol>
	20	Attestations
<b>Section 3. Value-based payment</b>	21-23	Narrative responses

<b>Section 4. Pay-for-Reporting (P4R) metrics</b>	24	Documentation
---	----	---------------

**There is no set template for the semi annual report.** ACHs have flexibility in how to put together the report, as long as all required elements are clearly addressed. ACHs may be requested to provide supporting information and/or back-up documentation related to the information provided to the IA and HCA.

### ***Achievement values***

Throughout the transformation, each ACH can earn achievement values (AVs), which are point values assigned to the following:

- a) Reporting on project implementation progress (Pay-for-Reporting, or P4R).
- b) Performance on outcome metrics for an associated payment period (Pay-for-Performance, or P4P).
- c) Reporting on Value Based Payment (VBP) milestones (Pay-for-Reporting, or P4R).

ACHs can earn AVs by providing evidence they completed reporting requirements and demonstrated performance on outcome metrics. The amount of incentives paid to an ACH region will be based on the number of earned AVs out of total possible AVs for a given payment period.

For DY 3, 75% of Project Incentives are earned through P4R, while 25% are earned through performance on P4P. This semi-annual report covering the period of July 1 through December 31, 2019 determines achievement for half of the available P4R-associated Project Incentives.

AVs associated with Project Incentives for this reporting period are identified in the table below.

*Table 1. Potential P4R Achievement Values (AVs) by ACH by Project for Project Incentives, Period July 1, 2019 – December 31, 2019*

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	6	6	-	-	7	-	-	5	24
Cascade Pacific Action Alliance	6	6	5	-	7	5	-	5	34
Greater Columbia ACH	6	-	5	-	7	-	-	5	23
HealthierHere	6	-	5	-	7	-	-	5	23
North Central ACH	6	6	5	5	7	-	-	5	34
North Sound ACH	6	6	5	5	7	5	5	5	44
Olympic Community of Health	6	-	-	5	7	5	5	5	33
Pierce County ACH	6	6	-	-	7	-	-	5	24
SWACH	6	6	-	-	7	-	-	5	24

For DY 3, up to 75% of VBP Incentives can be earned through achievement of P4R VBP milestones. Reporting is for the period of January 1 through December 31, 2019 and is reviewed to determine achievement for all available P4R-associated VBP Incentives.

Table 2 provides the AVs associated with VBP Incentives for this annual reporting period.

Table 2. Potential P4R VBP Achievement Values (AVs) by Milestone by ACH, Period January 1, 2019 – December 31, 2019

Milestone	BHT	CPAA	GCACH	HH	NC	NS	OCH	Pierce	SWACH
Identification of providers struggling to implement practice transformation and move toward value-based care	1	1	1	1	1	1	1	1	1
Support providers to implement strategies to move toward value-based care	1	1	1	1	1	1	1	1	1
Continue to support regional VBP attainment assessments by encouraging and/or incentivizing completion of state-issued Paying for Value Provider Survey	1	1	1	1	1	1	1	1	1
<b>Potential AVs</b>	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3

### ***Semi-annual report submission instructions***

ACHs must submit their completed semi-annual reports to the IA **no later than January 31, 2020 at 3:00p.m. PST.**

### **Washington Collaboration, Performance, and Analytics System (WA CPAS)**

ACHs must submit their semi-annual reports through the WA CPAS: <https://cpaswa.mslc.com/>.

**ACHs must upload their semi-annual report and associated attachments to the sub-folder titled “Semi-Annual Report 4 – January 31, 2020.”**

The folder path in the ACH’s directory is:

*Semi-Annual Reports* → *Semi-Annual Report 4 – January 31, 2020.*

See WA CPAS User Guide available in each ACH’s directory on the CPAS website for further detail on document submission.

### **File format**

ACHs must include all required attachments. ACHs must label and refer to the attachments in their responses, where applicable. HCA and the IA reserve the right not to review attachments beyond those that are required or recommended.

Files should be submitted in Microsoft Word, Microsoft Excel, and/or a searchable PDF format. Below are examples of the file naming conventions ACHs should use:

- *Main Report or Full PDF:* ACH Name.SAR4 Report. 1.31.20
- *Attachments:* ACH Name.SAR4 Attachment X. 1.31.20

**Upon submission, all submitted materials (except for the P4R metrics reporting workbook) will be posted publicly to HCA’s [Medicaid Transformation resources webpage](#).<sup>1</sup>**

***Semi-annual report submission and assessment timeline***

Below is a high-level timeline for assessment of the semi-annual reports for reporting period July 1, 2019 – December 31, 2019.

<b>ACH semi-annual report 4 – submission and assessment timeline</b>			
<b>No.</b>	<b>Activity</b>	<b>Responsible party</b>	<b>Anticipated timeframe</b>
A.	Distribute semi-annual report instructions for reporting period July 1 – December 31, 2019 to ACHs	IA	August 2019
B.	Submit semi-annual report	ACHs	January 31, 2020
C.	Conduct assessment of reports	IA	Feb 1-25, 2020
D.	If needed, issue information request to ACHs within 30 calendar days of report due date	IA	Feb 25-March 2, 2020
E.	If needed, respond to information request within 15 calendar days of receipt	ACHs	Feb 26-March 17, 2020
F.	If needed, review additional information within 15 calendar days of receipt	IA	Feb 27-April 1, 2020
G.	Issue findings to HCA for approval	IA	April 2020

***Contact information***

Questions about the semi-annual report template, submission, and assessment process should be directed to [WADSRIP@mslc.com](mailto:WADSRIP@mslc.com).

<sup>1</sup> <https://www.hca.wa.gov/about-hca/healthier-washington/ach-submitted-documents>  
Semi-annual reporting guidance  
Reporting period: July 1, 2019 – December 31, 2019

## ACH contact information

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

<b>ACH name:</b>	Olympic Community of Health
<b>Primary contact name</b>	Celeste Schoenthaler
<b>Phone number</b>	360-633-9241
<b>E-mail address</b>	celeste@olympicch.org
<b>Secondary contact name</b>	Margaret Moore
<b>Phone number</b>	360-689-2345
<b>E-mail address</b>	margaret@olympicch.org

## Section 1. ACH organizational updates

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

### Attestations

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

Foundational ACH requirements	Yes	No
1. The ACH has an organizational structure that reflects the capability to make decisions and be accountable for financial, clinical, community, data, and program management and strategy development domains.	X	
2. The ACH has an Executive Director.	X	
3. The ACH has a decision-making body that represents all counties in its region and includes one or more voting partners from the following categories: <ul style="list-style-type: none"> <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 (using this <a href="#">template</a> or a similar format) that addresses internal controls, including financial audits. <sup>2</sup>	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	

<sup>2</sup> <https://wahca.box.com/s/nfesjalde5m1ye6aobhiouu5xemeoh26>

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

**Attachments**

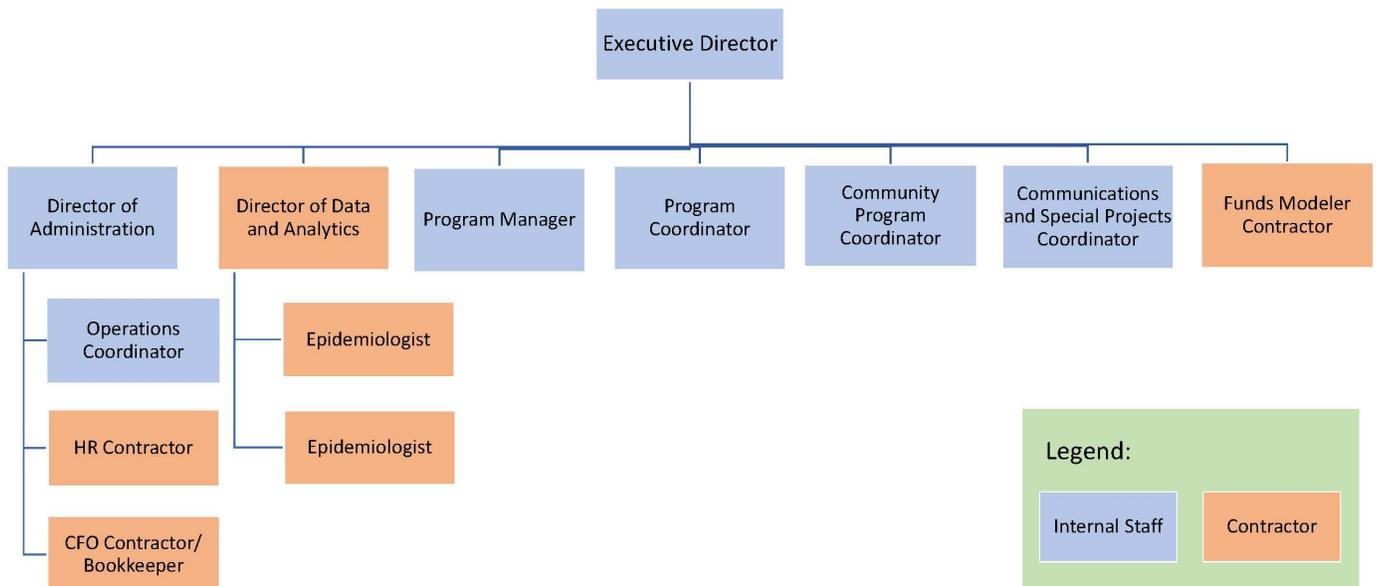
The ACH should provide applicable attachments or additional context for clarity that addresses the following:

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

***If applicable, attach or insert current organizational chart.***

Although there were not **key** staff position changes during this period, our current organizational chart is included below. During the reporting period, we hired 3 new staff, added one contractor, promoted two current staff, and the funding for one Department of Health-funded contractor (Pediatric Transforming Clinical Practices Initiative) ended and that contractor moved onto another role.

Olympic Community of Health Organizational Chart  
as of January 1, 2020



**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).

Olympic Community of Health maintains a Funds Flow workgroup that reports directly to our Board of Directors. We make incentive payments to partners twice per year in alignment with our Board policy. OCH draws down funds directly from the Financial Executor to pay for direct partner support activities, as approved by our Board of Directors, for expenses such as partner training, technical assistance, and events. All direct organizational operational expenses are paid through design funds (see question 12).

## 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.

OCH is fortunate to partner with the seven tribes in the Olympic region. Currently, three of those partners have a formal contract with OCH for transformation work and all regional tribes have a seat on our Board of Directors. During the SAR4 reporting period, OCH conducted site visits with all partners who have a change plan and contract with OCH, implementation partners, including three tribal health clinics (Jamestown Family Health Clinic, Port Gamble S’Klallam Health Services, and Sophie Trettevick Indian Health Center). OCH staff traveled to each of the three tribal health clinics to meet with their teams and learn more about the work that each clinic does, including successes and challenges with transformation efforts. These site visits demonstrate OCH’s commitment to spend time in communities throughout the region, including remote tribal communities.

Olympic Community of Health recently adopted an internal practice for Tribal Land Acknowledgement at all OCH-hosted meetings and events. As a component of our larger equity plan, land acknowledgement is one way to recognize the traditional First Nations and Indigenous people. OCH created a standard presentation slide to guide the practice of land acknowledgements, as it utilizes a verified online resource to identify tribal lands.

On December 4, 2019, OCH hosted an Integrated Managed Care forum catered towards the communities and providers of Clallam County. Prior to the IMC transition on January 1, 2020, Clallam did not have any mandated managed care for any health care providers including Indian Health Care Providers (IHCPs). Because of the large reach of IHCPs in Clallam County and the Olympic region, OCH invited HCA Tribal Affairs staff to provide an overview of Medicaid updates related to health care for American Indian/Alaskan Native populations. This provided an opportunity for OCH staff and the 75 participant providers (including IHCPs) to learn about the impacts of IMC on IHCPs, including a new Tribal FQHC option that will have deep impacts in the region.

## 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.

<b>Use Categories</b>	<b>Design Fund Expenditures to Date</b>	<b>Projected Future Expenditures</b>	<b>Expenditure details (narrative)</b>
<b>Administration</b>	\$682,052	\$1,245,732	Administration design funds are used to run the internal operations of OCH. Uses include expenses related to financial management, human resources, office supplies and similar expenses.
<b>Health Systems and Community Capacity Building</b>	\$165,716	\$307,112	Health systems and community capacity building design funds are used for the Digital HIT Commons (a Community Information Exchange platform we are exploring), and statewide strategic planning expenses.
<b>Project Management</b>	\$885,952	\$1,652,228	Project management design funds pay for the majority of programmatic personnel expenses (time is still coded to use categories as appropriate) to support the implementation of the Medicaid Transformation Project, as well as any expenses that directly support the work of our programmatic staff doing this work, such as supplies and communication expenses. In addition, multiple contracts that support this work are coded to this use category.
<b>Provider Engagement, Participation and Implementation</b>	\$319,628	\$616,831	Provider engagement, participation and implementation funds are used for expenses to communicate with and engage partners, including most communications staff salaries, event expenses for convenings and trainings, and expenses incurred for staff to meet with partners.
<b>Other (describe below):</b>	\$124,749.00	\$0	Other expenses were used for project plan development expenses. This use fund designation has since been retired.
<b>Total</b>	<b>\$2,178,097</b>	<b>\$3,821,903</b>	

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

- a) Note: Include any earned Integration Incentives, Project Incentives or other funds that have been or will be used.
- b) ACHs may use the table below or an alternative format as long as the required

information is captured.

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

Methodology to calculate OCH incentive dollars to support behavioral health providers transitioning to integrated managed care to date:

- Identify total incentives provided or planned to be allocated to behavioral health providers during MTP
- Calculate number of behavioral health change plan outcomes supporting integrated managed care
- Calculate a percentage of change plan outcomes supporting integrated managed care multiplied by the total pool

When answering this question in previous SAR reports, OCH inadvertently provided actual and projected funds available for integration incentives for **all partners**, instead of only behavioral health providers. After careful review of the prompt which requests “ACH incentives to support behavioral health providers,” we updated our methodology to include only those incentives available to behavioral health providers.

Use of incentives to assist Medicaid behavioral health providers		
Description of Use	Expenditures (\$)	
	Actual	Projected
Project Incentives to Implementation Partners to support clinical and financial integration	\$112,988	\$98,066

## Section 2. Project implementation status update

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

### Attachments

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

#### 14. Implementation work plan

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

The ACH must submit an **updated implementation plan** reflecting *progress made during the reporting period*.<sup>3</sup>

- 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

---

<sup>3</sup> Note: ACHs are not to submit the narrative component of the October 2018 Implementation Plan. Semi-annual reporting guidance  
Reporting period: July 1, 2019 – December 31, 2019

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.**

See attachments:

OCH.SAR4 Attachment 1. 1.31.20

OCH.SAR4 Attachment 2. 1.31.20

OCH.SAR4 Attachment 3. 1.31.20

The updated implementation plan reflects a reduced number of delayed work steps compared to the previous submission. A few work steps remain delayed and below is a summary of those work steps with mitigation strategies:

Stage	Milestone	Work Step	Deliverable	ACH Organization	Target Date	Start Date	Mitigation Strategy
2	Develop guidelines, policies, procedures and protocols (Completion no later than DY 3, Q2)	Review list of new promising guidelines, policies, procedures and protocols internally and/or with subject matter experts	Evaluation of gaps in guidelines, policies, procedures and protocols	Program Manager	6/30/19	4/1/19	OCH is developing a robust peer learning strategy for 2020, and policies/procedures/protocols will be widely shared on the OCH website. Jamestown Family Health Clinic and Northwest Family Medical Residency both revised their opioid prescribing policies and established standardized procedures through their engagement with Six Building Blocks. Sophie Trettevick Indian Health Center began evaluating all relevant policies and procedures in preparation to revise. OCH has planned strategies for wider engagement with 6BB in 2020.
		Share recommendation for refinements of guidelines, policies, procedures, and protocols related to PHBH and CBOSS <sup>+</sup> Change Plans on OCH website	Partner Resource page on OCH website	Program Manager	6/30/19	4/1/19	
2	Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities	Distribute learnings and updates from PreManage learning collaborative	Tools from PreManage learning collaborative	Program Manager	12/31/19	7/1/19	The Collective Ambulatory workgroup (led by Healthier Here) did not launch until December 2019. Therefore, no learnings have been available to distribute. OCH is actively engaged in the workgroup and will distribute learnings as they become available. Additionally, as an on-time Integrated Managed Care adopter, PreManage was not widely available until our IMC launch. OCH met with

	(Completion no later than DY 3, Q4)						regional MCOs directly to create a plan for increasing access to and use of PreManage in 2020.
2	Regional self-identified milestone: Proactively engage community-based organizations, Tribes, and the beneficiaries of services to ensure that their voice guides and informs the decision making of the Olympic Community of Health	Provide written reports and/or recommendations to the OCH Board and staff to summarize strengths and gaps in social justice and health equity in the work of the MTP	Reports recommendations	Executive Director	12/31/19	10/1/19	In 2019, OCH worked with an equity organization called Racing 2 Equity to conduct two internal equity trainings. We also created a long-term equity plan. OCH has a new contract with an organization called Collaborative Consulting for 2020 to assist OCH in an in-depth analysis of regional social determinants of health work. Written reports will be provided to the OCH Board of Directors, and a health equity training is planned during the OCH Board of Directors retreat in September of 2020.
3	Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies (e.g., the use of interoperable Clinical Information Systems by additional providers, additional populations, or types of information exchanged) (Completion no later than DY 4, Q4)	Include breakout sessions and/or training in chronic disease prevention and control at Natural Community of Care convenings	Convenings	Community Program Coordinator	12/31/20	10/1/19	In July of 2019, OCH conducted a survey with implementation partners and Board members to identify top training and technical assistance needs to advance MTP work. This information is being used to create a formal learning and convening plan for 2020 and our Board of Directors approved a new budget line item to support this need. This work step is marked as delayed, although the target date is not until DY4Q4.

The updated Implementation Plan no longer includes the following work steps. Rationale for the removal of each work step is listed below:

Stage	Milestone	Work Step	Deliverable	ACH Organization	Target Date	Start Date	Previously Reported Progress	Rationale
2	Establish mechanisms for coordinating care with related community-based services and supports (Completion no later than DY 3, Q4)	Select partner organizations for local oral health improvement network with Arcora Foundation	List of partner organizations for local health improvement network	Program Manager	12/31/19	4/1/19	Delayed, Remains in Progress	In January 2020, the OCH Board of Directors voted to not pursue establishing a Local Impact Network with the Arcora Foundation as the model was not appropriate for a three-county rural region. OCH will seek alternative partnering opportunities with Arcora Foundation and has already taken steps to coordinate increased use of the Arcora medical-dental practice coach.
2	Engage with payers in discussion of payment approaches to support access to oral health services (Completion no later than DY 3, Q4)	Facilitate Implementation Partners to establish connection with apparently successful bidders of dental managed care contracts	Communications	Executive Director	12/31/19	10/1/19	Not Started	Dental Managed Care (a state-level policy) did not move forward in 2019. OCH will support if/when this moves forward.
		Meet with future successful bidders of dental managed care contracts to discuss potential financial and technical support of oral health integration in primary care	Meetings	Executive Director	12/31/19	10/1/19	Not Started	
3	Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional	Form Local Improvement Networks to enhance oral health access in partnership with	Oral health local impact network implementation plan	Executive Director	7/1/20	1/1/19	Delayed, Remains in Progress	In January 2020, the OCH Board of Directors voted to not pursue establishing a Local Impact Network with the Arcora Foundation as the model

	communities (Completion no later than DY 4, Q4)	the Arcora Foundation						was not appropriate for a three-county rural region. OCH will seek alternative partnering opportunities with Arcora Foundation and has already taken steps to coordinate increased use of the Arcora medical-dental practice coach.
3	Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion (Completion no later than DY 4, Q4)	Provide progress reports to PHBH Implementation Partners related to Eight Change Concepts of the Patient Centered Medical Home Principles	Coaching report from Qualis Health	Qualis Health Practice Coach Connector	6/30/19	10/1/18	Completed, Deliverable Met	OCH worked with Qualis/Comagine to bring practice coaching to the region through the Spring of 2020. Comagine reassigned the practice coach to another ACH region and could not ensure continued in-person practice coaching for the Olympic region. OCH staff solicited feedback from regional partners and most partners did not want to continue with this resource. Due to these changes, OCH chose not to contract with Qualis Health/Comagine in 2020. Behavioral Health partners are asked to complete the MeHAF assessment as a part of their regular reporting and are updated on their progress at bi-annual site visits. OCH also hosts a comprehensive resource page on its website. OCH conducts interviews with partners regarding the collaborative successes of various MTP activities. OCH uses these interviews to create partner spotlight articles. These articles are shared with partners and community members through our website blog and distributed via OCH's weekly newsletter.
3	Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies (e.g., the use of interoperable Clinical Information Systems by additional providers, additional populations, or types of information exchanged) (Completion no later than DY 4, Q4)	Provide progress reports to Implementation Partners related to Eight Change Concepts of the Patient Centered Medical Home Principles	Coaching report from Qualis Health	Qualis Health Practice Coach Connector	2/31/20	10/1/19	Fulfilled for Quarter, Remains in Progress	

3	Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches (Completion no later than DY 4, Q4)	Collaborate with DOH to coordinate training for providers to become waived for MAT	MAT training	Director of Community and Tribal Partnership	12/31/20	10/1/20	Delayed, Remains in Progress	The Three-County Coordinated Opioid Response Project (3CCORP) Steering Committee has identified that, at this time, the Olympic region has enough MAT providers, and resources would be better used on other activities.
---	--	--	--------------	--	----------	---------	------------------------------	--

### 15. Partnering provider roster.

The roster should reflect **all partnering providers** that are participating in project implementation efforts through the ACH under Medicaid Transformation.<sup>4</sup> To earn the achievement value associated with this reporting component, ACHs are required to update and submit the list of **partnering provider sites** that are participating in Medicaid Transformation Project Toolkit activities in partnership with the ACH.

#### Instructions:

- a) HCA will process the partnering provider roster submissions for SAR 3 during August-September. The processing step is to update the state database, and apply consistent formatting for ease of maintenance for future reporting periods.
- b) By **October 15**, HCA will provide ACHs a clean version of the ACH’s partnering provider roster (based on SAR 3 submissions) to update for the SAR 4 reporting period.
  - i. This will be the version that ACHs maintain for the remaining semi-annual reporting periods.
- c) For each partnering provider site identified as participating in transformation activities, the ACH should indicate:
  - i. Whether the partnering provider site is pursuing tactics or strategies in support of specific project areas from the Project Toolkit. Place an “X” in the appropriate project column(s).
  - ii. When the partnering provider site starts and ends engagement in transformation activities according to project area by indicating the quarter and year.
- d) Update partnering provider site information as needed over each reporting period.

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

See attachment: [OCH.SAR4 Attachment 4. 1.31.20](#)

<sup>4</sup> Partnering providers are defined as any traditional and non-traditional Medicaid providers and organizations that have committed to participate in the ACH’s projects. Traditional Medicaid providers are those that bill for services, either to a managed care organization or to the state directly (e.g., hospitals, primary care providers). Non-traditional Medicaid partners may receive some Medicaid funding through programs that provide grant dollars, etc., but they do not provide billable healthcare services to Medicaid members (e.g., behavioral health organizations, community based organizations, fire districts).

## Documentation

The ACH should provide documentation that addresses the following:

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

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

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

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

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

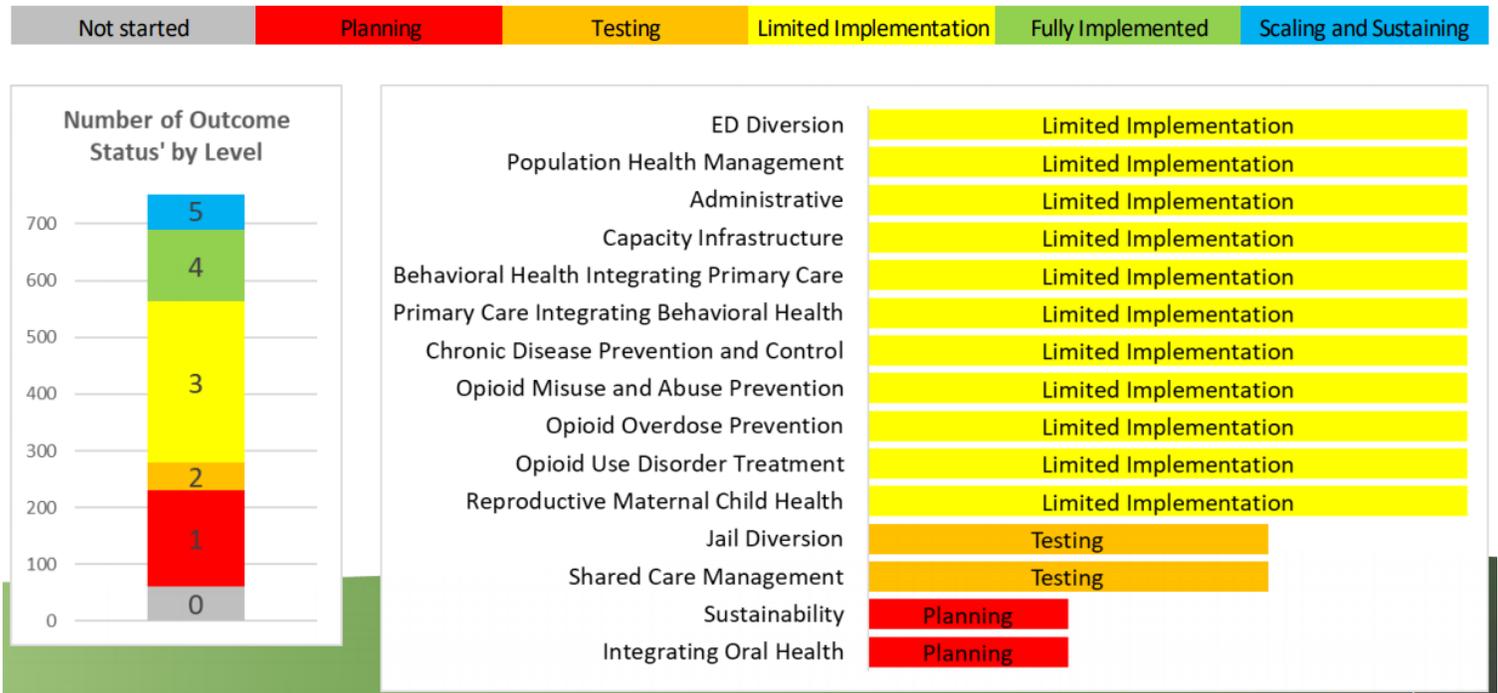
For this recurrent reporting requirement, HCA does not require that ACHs report site/provider organization-level quality improvement data. HCA will rely on these updates for evidence of forward momentum, including evidence that partnering providers have the resources and support required for success.

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

### **Quality improvement strategy update:**

- **Modifications to the ACH's quality improvement strategy:**
  - The only modification to OCH's quality improvement strategy is the discontinued use of the ORCA reporting platform. All partner reporting has been moved in-house and the ORCA platform is no longer available effective 1/1/2020. All implementation partners have been notified of the change and bi-annual reporting cadence remains unchanged. This change was made to better adapt the partner reporting template.
- **Summary of findings:**

- Progress-to-date on MTP activities in OCH implementation partner change plans is assessed twice per year at the following stages: not started, planning, testing, limited implementation, fully implemented, scaling and sustaining. Median scores across all implementation partners are assessed. Partner reporting was collected in July 2019, and again in December 2019. Median scores from the December reporting are not yet available for this report, they will be shared with partners and the OCH Board of Directors in early 2020 and included in SAR5. The graphic below details the progress of activities as of July 2019 partner reporting:



- Review of the most recent (10/23/2019) pay for performance (P4P) metrics indicate the following metrics at the OCH regional level have a less favorable result for 2018 baseline compared to 2017 baseline:
  - all-cause ED visits per 1000 MM age 0-17;
  - anti-depressant medication management (continuous and acute);
  - child and adolescent access to primary care practitioners ages 25months-6 years, 7-11 years, 12-19 years;
  - chlamydia screening among women ages 16-24;
  - HbA1c testing, medical attention for nephropathy;
  - mental health treatment penetration adults ages 65+;
  - percent homeless ages 18-64.

OCH staff utilize P4P metrics progress as an additional assessment of where to target trainings, technical assistance, and additional focus. The following metrics at the OCH regional level have improved for 2018 baseline compared to 2017 baseline:

- all-cause ED visits per 1000 MM age 18-64 and 65+;
- mental health treatment penetration 6-17 and 18-64;

- substance use disorder treatment penetration for all ages;
- and dental service utilization for all ages.

In 2020, OCH will focus convenings and peer learning opportunities around ED utilization, social determinants of health, and community-clinical linkages.

○ **Findings by project:**

- **Project 2A:** Median scores on progress-to-date reports indicated “limited implementation” in integration efforts. During the reporting period, much focus was placed on successful transition to financial Integrated Managed Care, and progress is expected to continue in 2020. Despite the focus on IMC, great strides have been made in all three counties to integrate both behavioral health and dental care into primary care, with our two local FQHCs leading the way.
- **Project 2D:** Median scores on progress-to-date reports indicated “limited implementation” in ED diversion activities and “testing” in jail diversion activities. Peninsula Community Health Services in Kitsap county integrated Community Health Workers into both the jail and local ED. Peninsula Behavioral Health in Clallam county streamlined care coordination for patients discharging from the local jail. Jefferson Healthcare in Jefferson county is in early stages of implementing a community paramedicine program with the local fire department.
- **Project 3A:** Median scores on progress-to-date reports indicated “limited implementation” in all opioid related focus areas of the change plan. OCH hosted its third Opioid Response Summit and 3CCORP remains active and continues to expand membership. Clallam county overdose-related deaths have significantly decreased. One partner successfully completed the Six Building Blocks program and an additional two clinics started the Six Building Blocks program.
- **Project 3B:** Median scores on progress-to-date reports indicated “limited implementation” and P4P data show a decrease in regional performance for chlamydia screening. Forks Community Hospital hired a midwife, which marks the first-time access to maternity services has increased in the west end of Clallam county since well-before MTP. Peninsula Community Health Services implemented One Key Question (a transformation tool related to family planning), North Olympic Healthcare Network continues to expand access to maternity services, and Kitsap county community organizations have streamlined referrals to support services for pregnant and parenting women.
- **Project 3C:** Two new dental clinics opened in Jefferson and Clallam counties to increase access to services during this reporting period. OCH coordinates with Arcora Foundation’s practice coach to enhance medical-dental integration throughout the region, particularly in rural communities where limited access to oral health services remains.
- **Project 3D:** Median scores on progress-to-date reports indicated

“limited implementation.” More behavioral health providers are screening and referring for physical health conditions. Primary care and community-based organizations are partnering to increase participation in chronic disease self-management and diabetes prevention programs, and OCH staff informally connect providers across its network with shared interests in chronic disease.

- **Adjustments and lessons learned:**

- OCH will have an increased focus in 2020 around ED utilization, access to care (behavioral and physical) and community-clinical linkages. OCH will require enhanced work from implementation partners around ED utilization, community-clinical linkages, and social determinants of health per the Board of Directors-approved 2020 payment model. The 2020 learning and convening plan includes convenings centered around ED utilization and social determinants of health. OCH continues to actively monitor Integrated Managed Care in 2020 to track access to care gaps across the region.
- To improve reporting consistency across implementation partners, OCH staff provided additional guidance and definitions for the stages of progress to date for the completion of the next submission (deadline was 1/6/20).
- The OCH Performance Measurement and Evaluation Committee (PMEC) met in November to learn about available data sources for assessment to guide adjustments and areas for deeper focus. Moving forward, PMEC will meet three times in 2020 to review data and make recommendations to the OCH Board of Directors for potential course corrections.
- Four out of five Managed Care Organizations have committed to sharing HEDIS metric data with OCH on a quarterly basis at the regional and county level; 3 MCOs have shared at least one report with OCH. These data will be used by PMEC and internally by OCH staff to identify areas of success and promote best practices, potential gaps, and make recommendations for course corrections.
- In September 2019, the OCH Board of Directors approved a revised set of intermediary metrics for partner reporting. The revised metrics were reviewed with partners at the fall site visits and the first report will occur in February 2020. Reporting on intermediary metrics will allow OCH staff to track progress towards P4P metrics at the individual organization level, more frequently and help prepare providers for value-based contracting.

- **Support provided to partnering providers to adjust transformation approaches:**

- OCH staff conducted a second round of site visits with all implementation partners between September and December 2019. All partners were provided a summary of their most recent report completed in June 2019. OCH staff collected a summary of success stories which will be shared to promote peer learning and collaboration. OCH staff individually follow up with every implementation partner following their site visit to respond to requests. For example, OCH connected two additional partners with the Arcora Foundation’s medical-dental practice coach as a direct result from requests received at the site visit.

- In September 2019, OCH hosted the third Opioid Response Summit, providing an opportunity for partners across all sectors to convene, learn, and share best practices and successes relating to the MTP Project 3A.
  - In November 2019, OCH convened all seven contracted community-based organizations and social service providers to promote peer learning and explore the potential value CBOs may bring in VBP.
  - In December 2019, in collaboration with HCA and the four MCOs that will be in the region in 2020, OCH hosted a Clallam Integrated Managed Care forum for physical health providers and community-based organizations to learn and prepare for Integrated Managed Care. The event included an overview of Integrated Managed Care, an opportunities and challenges activity, crisis system updates, early warning system update, Tribal Federally Qualified Health Center updates, and an MCO panel discussion.
  - OCH continued to contract with University of Washington to support implementation of the Six Building Blocks throughout 2019 and is collaborating to offer additional modes of engagement to increase learning opportunities in 2020.
- **Identified best practices on transformation approaches:**
    - Launch of embedded Community Health Worker at Harrison Medical Center ED, in collaboration with Peninsula Community Health Services.
    - Increase in walk-in services across the region and across sectors, including ‘walk-in Wednesdays’ at Olympic Personal Growth, a substance use disorder provider, and walk-in services at the North Olympic Healthcare Network dental clinic.
    - A centralized referral system for pregnant and new mom social support programs was established in Kitsap County by Answers Counseling in collaboration with Kitsap Public Health Department and other social service programs.
    - Jamestown Family Health Clinic completed the Six Building Blocks program. Northwest Family Medicine Residency will complete the program in 2020.
    - Olympic Medical Center began a patient navigator program to address specific patient needs and provide resources to help patients navigate through the health care system. Patient navigators help patients access community resources, including financial assistance, lodging, transportation, disease and treatment reference materials, community support, and respite housing.
    - Port Angeles Fire Department continued its community paramedicine program, in partnership with North Olympic Healthcare Network. The program’s successes were shared at the Opioid Summit and Jefferson Fire Department and Jefferson Healthcare are exploring the possibility of launching a similar program in Jefferson County.

## Narrative responses

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

## 17. General implementation update

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

Across the region, fourteen partner organizations reported implementing cultural competency trainings for staff in the reporting period.

### Example 1

OCH sponsored three community-based organizations and social services partners to attend the Health Care Authority MTP learning symposium in October 2019. The learning symposium provided opportunities for partners to learn more about statewide efforts to address social determinants of health and enhance community-clinical linkages. Partners reported they saw parallels between the discussions and their scope of work in their individual change plans. In 2020, OCH will contract with Collaborative Consulting and Pritpal Tamber to engage all partners in learning and action planning around health equity and social determinants of health. This partnership with Collaborative Consulting will allow OCH to further address the gap of knowledge and understanding regarding social determinants of health specific to the Olympic region.

### Example 2

In November 2019 Port Gamble S’Klallam Health Services, a tribal partner, provided on-site Nuka System of Care training for all health services staff. Nuka core concepts were introduced which will prepare staff to build and maintain effective relationships with their patient population. Port Gamble S’Klallam Health Clinic agreed to share their experience and subsequent results of the training widely with other partners in the region. Additional training is needed to build on basic concepts and reach additional staff as turnover occurs. Other tribal partners in the region have indicated interest in receiving Nuka System of Care training.

### Example 3

Discovery Behavioral Health required staff to complete two cultural competency trainings in 2019. The trainings were sponsored by the National LGBT Health Education Center. One addressed the impact of social determinants of health for the LGBT community. The second provided employees with best practices for addressing behavioral health needs for transgender

adults. Both trainings aimed to improve the ability of staff to provide care for populations facing disparities. Discovery Behavioral Health develops an annual training calendar to address gaps and provide evidence-based guidelines for staff; in 2020, two additional trainings related to cultural competency and health equity were identified.

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

### **Example 1**

Forks Community Hospital implemented and continues emergency department tracking reports which show a 50% reduction in emergency department re-visits. Each morning, care coordination staff pull a report of the previous day's emergency department visits, review each chart and prioritize each case. Staff then reach out to each patient within 7 days of discharge, and some patients are seen for follow up care the same day. The hospital partners collaborate with local primary care and behavioral health clinics for referrals for follow-up care and to track additional measures: emergency department return visits, total emergency department visits, and the number of patients receiving follow-up via phone or in-person appointment within 7 days of discharge.

### **Example 2**

Port Gamble S'Klallam Health Services, a tribal partner, created and implemented a shared consent form which has been operationalized in both primary care and behavioral health clinics. This reduced communication barriers between provider types, streamlined coordination of care, and provided the opportunity to begin tracking a closed-loop referral system for shared patients. Port Gamble S'Klallam Health Services reports a next step is to implement the shared consent form with their dental services.

### **Example 3**

Jefferson Healthcare primary care provided read-only access to Epic for local pharmacies in Jefferson County. This allows community pharmacists to help manage patient medication lists as well as improve accuracy of dispensing. In 2020, they plan to focus on expanding access for community partners to better manage shared patient populations.

### **Example 4**

All ACH Executive Directors across the state 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.*

The ACHs will discuss goals and recommendations with stakeholders and determine how each fit with the ACHs' priorities, projects, and roadmaps, and adding relevant activities to

their plans for 2020 and beyond.

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

### **Example 1**

Kitsap Mental Health Services utilizes PreManage as a risk stratification tool and to provide real time assistance to the emergency room for shared clients. The ability to identify the highest utilizers of the emergency room and provide wrap around additional services has improved client care. Additional services include assigning peer supports and/or care coordinators who can help connect clients to appropriate community-based supports such as housing and focus on skill building around education and employment solutions. Peer supports utilize both in-house services, such as the Keller House, a transitional housing unit on-site for transitional care from in-patient to home, and community-based supports such as Kitsap Community Resources, a local hub for community supports including long-term housing placement and mitigation services to keep people in current housing.

### **Example 2**

Olympic Medical Center, a hospital in Port Angeles, established a social services department with care coordinators who develop transitional care plans for patients discharging from inpatient units. Care coordinators are familiar with local community-based organizations and supports to tailor transitional care plans for each patient. Care Coordinators connect with programs through the Peninsula Housing Authority and Olympic Community Action Programs to provide housing assistance for patients experiencing homelessness and First Step Family Support Center for ongoing infant case management and other supportive parenting programs. Additionally, Olympic Medical Center and Olympic Peninsula Healthy Communities Coalition have partnered to provide healthy food packages to patients discharging from the hospital, who may not have access to healthy food upon their return home.

### **Example 3**

Answers Counseling partners with the Northwest Washington Family Medical Residency to provide Maternity Support Services. Answers Counseling assumes primary responsibility for the care management of referred patients and coordinates appropriate referrals and follow up care. Additionally, Answers Counseling partnered with Kitsap Public Health District to coordinate a centralized referral hub in Kitsap county for all pregnant and early childhood support programs. A cross-organizational team reviews referrals and follows established guidelines to direct clients to the most appropriate service(s).

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

### **Example 1**

Jefferson Healthcare provides quarterly reports on measures to all primary care providers. The primary care providers selected four quality incentive measures to monitor in 2019: current naloxone prescription for high-MEDD patients, opioid risk tool utilization, controlled medication agreement in chart, and depression screening with follow-up. Providers set performance goals for 2020 and track progress throughout the year.

### **Example 2**

Discovery Behavioral Health's quality management committee implemented a Plan, Do, Study, Act (PDSA) framework to manage opioid-related change plan activities. Through this framework, a Medication Assisted Treatment (MAT) project leader collaborates with the quality management committee to implement recommendations and feedback to improve efficiencies within the project. Specifically, the committee recognized that aligning change plan activities with Beacon of Hope, a local substance use disorder provider and OCH implementation partner, would improve coordination between the agencies. The administration team of Discovery Behavioral Health and Beacon of Hope regularly meet and discuss ways to improve care coordination.

### **Example 3**

Kitsap Recovery Center recently developed a quality improvement team composed of employees. The team was established and met three times during the reporting period, as a direct result of direction provided in their change plan. The team utilizes client surveys, grievances, and incident reports to identify potential gaps in care and strategize methods for improvement. As a result, improvements to medication systems have been made to reduce potential for errors and ensure better tracking. Additionally, systems to screen and track physical health conditions have been established, in partnership with the electronic health record, and 1 patient with undiagnosed diabetes was identified and referred to appropriate primary care during the reporting period.

- ii. For each project in the ACH Project Plan, provide clear, specific, and concise responses to the below as applicable. For projects the ACH is not implementing, indicate "Not Applicable."
  1. Project 2A: Provide a summary of financial resources provided to participating providers and organizations to offset the costs of infrastructure necessary to support integrated care activities.

The OCH change plan template includes mandatory and voluntary outcomes for care integration and encourages partners to commit to these outcomes in order to earn incentives. In 2019, integration outcomes accounted for 4.4% of potential change plan incentives for primary care partners, and 7.6% of incentives for behavioral health partners. The actual dollar value of integration-related change plan incentives is dependent on the specific performance of individual implementation partners relative to all other partners in their incentive sub-pool. Actual awards will vary based on the relative performance of partners. Implementation partners are not required to report utilization of received funds to OCH.

2. Project 2B: Provide information related the following:
  - a. Schedule of initial implementation for each Pathway.

Not applicable.

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

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

Not applicable.

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

Not applicable.

CCA Name	Total # of Referrals to CCA for any Pathway

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

Not applicable.

- 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.

Not applicable.

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

mandatory versus individual goals-based, and key partners to include in offering trainings.

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

4. Project 3A: Provide two examples of the following:
  - a. Strategies and approaches implemented across each of the core components: prevention, treatment, overdose prevention, and recover supports.

## Opioid Misuse and Abuse Prevention

### Example 1

Peninsula Community Health Services (PCHS) is now providing syringe exchange at five of their pharmacies. Kitsap Public Health District is partnering with PCHS to transition the public health district's syringe exchange services to a network of fixed-location health care facilities while the health district continues to provide a mobile syringe exchange program in rural areas of Kitsap County. PCHS provides medication assisted treatment and this change will increase linkage between needle exchange and treatment services.

### Example 2

OCH brought together the University of Washington and five clinics to implement Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care (6BB). The 6BB program was developed at the University of Washington in response to opioid crisis with the goal of developing organization-wide consensus, policies, and procedures for more selective and cautious opioid prescribing. 6BB provides an evidence-based quality improvement roadmap to help primary care teams implement effective, guideline-driven care for their chronic pain and long-term opioid therapy patients. OCH has committed to supporting implementation for up to ten clinics. Thus far one clinic has completed and four have begun the 18-month 6BB implementation and training program with participation from across the Olympic region. Jamestown Family Health Clinic (JFHC) is the first to complete the entire training program, serving approx. 20,000 clients. From our site visit with JFHC we learned of their intention to work with other organizations to standardize opioid prescribing practices across Clallam County with partners including Olympic Medical Center and North Olympic Healthcare Network.

## Opioid Treatment

### **Example 1**

A new treatment center, BAART Port Angeles, opened and is providing Medication Assisted Treatment (MAT) for opioid use disorder along with other services including case management, individual and group counseling, and referrals to community resources that may help patients struggling with addiction. The treatment center is serving more than 20 patients and has a waiting list.

### **Example 2**

Reflections Counseling is now running two MAT groups with one in the evening to increase access to services.

### **Example 3**

Discovery Behavioral Health is training staff in MAT with focus on serving clients with severe mental health disorders.

### **Example 4**

Jefferson Healthcare integrated MAT into their primary care teams for a whole patient approach to health care at their five locations (Port Townsend Primary Care Clinics, Port Ludlow Clinic, and South County, Quilcene).

## **Opioid Overdose Death Prevention**

### **Example 1**

Prevention Coalition in Jefferson County is actively planning an overdose prevention campaign.

### **Example 2**

Naloxone training was provided, and overdose prevention kits were distributed by the Department of Health during the third OCH Opioid Response Summit in September 2019.

## **Recovery Supports**

### **Example 1**

A new community-based organization “Voices for Health and Healing” was formed in Clallam County to support recovery and additional MAT locations on the north Olympic Peninsula. The organization seeks to decrease stigma associated with recovery and increase the community’s knowledge of the recovery process. The organization does this health promotion and community engagement by speaking at public events, writing letters to the editor and placing display ads in two local newspapers, and creating a strong social media presence on Facebook.

### **Example 2**

Port Angeles Fire Department hired a community paramedic who works with the Port Angeles Police Department social worker to remove barriers to recovery. The Community Paramedic and Social Worker remove barriers by identifying high risk individuals, coordinating care, providing transportation, and conducting outreach with the homeless community via homeless shelters and visits to homeless camps.

- 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.

OCH monitors state-level modifications to the 2016 Interagency Opioid Working Plan and related clinical guidelines through participation in the monthly Opioid Response Workgroup (ORW) meetings and through surveillance of documents and information provided on the Washington Department of Health webpages and in the Opioid Response Portal documents, including annual Response Plans and Progress Reports. OCH tracks ORW metrics and incorporates them into our project implementation plans. OCH utilizes the metrics to identify our regional strengths and opportunities and shares the findings at workgroup meetings and at annual Opioid Response Summits.

**Examples include:**

1. Implementing actions to improve our outcomes for the metric “Patients on high-dose chronic opioid therapy > 90 mg MED” with resulting downward trend from greater than 13 per 1,000 in 2012 to 3.8 per 1,000 in 2019.
2. Implementing activities to measure and treat opioid use disorder leading to an increase in % Medicaid clients with an opioid use disorder receiving medication assisted treatment from 25% in 2016 to 40% in 2018.
  - 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.

**Example 1**

The Three County Coordinated Opioid Response Project (3CCORP) consists of a Steering Committee and three workgroups: Treatment, Abuse and Misuse Prevention, and Overdose Death Prevention. The Steering Committee reports to the OCH Board of Directors and provides guidance and recommendations to ensure that the implementation of the MTP opioid response plan addresses the needs and resources of the diverse stakeholders and partners across three counties. A member of the Steering Committee serves as chair for each of the workgroups. The Steering Committee and three workgroups have over 100 members representing public, behavioral, and physical health care organizations, community-based organizations, consumers, education, tribal leadership, elected officials, emergency medical, and law enforcement.

Successes include:

- 1) an actively engaged group of over 20 members serving on the Steering Committee, serving as leaders and champions for engaging community on improving and enhancing local and regional response to opiate use disorder
- 2) Creation of 2 new MAT clinics in Clallam and Kitsap County to help meet the need for increased medication assisted treatment services in our region
- 3) A coordinated effort by the treatment workgroup to increase uptake of the Six Building Blocks: A Team-Based Approach to Improving Opioid Management in Primary Care. The 6BBs represent six key work areas a clinic can redesign to improve management of patients who are on long-term opioid therapy. With guidance from the University of Washington, five clinics across the Olympic Region have begun the process of implementing the 6BBs and one clinic (Jamestown Family Health Center) has fully implemented this improved patient with OUD management strategy.

A challenge experienced by our region is a continuing high rate of death by opioid overdose; the age adjusted rate for all opioid overdose in the Olympic region is 10.5 per 100,000 compared with age adjusted rate of 9.6 per 100,000 for the state (source: Washington Department of Health Opioid Overdose Dashboard for 2015-2017). 3CCORP’s plan of action is to identify champions for our Overdose Death Prevention workgroup and lead a regional effort to 1) increase the number of agencies that have overdose kits on site with staff trained to use them and 2) increase the number of agencies without ability to prescribe/provide overdose kits that refer individuals to other partners for overdose kits. The 3CCORP Steering Committee will begin this work in 2020.

### **Example 2**

The third annual Opioid Response Summit took place on September 13, 2019. The summit provided opportunity to convene regional partners and community members to celebrate successes, identify persistent gaps, and to issue a call-to-action. The summit included five primary agenda topics each of which was followed by small group discussion or Q&A so that participants had opportunity to discuss and synthesize the information. The five topics included: data as transformation – regional successes and gaps, best practices for treatment of opioid use disorder – destigmatizing our community, best practices in youth prevention, Clallam County community paramedicine, and a criminal justice and first responder panel. The summit concluded with two optional events: 1) a training on how to recognize and appropriately respond to an opioid related overdose, and 2) office hours with regional opioid use disorder treatment agencies. 179 attendees representing providers, first responders, law enforcement, consumer representatives, state/local/tribal public health, education, and community-based service providers. As a result of the summit: 42 attendees answered our call-to-action and signed up to become involved in 3CCORP. Several Steering Committee members committed the additional time necessary for planning and leading this convening. The Suquamish Tribe provided a beautiful space for the event to be held. Police and Fire Chiefs took the lead on a criminal justice panel. Participant evaluation informed that participants were surprised at the number of people and sectors engaged and a take-away was learning of the “engagement and compassion of law enforcement”. Moving forward we will use the takeaway learning to enhance opportunities for collaborative partnership with a focus on incorporating law enforcement and first responder organizations and strategies into 3CCORP. Those who answered our call-to-action are signed up for 3CCORP workgroups and will lend additional voices and perspective to the work.

- 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.

Providers report that some clients referred to recovery services are not accessing the recovery services they need. Barriers to accessing recovery services include technology limitations and differing standards of care that prevent streamlined care coordination between agencies, client access to reliable transportation, and matching available MAT prescriber services with available outpatient treatment support programs. 3COORP plans to address these gaps using two strategies:

### **Example 1**

Develop regional standards of care and regional ROI to facilitate care coordination and increase access to treatment and recovery services. Our planned approach incorporates two

steps: 1) 3CCORP treatment workgroup to review recent HCA guidance *Sharing Substance Use Disorder Information: A Guide for Washington State* and make a recommendation on using this as a standard of care for our region. This will help clarify the state and federal laws that limit the use and disclosure of SUD treatment information so that providers can be more confident in what and how they share treatment information with other recovery support services. Better information sharing will help providers work together to support their patients, assure medications are prescribed safely, and identify gaps and limit duplication of services. 2) Convene Clallam Health Network and pilot test a CIE (Digital HIT Commons) between primary care, first responders, and, ideally, recovery support services. This information sharing and analytics platform will link referrals and data across clinical and social sectors, as well as linking and communicating with patients. With this tool, we can identify and prevent gaps in access to recovery support services. This activity has the potential to impact the number or location of current providers based upon gaps identified.

### **Example 2**

Develop a regionally integrated system to achieve warm handoffs between primary care providers, OUD treatment providers, and social service providers. The approach will increase the number of providers offering case management and care coordination. A first step is to convene one meeting in each OCH county, beginning with Clallam County, for a discussion among the key partners. A second step includes implementing a tracking system to measure the number of people receiving OUD treatment who are successfully connected to outpatient services. Through earlier work done by 3CCORP the Olympic region developed two Hub and Spoke networks serving the Olympic Region, the Peninsula Community Health Services Network and the Olympic Peninsula Health Network. As established referral networks, these Networks will facilitate filling the gap and implementing development of a regionally integrated system for warm handoffs. Recovery support services are increasing now that services by peer recovery support specialists are billable enabling more agencies to hire peer recovery support specialists in our region.

5. 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.

A range of mechanisms have been established for coordinating care with community-based services in the Olympic region. Among the most common include fax, email, and phone calls. Several partnering agencies provide dental care onsite which allows care coordination to be completed electronically through EHR systems. These partners have developed strong relationships and subsequent referral mechanisms, to accept and serve Medicaid clients from other community-based organizations. Local agreements are made between partnering organizations and clinical providers to serve the specialty dental care needs of clients.

1. Kitsap Mental Health Services (KMHS) developed a relationship with Peninsula Community Health Services, who opened a dental clinic at the main KMHS campus and maintain daily standing appointments for clients.
2. West End Outreach Services relies on charity care from the twice-a-year SmileMobile to serve children. Historically, adult clients had to travel from the west end of Clallam county to

Bremerton to access regular dental care, however, this has improved with the opening of a new dental clinic at North Olympic Healthcare Network, the FQHC in Port Angeles.

3. North Olympic Healthcare Network partners with First Step Family Support Services to reduce access barriers for clients living in the west end of Clallam county. First Step provides transportation and North Olympic Healthcare Network makes weekend appointments.
  - 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.

### **Example 1**

Bogachiel and Clallam Bay Primary Care Clinics implemented a medical-dental integration program. Providers and support staff were trained by the Arcora Foundation's practice coach to provide fluoride treatment, educate patients, and refer to a dental home. This program is designed for children due to the Medicaid reimbursement structure.

### **Example 2**

Jefferson Healthcare's primary care clinics refer patients to their internal dental clinic through their EHR, Epic. The dental clinic identifies and prioritizes high risk clients, such as those undergoing infusion treatment for cancer or pregnant women. To divert clients away from the emergency department, Jefferson Healthcare is implementing a dental-specific workflow to avoid emergency department misuse for dental-related issues. These workflow changes have been made possible due to Epic EHR capabilities.

- 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 varies across the region. As dental managed care did not move forward in 2019, partners currently operate fee-for-service models, sliding scale fee models, and two have negotiated encounter-based payments with the Health Care Authority.

6. Project 3D: Provide the following:
  - a. Description of status of activities that have been conducted based on the Chronic Care Implementation Plan, including a summary of how the ACH is ensuring integration of clinical and community-based strategies through communication, referral, and data sharing strategies.

Physical health, behavioral health, and hospital change plans all have a "chronic disease prevention and control" focus area, with relevant outcomes, tactics and sub-tactics. The community-based organization and social services change plan includes relevant tactics and sub-tactics to ensure coordination of efforts across provider types. In the July 2019 qualitative partner reporting, the median status for the "chronic disease prevention and control" focus area was limited implementation. These data were shared back with all partnering providers during fall site visits and with the OCH Board of Directors. There is agreement across partners to increase focus of chronic disease moving forward in 2020. In September 2019, the OCH Board of Directors approved the revised intermediary metrics, including intermediary metrics for the MTP project 3D P4P metrics. These intermediary metrics will allow OCH staff to predict

performance on P4P metrics at the organizational level, track progress across the region with more timely data, and recommend adjustments to the region’s strategy and approach. OCH staff participate in various community meetings related to MTP Project 3D including the Jefferson Community Health Improvement Plan and Olympic Peninsula Healthy Communities Coalition to ensure collaboration and alignment with other local efforts.

- 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).

OCH did not select community-based care coordination or transitional care as an MTP project. However, in accordance with the MTP toolkit for project 3D, the change plan includes outcomes and tactics that detail care coordination and community-clinical linkage strategies, including implementation of the chronic care model, as well as expectations for incorporating screening, tracking, and referral of social determinants of health.

**Example 1**

North Olympic Healthcare Network, an FQHC in Clallam county, hired a Patient Navigator specifically to help patients with social support connections. As social needs are identified, patients are referred to the Patient Navigator who assists with referral to appropriate services, tracking, and closing the loop.

**Example 2**

Kitsap Mental Health Services identifies social needs of clients upon intake. Care coordination staff then work with housing agencies, food banks, and employment services to address social needs outside of clinical care. Information is shared through fax, email and in person once a release of information form is obtained.

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

	Challenges/Risks	Potential Impacts/Mitigation Strategies
HIT/HIE	<ul style="list-style-type: none"> <li>• Providers are using EHRs with limited functions without resources to upgrade to more robust EHRs. Even those with more robust EHRs still lack sophisticated tools to seamlessly carry out care coordination and population health management.</li> <li>• Lack of interoperability remains an issue for achieving seamless care coordination or sharing of client records</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate smaller providers to gain Epic view-only access to access shared client records in 4 of the bigger healthcare systems (Jefferson Healthcare, Jamestown Family Health Center, Olympic Medical Center, and North Olympic Healthcare Network)</li> <li>• Pursue Health Commons as CIE (pilot planned for Clallam County in 2020)</li> <li>• Implementation of PreManage for behavioral health providers</li> </ul>
VBP	<ul style="list-style-type: none"> <li>• Behavioral health providers have</li> </ul>	<ul style="list-style-type: none"> <li>• Continue to facilitate information</li> </ul>

	<p>been focused on transitioning to financial integrated managed care and most do not have information on future VBP contracting expectations.</p> <ul style="list-style-type: none"> <li>• CBOs are struggling to connect with clinical providers to assert if/how they may add value in VBP contracting</li> </ul>	<p>sharing and convening as necessary between MCOs and providers</p> <ul style="list-style-type: none"> <li>• Convene CBOs to discuss value in VBP contracting and prepare for sub-contractual relationship with clinical providers</li> </ul>
Integration	<ul style="list-style-type: none"> <li>• Clinical integration work has been delayed for some partners due to current focus on financial integration</li> </ul>	<ul style="list-style-type: none"> <li>• Work closely with SBHO (now the SBH-ASO), MCOs, and HCA through the Interlocal Leadership Structure and Early Warning System to ensure successful transition to integrated managed care</li> <li>• Promote peer learning opportunities and highlight clinical integration success stories</li> <li>• Provide opportunities for partners to expand change plan activities to promote increased focus on clinical integration</li> </ul>

**Acronyms used in this table:**

*EHR – Electronic Health Record, HCA – Health Care Authority, HIE – Health Information Exchange, HIT – Health Information Technology, MCO – Managed Care Organization, SBHO – Salish Behavioral Health Organization, VBP – Value Based Payment*

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

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

In response to an increasing trend of emergency service utilization for non-emergent situations, the Port Angeles Fire Department implemented the Port Angeles Community Paramedicine pilot program. The Community Paramedic works alongside North Olympic Healthcare Network, Olympic Medical Center, Peninsula Behavioral Health, Jamestown Family Health Clinic, Lower Elwha Tribal Clinic, and Port Angeles Police Department & Olympic Peninsula Community Clinic. These partnerships allow the Community Paramedic to equip community members with a wide variety of resources and services.

In just six months, the Community Paramedicine program saw a 50% decrease in EMS calls and transports to the emergency room after initial contact with the Community Paramedic. The impact goes beyond the numbers. Fire Chief Ken Dubuc describes, "[The pilot] resulted in better patient outcomes. I don't want to lose sight of the reason that we are doing this: to provide a better level of care." DSRIP funds made this collaboration possible. Dubuc explains, "if the OCH had not been formed, none of this would have happened. It was the OCH call for Change Plans that prompted all of this."

**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?

Not applicable

- 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.

OCH and Salish Behavioral Health Organization (SBHO, now the SBH-ASO) leadership held monthly Interlocal Leadership Structure (ILS) meetings throughout the reporting period with MCOs, HCA, providers, and county commissioners to develop collaborative plans for these three workgroups:

Provider readiness/technical assistance workgroup	Early warning system	Communications workgroup
<p>The Salish provider readiness workgroup launched in March of 2019. This workgroup continued to meet monthly led by SBHO. During this reporting period, there were 4 provider readiness meetings, 2 MCO-hosted learning symposiums, and 1 SBH-ASO-hosted learning symposium. Additionally, OCH hosted 1 IMC learning session for Clallam county physical health providers, IHCPs, and community partners.</p>	<p>This workgroup launched in August of 2019. OCH served as the lead coordinating entity of the group and participants include SBHO, HCA, MCOs, providers, community members, a county commissioner, and others. The workgroup met 3 times during this reporting period to finalize the set of regional IMC indicators. At the IMC learning session for Clallam county, the agenda included a discussion dedicated to early warning system updates. The OCH Board of Directors also received a briefing on this system.</p>	<p>This workgroup launched in August and was co-led by SBHO and HCA. OCH and various providers from across the region participated. The group met twice during the reporting period to provide feedback and finalize communication materials. Resources such as statewide MCO contact lists, FAQ sheets and informational guides regarding claims and encounters, overviews of county specific changes with IMC, and more are shared on OCH’s IMC Resources webpage. Resources are also distributed in OCH’s weekly email communications, with reach to over 600 individuals.</p>

**Acronyms used in this table:**

*ACH – Accountable Community of Health, HCA – Health Care Authority, MCO – Managed Care Organization, OCH – Olympic Community of Health, SBHO – Salish Behavioral Health Organization*

- 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?

**Behavioral health provider readiness:**

- Behavioral health providers actively participate in the monthly provider readiness workgroup. During this reporting period, organizations worked directly with MCOs on testing claims processes.
- All behavioral health providers currently in-network with the SBHO have signed contracts with the MCOs. MCOs state they have met network adequacy in the OCH region.

**Physical health provider readiness:**

- Clallam county was not mandated to contract with MCOs to provide Medicaid services prior to 1/1/2020, so readiness in Clallam included both behavioral and physical health providers. OCH, in partnership with the HCA, MCOs, and SBHO hosted a Clallam county IMC learning forum.

**Technical assistance needs:**

- Interlocal Leadership Structure (ILS) meetings: OCH provides meeting space for SBHO to host monthly ILS meetings. OCH staff participate in these meetings along with HCA, MCOs, some providers, and County Commissioners. The executive directors of OCH and SBHO meet regularly to plan the agenda for these meetings.
- Communications platform: MCOs, HCA, and providers needed an online platform that could serve as a repository for files and learning space. OCH created an Integrated Managed Care resource page on our public website and regularly promotes materials via weekly emails.
  - Staffing needs: SBHO and OCH collaborated to distribute the work of leading IMC workgroups. OCH staffed the EWS workgroup while the SBHO staffed the communications workgroup.

**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> <p>b) Identification of partnering provider candidates for key informant interviews.</p>	X	

	Yes	No
c) ACH participation in key informant interviews. Note: Participation in interviews for the evaluation is voluntary.		
d) 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.		

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

## Section 3. Value-based Payment

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

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

### Narrative responses

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

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

Methods used to identify providers struggling to implement practice transformation, move toward value-based care, and overview of activities OCH conducts to support those providers:

- OCH asks providers to report on progress, barriers, and lessons learned with VBP contracting in bi-annual qualitative reporting.
- OCH also uses results from the VBP survey to identify top barriers in the region towards VBP contracting progress.
- In September 2019, the OCH Board of Directors approved the OCH intermediary metrics, which were dispersed to providers and discussed during fall 2019 site visits to help prepare providers prepare for reporting in 2020. The intermediary metrics will provide OCH with more timely data of the region's progress towards pay for performance measures and are designed to prepare providers for value-based contracting.
- VBP resources are easily accessible on OCH's VBP resources webpage and promoted in weekly emails to OCH's growing distribution list.
- In 2019, OCH conducted 2 site visits with each contracted partner where challenges and barriers to implement practice transformation were discussed and targeted follow-up resources were provided to each partner.
- In June 2019, OCH hosted a regional convening and space for breakout sessions by provider type was provided so partners could share lessons learned and problem solve common struggles in transformation work.

#### Example

In response to physical health and community partner feedback, OCH, in partnership with HCA, MCOs and the SBHO, hosted a Clallam IMC learning event attended by 75 individuals. The learning event provided space for the community to learn how IMC fits into the larger purpose of the MTP goals, opportunities to engage with MCOs and HCA, and resources for

partners to learn more about value-based care. In pre-event surveys providers identified struggles in understanding what IMC and VBP changes will mean for client care and client experience. In post-event evaluations, attendees requested more learning opportunities around social determinants of health, information on crisis system updates, and ongoing information on the status of the local tribes pursuing FQHC models. In response, OCH contracted for consultation and training around social determinants of health in 2020, posted crisis-system updates to the OCH website, and continue to engage in conversations with tribes and at the state level to keep up to date on Tribal FQHC matters. From this event, OCH learned the importance of including non-traditional partners in ongoing learning opportunities around value-based payment and upcoming changes in health care delivery.

**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.

<b>Intended audience</b>	<b>Provider needs</b>	<b>Supportive Activities</b>	<b>Description of Action Plan and Key Milestones Achieved</b>
<i>Providers with low Value-Based Payment (VBP) knowledge or significant barriers/challenges: Clallam county physical health providers and community partners</i>	<p>Knowledge of IMC transition and potential impacts on patients. Clallam County has not had mandated managed care for physical health.</p> <p>Understanding how IMC fits into larger journey of statewide progress towards VBP.</p>	In collaboration with HCA and the four MCOs, OCH hosted a Clallam Integrated Managed Care learning forum in December 2019. HCA presented on VBP.	This event engaged a wider provider audience than signed implementation partners. A follow-up email with resources was sent out to the registrant list, and VBP resources are posted on the OCH website. Registrants were included in future IMC communications.
<i>Small providers (25 FTEs or fewer): Signed Community Based Organizations and Social Services partners</i>	<p>Knowledge of IMC transition and potential impacts on shared clients.</p> <p>Knowledge of VBP principles and targets.</p> <p>Building a value proposition and</p>	OCH convened the seven contracted CBOs in November 2019 to provide information level setting around IMC and VBP. All four regional MCOs participated, and CBOs had opportunities to	<p>OCH connected CBOs with VBP resources and peer learning opportunities.</p> <p>CBOs had the opportunity to ask questions and network with MCOs.</p>

	understanding possible roles for CBO's in VBP.	discuss possible roles for CBOs in VBP.  Site visits conducted with each of the seven contracted CBOs.	OCH plans to reconvene the CBOs in March 2020 to continue value proposition discussion.
<i>Behavioral health providers: Behavioral health providers</i>	<p>Knowledge of VBP principles, targets, and future contractual expectations.</p> <p>Incorporating VBP principles into first time contracting with MCOs.</p> <p>Preparing billing and records systems for VBP contracting.</p>	OCH hosted a regional convening in June 2019. Space was provided for breakout sessions by both provider type and by county. Behavioral health providers met to identify and discuss shared needs. Providers then shared back learnings and requests with cross-sector colleagues during county breakout session.	<p>In follow up from requests made by behavioral health providers, OCH hosted a Clallam IMC learning forum, added VBP learning materials to its website resource library, and plans to release results from the VBP survey in early 2020.</p> <p>All BH providers previously contracted with SBHO contracted with MCOs for IMC, and many report maintaining the same contract expectations as with the SBHO for 2020 to ensure successful transition.</p>

**Acronyms used in this table:**

CBOs – Community Based Organizations, IMC - Integrated Managed Care, MCOs – Managed Care Organizations, OCH – Olympic Community of Health, VBP – Value Based Payment

**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>Tactic</b>	<b>Incentives offered? (Yes/No)</b>	<b>New tactic? (Yes/No)</b>
Present to OCH Board of Directors on MTP incentive flow	No	Yes

structure, including VBP P4R incentives.		
Promote participation in weekly email communication to broad distribution list.	No	Yes
Individual, targeted outreach to providers that had not completed the survey.	No	No

- 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.

OCH reviewed individual responses and aggregate data of Paying for Value surveys internally in 2019. Results from the survey were not used to inform communications or to identify providers in need of technical support in 2019 but will be used moving forward in 2020.

Completion of the survey is built into the 2020 partner payment model, so partners will receive monetary incentives for completing the survey in 2020. JD Fischer will share results from the 2019 survey with the OCH Board of Directors in March 2020. Materials from his presentation will be included on OCH’s weekly email that goes out to a large distribution list. OCH is in the process of developing strategies to grow participation for future administration, including summarizing 2020 survey results in weekly emails, reviewing results for possible technical assistance opportunities in the region, and growing the OCH email distribution list to extend a wider reach to potential partners and interested community members.

## 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.<sup>5</sup> Twice per year, ACHs will request partnering providers participating in Project 2A and 3A to respond to a set of questions. Potential respondents should be consistent with the list of partnering provider sites identified in the ACH's Partnering Provider Roster affiliated with Project 2A and 3A. ACHs will gather the responses and report an aggregate summary to the state. ACHs will receive credit for timely reporting on these indicators of project implementation progress.

*Related resources and guidance:*

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

#### **Instructions:**

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

#### **Format:**

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

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

See attachment: [OCH.SAR4 Attachment 5. 1.31.20](#)

---

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

# Olympic

*July 1, 2019- December 31, 2019*

**Table 1: Incentives earned**

	Q3	Q4	Total
Project 2A	\$ -	\$ 460,703.00	\$ 460,703.00
Project 2D	\$ -	\$ 187,161.00	\$ 187,161.00
Project 3A	\$ -	\$ 57,588.00	\$ 57,588.00
Project 3B	\$ -	\$ 71,985.00	\$ 71,985.00
Project 3C	\$ -	\$ 43,191.00	\$ 43,191.00
Project 3D	\$ -	\$ 115,176.00	\$ 115,176.00
Integration	\$ -	\$ -	\$ -
VBP	\$ -	\$ -	\$ -
<b>Total</b>	\$ -	\$ 935,804.00	\$ 935,804.00

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

	Q3	Q4	Total
Interest accrued	\$ 4,235.66	\$ 4,093.82	\$ 8,329.48

**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	\$ -	\$ -	\$ -
Community health fund	\$ -	\$ -	\$ -
Health systems and community capacity building	\$ -	\$ -	\$ -
Integration incentives	\$ -	\$ -	\$ -
Project management	\$ -	\$ -	\$ -
Provider engagement, participation, and implementation		\$ 1,968,867.00	\$ 1,968,867.00
Provider performance and quality incentives	\$ -	\$ -	\$ -
reserve/contingency fund	\$ -	\$ -	\$ -
<b>Total</b>	\$ -	\$ 1,968,867.00	\$ 1,968,867.00

**Source:** Financial Executor Portal

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