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CERTIFIED PUBLIC ACCOUNTANTS

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

Healthier Washington Medicaid Transformation

Independent Assessment of Semi-annual Report 2

Reporting Period July 1, 2018 – December 31, 2018

Findings Report: March 2019

Table of Contents

1. Overview

The Washington State Health Care Authority (HCA) engaged Myers and Stauffer LC (Myers and Stauffer) to serve as the Independent Assessor for the state's Healthier Washington Medicaid Transformation (Medicaid Transformation), Section 1115 Medicaid waiver. The focus of the Independent Assessor's work is on Initiative 1, Transformation through Accountable Communities of Health (ACHs).

As part of this engagement, and as required by the Special Terms and Conditions (STCs) of the waiver, Myers and Stauffer assesses semi-annual reports submitted by each of the nine ACHs. These reports must demonstrate progress and attainment of project-specific milestones and metrics achieved during the reporting period to receive incentive dollars. This findings report represents Myers and Stauffer's assessment of ACH semi-annual reports for reporting period July 1, 2018 – December 31, 2018.

2. Independent Assessor Review Process

The Independent Assessor (IA) used the following process to conduct the assessment to review submitted semi-annual reports (SAR).

- **Minimum Submission Requirements Review.** Upon receipt of each ACH's report, a high-level review was conducted to confirm the ACH submitted responses to all questions. Where missing information was identified, a request was made to the ACH for an updated submission.
- **Detailed Assessment.** Primary reviewers conducted detailed assessments of the Implementation Plan (IP) Workbook and Portfolio Narrative based on the SAR Template provided by HCA. The IA assessed that each ACH addressed all sections of the report and that responses provided detail to confirm progress is being made. Each response to a question within a report sub-section was assessed as complete or incomplete. In addition, the IA assessed that all Stage 1 work plan measures within the IP Workbook were addressed by the ACH for progress. Where the primary reviewer found a response to be incomplete or requested an additional review for confirmation, a secondary reviewer conducted additional assessment.
- **Requests for Additional Information.** The IA sent requests for additional information (RFIs) to eight ACHs. The RFIs served as an opportunity for ACHs to offer clarification to responses that were initially found to be incomplete and to address identified gaps. Three conference calls were held with ACHs that requested additional consultation about the RFI comments and questions.

3. Highlights of the ACHs' Semi-Annual Report 2

The following summary describes findings and highlights examples of activities noted by ACHs within their SAR 2 narratives, workbooks or implementation plans update.

- **Achievement Award.** All ACHs submitted their SARs by the January 31, 2019 deadline. Upon submission of RFI responses, all SARs included sufficient detail to show progress made during the reporting period of July 1, 2018 to December 31, 2018. The Independent Assessor recommends HCA approval and full credit awarded to ACHs for achievement.
- **Project 2B: HUB Lead Entity and Certification.** Six ACHs are participating in Project 2B. Five of those ACHs have selected the ACH to be the Lead Entity. One ACH has decided that Community

Choice dba Action Health Partners (AHP) will be the Lead Entity. During this reporting period, three of the ACHs committed to moving forward with HUB certification.

- **Finances.** In total, ACH's have spent 31% of their design funds with expenditures primarily focused on administration and project management. Design fund spending is starting to be seen in health system and community capacity building along with provider engagement, participation and implementation. For project incentives, the majority of spending is being used for provider engagement, participation and implementation (34% of total ACH spending) as well as shared domain 1 incentives (35% of total ACH spending).

- **Partnerships for Support/Technical Assistance (TA).** ACHs have developed partnerships with external vendors to help support their partnering providers and the transformation efforts in their region. Examples include:

    - Xpio provides support and TA regarding billing and claims testing, and information technology (IT) and electronic health record (EHR) readiness.

    - Spokane Regional Health District helped develop a framework for identifying and measuring equity gaps in the community.

    - Washington State University (WSU) School of Pharmacy hosted a Naloxone training for behavioral health (BH), substance use disorder (SUD) and primary care providers and staff.

    - Qualis Health completed individual integrated managed care (IMC) readiness assessments with BH agencies.

    - Oregon Health Science University independently assessed implementation partners to reduce the risk of partiality.

    - Quad Aim Partners contracted with an ACH to develop a Health Commons model that works to digitally integrate community services by connecting agencies to a next generation IT system called Commons Network.

    - Local health improvement networks will contract with an ACH to act as "mini" ACHs across the region to address local health priorities.

- **ACH Areas of Opportunity.**

    - **Implementation Plan.** Many ACHs indicated completion of implementation plan work steps, but some steps were noted as new, adjusted, or "delayed, remains in process". This impacted Stage 1 Planning, Stage 2 Implementation and Stage 3 Sustainability.

    - **Key Staff Changes.** Eight of the nine ACHs experienced a change in key staff during this reporting period. Three of those eight ACHs had a change in the CEO/Executive Director role. The ACHs also emphasized the need for roles to focus on tribal efforts and the opioid crisis adding roles such as a Tribal Liaison and Opioid Resource Network Specialist.

    - **Policies.** The ACHs have the opportunity to work together with HCA to track and make progress on the ACHs policy and advocacy agendas in 2019.

- **Pathways Model.** ACHs outlined interest in obtaining additional support from MCOs for outcome payment of the Pathways model to ensure long-term sustainability.
- **Workgroups.** The ACH 2020 adopters are in the planning phase for establishing an Early Warning System (EWS) and/or IMC Communications workgroup. The adopters noted that these workgroups are not requirements in the ACH contracts with HCA.
- **Changes to Target Populations/Evidence Based Approaches.** One ACH adjusted their target population during the reporting period due to challenges in reaching the number of clients needed for the project to be sustainable.
- **External Reporting.** ACHs should consider external reporting will be shared at meetings based on HUB data and results. Reports that substantiate improved coordination and patient outcomes will be critical for long-term buy-in and fidelity to the model.
- **Community-Clinical Linkages.** Partner organizations have articulated to the ACHs the need for strengthened community-clinical linkages throughout regions. ACHs may choose to focus on partner networks and project collaboration to form stronger linkages and further break down traditional siloes.
- **ACH and MCO Collaboration.** The ACH MCO Collaborative Workgroup was developed to advance consistency across regions, adopt proposals that have broad value and commitment, and identify long-term viability and sustainability of the projects beyond the Medicaid Transformation Project (MTP). Five of the nine ACHs have reviewed the charter for this collaborative effort, although efforts are underway to reach full participation.
- **Provider Training.** Many ACHs have identified areas of need for training among their providers and staff. The ACHs should consider developing and maintaining a training and TA matrix to capture common statewide needs. The ACHs may want to consider pooling resources and offering statewide training, which will support consistent, statewide messaging and education.

4. Summary Recommendations for Payment of Incentives

Tables 1 through 3 below provide an overview of ACH projects, Achievement Values (AVs), and incentives that can be earned for achieving milestones for the reporting period July 1, 2018 – December 31, 2018. Each ACH can earn 1.0 AV per milestone per project. After review of responses to requests for additional information, the Independent Assessor found all ACH reports to be fully responsive and complete and recommend full credit be awarded for all milestones as noted in Table 2.

Table 1 provides the total potential achievement values for each ACH by project that can be earned. If an ACH is not participating in a project, the table will display a dash (-).

Table 1. Potential Achievement Values by ACH by Project for Semi-annual Reporting Period July 1 – Dec 31, 2018

ACH	2A	2B	2C	2D	3A	3B	3C	3D	Total Potential AVs
Better Health Together	4	5	-	-	4	-	-	4	17
Cascade Pacific Action Alliance	5	5	4	-	4	4	-	4	26
Greater Columbia ACH	4	-	4	-	4	-	-	4	16
HealthierHere	4	-	4	-	4	-	-	4	16
North Central ACH	4	5	4	4	4	-	-	4	25
North Sound ACH	4	5	4	4	4	4	4	4	33
Olympic Community of Health	5	-	-	4	4	4	4	4	25
Pierce County ACH	4	5	-	-	4	-	-	4	17
SWACH	4	5	-	-	4	-	-	4	17

Note: Cascade Pacific Action Alliance and Olympic Community of Health are moving to integrated managed care (IMC) in 2020 and have one additional milestone/reporting requirement for which they must demonstrate progress towards IMC.

Table 2 depicts the number of AVs each ACH has earned by milestone for the reporting period based on the independent assessment.

Table 2. Achievement Values (AVs) by ACH for Semi-annual Reporting Period July 1 – Dec 31, 2018

	BHT	CPAA	GCACH	HH	NC	NS	OCH	Pierce	SWACH
Number of Projects in ACH Portfolio	4	6	4	4	6	8	6	4	4
Potential AVs for semi-annual reporting period July 1 – Dec 31, 2018									
Completion of Implementation Plan	4	6	4	4	6	8	6	4	4
Completion of Semi-annual Report	4	6	4	4	6	8	6	4	4
Milestone: Engagement/Support of IEE Activities	4	6	4	4	6	8	6	4	4
Milestone: Completion of Partnering Provider Roster	4	6	4	4	6	8	6	4	4
Milestone: Identified HUB Lead Entity (Project 2B only)	1	1	-	-	1	1	-	1	1
Milestone: Support Regional Transition to Integrated Managed Care (Project 2A / 2020 Regions only)	-	1	-	-	-	-	1	-	-
Total AVs	17	26	16	16	25	33	25	17	17
Achievement Values Earned for Second Reporting Period									
Achievement Values Earned for Implementation Plans - *Assessed October 2018*	4/4 **Full Credit**	6/6 **Full Credit**	4/4 **Full Credit**	4/4 **Full Credit**	6/6 **Full Credit**	8/8 **Full Credit**	6/6 **Full Credit**	4/4 **Full Credit**	4/4 **Full Credit**
Achievement Values Earned for SAR 2 *Assessed February 2019*	13/13	20/20	12/12	12/12	19/19	25/25	19/19	13/13	13/13

	BHT	CPAA	GCACH	HH	NC	NS	OCH	Pierce	SWACH
	Full Credit	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**	**Full Credit**
Total AVs Earned	17/17 **Full Credit**	26/26 **Full Credit**	16/16 **Full Credit**	16/16 **Full Credit**	25/25 **Full Credit**	33/33 **Full Credit**	25/25 **Full Credit**	17/17 **Full Credit**	17/17 **Full Credit**

For each ACH, Table 3 provides incentives available by funding source for completion of Semi-annual Report 2. Earned payments are estimates and subject to change depending on IGT participation and final DSHP funding.

Table 3. Total P4R Project Incentives Available by ACH for Semi-annual Reporting Period July 1- Dec 31, 2018

ACH	Earned AVs	Project Incentives (DSHP)	Project Incentives (IGT)	Total Incentives
Better Health Together	17	$8,900,258	$3,214,914	$12,115,172
Cascade Pacific Action Alliance	26	$8,091,144	$2,922,648	$11,013,792
Greater Columbia ACH	16	$11,327,602	$4,091,708	$15,419,310
HealthierHere	16	$17,800,517	$6,429,827	$24,230,343
North Central ACH	25	$4,045,572	$1,461,325	$5,506,897
North Sound ACH	33	$12,136,716	$4,383,973	$16,520,689
Olympic Community of Health	25	$3,236,458	$1,169,059	$4,405,517
Pierce County ACH	17	$9,709,373	$3,507,178	$13,216,551
SWACH	17	$5,663,801	$2,045,854	$7,709,655
Total		**$80,911,440**	**$29,226,486**	**$110,137,926**

ACHs were asked to provide information about use of design funds to date. *Table 4* provides the percent funding each ACH had remaining in design funds, and then shows by use categories the percent of expenditures made. ACHs are allocating and using design funds and DY 1 earned incentives in a variety of ways. This table provides a snapshot of spending of design funds across ACHs, but cannot be used for comparison, as ACHs are proceeding differently in categorization of activities and use of funds.

Table 4. Allocation of Design Funds by ACH

Percent Design Funds Remaining as of December 31, 2018									
	BHT	CPAA	GCACH	HealthierHere	NC ACH	NS ACH	OCH	Pierce County ACH	SWACH
Percent Design Funds Remaining	67%	60%	85%	45%	76%	83%	82%	75%	49%
Percent Design Funds Expenditures by Use Category									
Use Categories									
Administration	27%	9%	64%	100%	45%	5%	25%	18%	42%
Community Health Fund	-[1]	-	-	-	-	4%	-	-	-
Health Systems and Community Capacity	49%	7%	1%	-	15%	6%	14%	45%	19%
Integration Incentives	-	-	-	-	1%	-	-	-	-
Project Management	16%	76%	-	-	40%	80%	33%	25%	10%
Provider Engagement, Participation and Implementation	9%	-	20%	-	-	5%	17%	11%	29%
Provider Performance and Quality Incentives	-	-	-	-	-	-	-	-	0% [2]
Reserve/ Contingency Fund	-	-	-	-	-	-	-	-	
Shared Domain 1 Incentives	-	8%	-	-	-	-	-	-	
Other	-	-	15%	-	-	-	11%	-	

Note: Values in Table 4 are displayed to the nearest percent.
1. BHT indicated this has not been spent but 10% of design funds are held in reserve.
2. SWACH spent less than 0.1% on Provider Performance and Quality Incentives.

5. Key Considerations by ACH

In addition to the overall trends identified in Section 4 across ACHs, *Tables 5-22* below provide key considerations for each ACH for HCA review for purposes of ongoing monitoring that may want to be shared across ACHs. Identified opportunities are based solely on information provided in the semi-annual reports. Upon requests for additional detail or discussion, ACHs may be found to have more extensive work occurring in the identified areas. Recommendations provided by the IA were developed with HCA monitoring in mind. Each ACH may also assess whether the recommendation should be implemented within their region based.

Better Health Together (BHT)

Table 5. Better Health Together (BHT) Key Considerations

Findings for Better Health Together	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• In DY2 Q3, BHT received 44 Transformation Plans from Partnering Providers. This includes plans from six of the seven tribal providers in the BHT region. • BHT's Spokane Jail Transitions Pilot utilizing the Pathways HUB model launched in November of 2018. SNAP and Community Minded Enterprises were selected as the CCAs for this project. • In partnership with the Spokane Regional Health District, BHT developed a framework for identifying and measuring equity gaps in the community. • BHT maintains an IMC Transition Webpage with resources and updates for Partnering Providers. • BHT contracted with Xpio to provide one-on-one support and TA to Partnering Providers around billing and claims testing, and IT/EHR readiness. • BHT utilized new tactics to support completion of the state's 2018 provider VBP survey, including advertisement of the survey on the BHT Collaborative webpage, the BHT Facebook page and the BHT Twitter page. • BHT and WSU School of Pharmacy hosted a Naloxone training. Thirty-two participants from 13 organizations including behavioral health, SUD and primary care providers and staff attended. • BHT led a meeting in October 2018 with HCA, MCOs, and other ACHs to discuss alignment of Pathways work to prevent duplication of effort for evaluation.	• BHT notes that workforce issues as a top concern and the shortage of providers may impact regional capacity for service and transformation. ***Recommendation:*** Domain 1 includes the development and implementation of resources to support workforce strategies at statewide and regional levels. HCA may seek to expand methods for regular collection and strategic collaboration for workforce development. • BHT identified housing instability as a top risk to transformation efforts. BHT plans to launch a policy and advocacy agenda in 2019 to begin tracking policy opportunities. ***Recommendation:*** Continue monitoring the referral pattern and resources available to address the social determinants of health, particularly housing support. HCA may seek support from BHT to advance policy issues at the state level. • BHT has found it challenging to maintain consistent attendance from Medicaid members in their Community Voices Council, which ensures the consumer voice is embedded in ACH decision-making. ***Recommendation:*** HCA may consider sharing successful ACH approaches that maximize member attendance (e.g., joint ACH meetings, reimbursement for lunch, incentive cards). • The ACH outlined interest in obtaining additional support from MCOs related to the Pathways HUB model to ensure long-term sustainability. ***Recommendation:*** HCA may consider sharing successful approaches that maximize coordinated HUB incentives. • Target populations have been adjusted for the Ferry County Jail Transitions Pilot program which struggled to reach a high enough number of participants to be sustainable due to the size of the jail. Additionally, the ACH noted that outside of Adams County, most rural counties do not have the volume of Medicaid births for the target population. ***Recommendation:*** Assess whether ACH methods for capturing the volume of projects' target populations are sufficiently robust to monitor for statewide transformation impact.

Table 6. Achievement Values and Earned Incentives for Reporting Period July 1, 2018 – December 31, 2018

Better Health Together			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	4	4	$5,874,023
2B: Community-based Care Coordination	5	5	$4,038,391
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	4	4	$734,253
3D: Chronic Disease Prevention and Control	4	4	$1,468,506
Total	**17**	**17**	**$12,115,172**

Cascade Pacific Action Alliance (CPAA)

Table 7. Cascade Pacific Action Alliance (CPAA) Key Considerations

Findings for CPAA	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• CPAA has finalized partner change plans and contracts, along with the identification of interim measures to monitor partner progress. • Qualis Health completed several individual IMC readiness assessments with behavioral health agencies and led an IMC learning summit. • CPAA's Opioid Response Program Manager organized a behavioral health forum with the Thurston Asset Building Coalition to allow stakeholders to discuss IMC and consumer populations affected by transition. • CPAA's Community and Tribal Liaison attended an IMC Consumer Forum in Leis County, which was designed to educate consumers and receive feedback. • CPAA has contracted with CCS as the platform to provide Pathways, which has received Health Information Trust Alliance certification. • CPAA worked with an independent assessor, Oregon Health Science University, in the selection of implementation partners to reduce the risk of partiality. • CPAA has promoted networking throughout the region, facilitating partnerships that will impact the region well beyond the waiver, to address communication barriers inherent to traditionally siloed healthcare service delivery services between partners. • Molina Health Care serves over 50% of Medicaid members in the region. Monthly reports will be made available on year-to-date performance for Molina members for the region by county to allow CPAA to monitor progress via current claims data. • CPAA established a Capacity Development Fund with Year 1 funding to engage providers and community partners that were not selected as paid implementation partners but provide specialty services critical to transformation success.	• The ACH experienced a change in key including the CEO. ***Recommendation:*** Continue to monitor staff turn-over and opportunities for new staff to be quickly trained on the key elements of MTP. • CPAA, county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners have yet to develop a comprehensive plan for regional transition to integrated managed care. However, Interlocal Leadership Structures are expected soon which will allow the BHO to make progress on this action. ***Recommendation:*** Monitor alignment and progression of activities for IMC. • One of two regions within CPAA has yet to establish a EWS Workgroup. ***Recommendation:*** Continue to monitor ACH alignment and progression of activities to ensure the ACH is alert to transformation issues. • Partners have articulated the need to build stronger community-clinical linkages and participation of community-based social service organizations throughout the region. CPAA is planning more events specifically for partner networking and project collaboration. ***Recommendation:*** HCA may consider sharing successful ACH approaches that maximize CBO participation (e.g., messaging outcome success, group or one-on-one leadership meetings, etc). • The ACH noted that siloed communication is a risk. A strong mitigation approach that five ACHs are pursuing includes holding an ACH MCO Collaborative Workgroup dedicated to advancing consistency across regions, adopting proposals with broad value and commitment, and identifying long-term viability and sustainability of the projects beyond the waiver. Although not all ACHs have reviewed the charter, efforts are underway to expand to all nine ACHs. ***Recommendation:*** Continue monitoring collaboration across MCO and ACH to ensure that aligned messaging and coordination are effectively leveraged.

Table 8. Achievement Values and Earned Incentives for Reporting Period July 1, 2018 – December 31, 2018

Cascade Pacific Action Alliance (CPAA)			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$4,195,730
2B: Community-based Care Coordination	5	5	$2,884,565
2C: Transitional Care	4	4	$1,704,515
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	4	4	$524,466
3B: Reproductive and Maternal and Child Health	4	4	$655,583
3D: Chronic Disease Prevention and Control	4	4	$1,048,933
Total	**26**	**26**	**$11,013,792**

Greater Columbia ACH (GCACH)

Table 9. Greater Columbia ACH (GCACH) Key Considerations

Findings for Greater Columbia	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• GCACH crafted a comprehensive and detailed toolkit and workbook for providers undergoing Practice Transformation. The toolkit and workbook borrow from the CMS' Comprehensive Primary Care Implementation and Milestone Reporting Summary Guide. • The ACH met with all 17 behavioral health agencies associated with the region. Each organization completed the Maine Health Access Foundation (MeHAF) and the Billing and Information Technology Self-Assessment Survey Tool. These two tools allowed for the identification of strengths and areas of opportunity that applied to Integrated Managed Care. • Lourdes Health Network in Benton and Franklin counties achieved bi-directional integration in their family medicine clinic and behavioral health counseling center. They adopted a shared care plan based on the Bree Collaborative guidelines and it is embedded into their EHR. • GCACH contracted with Quad Aim Partners to support Kittitas County Health Network to develop a digitally integrated community services model by connecting agencies to a next generation IT system called Commons Network. • GCACH created a Practice Transformation department with a director and two Practice Transformation Navigators, which is devoted to assisting each Practice Transformation with resources and TA throughout the MTP. • GCACH is contracting with six Local Health Improvement Networks that act as "mini" ACHs across the nine-county region to address local health priorities. • Three new tactics were implemented this reporting period to support completion of the state's 2018 provider VBP survey, including offering an incentive for individuals to participate on the Practice Transformation Workgroup, promotion on the GCACH website and in newsletters.	• After the ACH established the Community Health Fund to address social determinants of health (SDOH), communities throughout the region conducted close to 1,500 surveys to capture Medicaid consumer voices on what social factors are affecting their health. The most common determinants in the region: housing, food insecurity, transportation, mental health, and education. ***Recommendation:*** Develop monitoring mechanisms related to the referral patterns of ACH partners and the resources available to address the social determinants of health. Consider gathering reporting data on SDOH outcomes.

Table 10. Achievement Values and Earned Incentives for Reporting Period July 1, 2018 – December 31, 2018

Greater Columbia ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	4	4	$8,656,455
2C: Transitional Care	4	4	$3,516,685
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	4	4	$1,082,057
3D: Chronic Disease Prevention and Control	4	4	$2,164,114
Total	**16**	**16**	**$15,419,310**

HealthierHere

Table 11. HealthierHere Key Considerations

Findings for HealthierHere	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• HealthierHere and select Practice Partners traveled to New York to visit four Performing Provider Systems (PPSs). The PPSs shared lessons learned, recommendations for supporting providers' transitions to VBP, opportunities for the ACH to offer assistance, and how to effectively work with MCOs. • The ACH stratified its partners into Innovation Partners and Practice Partners based on the results of the Current State Assessment and Health Information Exchange and Technology Assessment. This partner engagement strategy allows HealthierHere to engage with partners according to their level of readiness. • Practice Partners with low VBP knowledge subsequently received one-on-one meetings to discuss VBP readiness and tools. • Recognizing the need for dedicated staff support for tribal engagement, HealthierHere developed a Tribal Engagement Manager position. This position will be responsible for assisting the design and implementation of the ACH's overall engagement. • The ACH developed an Investment Prioritization Tool (IPT) to ensure investment decision making is guided by core values and potential impact on P4P metrics. • HealthierHere worked closely with subject matter experts and design teams to develop clinical summaries, detailing for each project: - Immediate and long-term goals - Focus populations - Key project elements, including required interventions - Pay-for-performance and other potential reporting metrics - References and guidelines • HealthierHere launched a small grants program for community partners to conduct education within the community about Medicaid transformation work. Twenty-two organizations participated.	• HealthierHere noted a concern regarding access to timely data from the state and Practice Partners that may impact the ACH's ability to track Practice Partner as well as ACH-wide performance on P4P metrics and make data-driven decisions about when and how to adjust course. ***Recommendation:*** Evaluate HealthierHere's comprehensive data strategy after its development in DY3 Q2. • HealthierHere is experiencing a tension between investing in foundational system-level needs and investing in innovative initiatives. ***Recommendation:*** HCA may consider sharing ACH approaches that successfully utilize quality improvement science methodologies to rapidly and systematically evaluate outcome and return-on-investment results to support on-going or new capital investment decisions. • The ACH has identified providers in King County that have significant gaps in their readiness to transition to VBP. Behavioral health agencies (BHAs) lag behind hospitals/health systems and FQHCs in their readiness for VBP, and some Practice Partners lack internal data and reporting capabilities to effectively measure and track their performance over time. ***Recommendation:*** Continue monitoring the effectiveness of VBP outreach, engagement and training to partnering organizations, particularly related to data collection and analysis.

Table 12. Achievement Values and Earned Incentives for Reporting Period July 1, 2018 – December 31, 2018

HealthierHere			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	4	4	$13,603,000
2C: Transitional Care	4	4	$5,526,219
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	4	4	$1,700,375
3D: Chronic Disease Prevention and Control	4	4	$3,400,750
Total	**16**	**16**	**$24,230,343**

North Central ACH

Table 13. North Central ACH Key Considerations

Findings for North Central ACH	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• MOUs with partners are in place, marking the implementation of various strategies across the entire project portfolio. • NCACH Governing Board approved Community Choice dba Action Health Partners (AHP) as the Pathways Community HUB lead agency in June 2018. The NCACH Pathways Community HUB officially launched on October 1, 2018. • In an effort to assess outpatient provider needs and gaps in addition to the Patient-centered Medical Home Assessment (PCMH-A)/Maine Health Access Foundation (MeHAF), the ACH developed and conducted a 52-question survey covering quality improvement and practice coaching, workforce challenges, VBP strategies, HIT/HIE, access to care, and care coordination. • Although no financial incentive was given to providers to complete the Washington State VBP Survey, NCACH had one of the highest percentages of local providers responding to the survey. • NCACH hired consultants and is hiring internal practice facilitation coaches to assist providers in making the needed clinical process improvement changes in their organizations. • NCACH is participating in weekly rapid response calls with Okanogan County providers. • Open registration for two Bi-Directional Integration LANs began in late 2018. • NCACH has built its reporting template to allow for site-level reporting. The ACH is allowing each organization to decide how to approach change management. • Several mechanisms were used to engage partners, including the NCACH project manager playing an integral role in creating the North Central Community Partnership for Transition Solutions, which is designed to convene various stakeholders who are committed to working together to support successful transitions and better coordinate services for people reentering communities after incarceration.	• The ACH noted that an early and ongoing challenge for care coordinators is locating people who meet the eligibility criteria for the HUB. ***Recommendation:*** Continue to monitor processes in this area, specifically developing reporting mechanisms for patient identification and referral. • Several ACH clinics scored low on empanelment on the PCMH-assessment. As a building block of PCMH, empanelment supports population health management, allowing care teams to manage the preventive care, disease management and acute care for a set panel of patients. As a result, the ACH provided additional coaching to develop processes to better empanel their patients. ***Recommendation:*** Continue to monitor processes in this area, and identify opportunities to share broadly successful management of patient identification and empanelment. • MCOs have identified the MCO Symposium (post-integration) that was facilitated in May 2018 as a best practice and intend to offer a similar opportunity moving forward. ***Recommendation:*** HCA may consider engaging directly with MCOs to support this learning opportunity that can bridge current transformation development with long-term sustainability. • NCACH, like other ACHs, considered low engagement of community-based organizations as a risk to MTP. ***Recommendation:*** Determine if there are opportunities to capture the organization type on the partner roster to maintain counts of community-based partners. • NCACH, like other ACHs, considered access to actionable data as a risk to transformation success. ***Recommendation:*** Form communication messaging related to IT and data analytical capabilities to offer actionable information.

Table 14. Achievement Values and Earned Incentives for Reporting Period July 1, 2018 – December 31, 2018

North Central ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	4	4	$1,915,442
2B: Community-based Care Coordination	5	5	$1,316,867
2C: Transitional Care	4	4	$778,148
2D: Diversions Interventions	4	4	$778,148
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	4	4	$239,430
3D: Chronic Disease Prevention and Control	4	4	$478,861
Total	**25**	**25**	**$5,506,897**

North Sound ACH

Table 15. North Sound ACH Key Considerations

Findings for North Sound ACH	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• ACH staff developed the North Sound ACH Change Plan after incorporating partner feedback into the implementation planning process and the Partner retreat. The ACH held one-on-one meetings with partners to discuss their Change Plan submission, clarify their commitment to and ability to implement the strategies they selected. • North Sound ACH has contracted with BlueOrange Compliance to ensure that all policies, procedures, and protocols for information technology and exchange are in compliance with HIPAA and other security standards. • North Sound BHO hired XPIO to conduct assessments of BHA provider systems and recommend investments in specific BHAs to prepare them for MCO billing. • All ACH partners who had completed Part 1 and Part 2 of the Partner Application process participated in a two-day partner retreat at Everett Community College. • The ACH has begun development of an Oral Health Local Impact Network with the Arcora Foundation. Engagement of partners will begin in DY3. • The ACH has coordinated with four other ACHs to draft a charter for an ACH/MCO collaborative to increase cross-regional discussions and plan coordinated action. • The ACH restructured the Board's Community Leadership Council to allow it to be more accessible to community members and individuals who directly serve Medicaid members and to facilitate more efficient provision of meaningful feedback to the board and staff about community needs.	• The ACH experienced a change in key including the CEO. ***Recommendation:*** Continue to monitor staff turn-over and opportunities for new staff to be quickly trained on the key elements of MTP. • The Tribal Alignment Committee of the North Sound ACH Board reached consensus to extend a request to the Northwest Washington Indian Health Board to consider expanding from the current board (which includes five tribes in two counties) to one that includes all eight tribes in the North Sound region. The Northwest Washington Indian Health Board began taking steps to consider this goal. ***Recommendation:*** Monitor and share strategies such as these that may expand tribal engagement and support. • The ACH experienced partner misunderstanding (or potential misunderstanding) about implementation requirements and expectations, and those misunderstandings affect the strategies and tactics partners committed to in their Change Plans. This may result in a lack of partners committing to each strategy across the region. This information will not be known until after the ACH has reviewed Change Plans in Q1 2019. To mitigate this risk, the North Sound ACH staff are tracking the number of partners committed to specific strategies and tactics and will be able to identify areas where a gap is likely to occur. ***Recommendation:*** Consider collecting additional specificity at the partner level, the intervention approaches and geographic spread of MTP projects. This information offers the state perspective on infrastructure changes that can be leveraged now and in the future. • The ACH has an unclear process for continued partner collaboration. The ACH staff will be developing a 2019 calendar for North Sound partner convening and opportunities for facilitated collaboration, across the project portfolio, for each of the four initiatives and for specific strategies and/or tactics. This calendar should be ready in Q1 2019. ***Recommendation:*** Project coordination is critical for progress and attainment of outcomes in later DSRIP years. Ensure EWS committees align with state expectations to monitor and receive alerts on key success factors.

Table 16. Achievement Values and Earned Incentives for Reporting Period July 1, 2018 – December 31, 2018

North Sound ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	4	4	$5,286,621
2B: Community-based Care Coordination	5	5	$3,634,552
2C: Transitional Care	4	4	$2,147,690
2D: Diversions Interventions	4	4	$2,147,690
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	4	4	$660,828
3B: Reproductive and Maternal and Child Health	4	4	$826,034
3C: Access to Oral Health Services	4	4	$495,621
3D: Chronic Disease Prevention and Control	4	4	$1,321,655
Total	**33**	**33**	**$16,520,689**

Olympic Community Health (OCH)

Table 17. Olympic Community of Health (OCH) Key Considerations

Findings for Olympic Community of Health	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• Contracted Implementation Partners: 33 partners submitted a Change Plan and signed a contract with OCH. These partners submitted 38 change plans: 12 primary care, 14 behavioral health, 4 hospital, and 8 community based organizations and social services. These 33 partners signed up for a total 2,556 Tactics. • OCH integrated the practice coach and practice facilitator that had been working in the region since 2017 through Qualis Health and the Department of Health • New remote and rural clinics began participating during this reporting period: Sophie Trettevick Indian Health Center, Kitsap Recovery Center, Beacon of Hope/Safe Harbor Recovery SUD, True Star Behavioral Health, Peninsula Behavioral Health and Catholic Community Family Services. • Qualis Health provided TA to a select group of behavioral health agencies in the region to determine readiness to transition to IMC. Eleven sites in the OCH region participated, including 4 BHAs and 7 SUD providers. • OCH launched the Six Building Blocks evidence-based model in the region. This is a program for improving opioid management in primary care related to Project 3A. • OCH hosted the 2nd Annual Olympic Regional Opioid Summit on October 17, 2018, at which there were approximately 300 attendees. • OCH hired a Communications and Development Coordinator in July of 2018 to coordinate activities related to OCH's mission and MTP and maintain clear, consistent, culturally appropriate messaging about the mission, vision and work that the OCH is doing. • OCH stated the OCH Tribal Collaboration and Communication Policy as approved by the OCH Board was significantly developed and made stronger than the model policy. • The Performance, Measurement and Evaluation Committee developed a slate of reporting metrics for Implementation Partners: a total of 66 metrics were developed for five partner types: Hospital, Primary Care, Mental Health, SUD and Community-Based Organization/Social Service Organization.	• The ACH marked "no" to the attestation regarding engaging and convening county commissioners, tribal governments, MCOs, behavioral health and primary care providers, and other critical partners to discuss a process and timeline for regional transition to integrated managed care. A rationale was provided and the ACH noted that in December 2018, OCH and Salish Behavioral Health Organization (SBHO) began discussions to explore a joint effort to convene and engage providers in preparation of the IMC transition. ***Recommendation:*** Continue to monitor IMC and progression of activities for IMC. • Technical needs requested in the region have included: comprehensive training around the transition to IMC, electronic health record assessment for success in a direct billing environment, clinical and operational documentation requirements, transition planning from SBHO model to IMC billing, PreManage communication systems and care coordination strategies, MCO contracting strategies and best practices in regions of our state that have already transitioned to direct billing. ***Recommendation:*** Continue to monitor required partner needs and funding support for critical implementation resources. • Olympic noted that several Implementation Partners might be at risk for not being able to carry out their MTP work due to organizational financial instability and lack of funds to cover costs associated with MTP work. ***Recommendation:*** Continue to monitor funding expenditures on critical infrastructure resources and communicate with ACHs related to their concerns over a lack of funding.

Table 18. Achievement Values and Earned Incentives for Reporting Period July 1, 2018 – December 31, 2018

Olympic Community Health			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	5	5	$2,168,870
2D: Diversions Interventions	4	4	$881,103
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	4	4	$271,109
3B: Reproductive and Maternal and Child Health	4	4	$338,886
3C: Access to Oral Health Services	4	4	$203,332
3D: Chronic Disease Prevention and Control	4	4	$542,217
Total	**25**	**25**	**$4,405,517**

Pierce County ACH

Table 19. Pierce County ACH Key Considerations

Findings for Pierce County ACH	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• The ACH, via the IMC Learning Network, helped provide a peer forum for partners to learn from each other during the IMC payment transition. The ACH provided one-on-one coaching to partners. • The ACH convened the Whole Person Care Collaborative Guide Team to design a 12-month learning initiative for care teams transitioning to bi-directional care. • The ACH launched and continues to support the Community HUB in Pierce County. The ACH will complete HUB certification. • The ACH has entered into direct partnerships with key local government agencies, including the Tacoma Pierce County Health Department and the Pierce County Office of the Executive. • The ACH is piloting other projects with complex care teams embedded in partner organizations to test outcomes and impact to cost curve, an effort that the ACH indicates will help establish an empirical basis for shared-savings-type financial models. • Pierce County ACH began exploring a range of potential joint contracting opportunities with other ACHs on a project-specific basis. • The ACH sponsored IHI Culture. Community. Action., a daylong conference for all partners, MCOs, and community members to learn about IHI's model for equitable population health and how that model will be instilled within Pierce County's health equity work. The ACH adopted IHI's Health Equity Organizational Assessment Tool as a requirement for partnering organizations. • The ACH has developed and deployed a Strategic Improvement Team that includes a Director of Strategic Improvement and three Improvement Advisors grounded in the IHI Model for improvement. • The ACH has sponsored two cohorts of eight individuals from partnering providers and community-based organizations to attend an intensive 10-month Improvement Advisor Training at the IHI.	• ACH has had staff adjustments, including the addition of a Strategic Improvement Team Advisor and Data and HIT Manager. ***Recommendation:*** Continue to monitor staff turn-over and opportunities for new staff to be quickly trained on the key elements of MTP and required measurement outcomes. • Pierce County ACH is preparing for risks with implementation in the instance that Pierce County providers and MCOs do not successfully launch in 2019. To mediate, the ACH indicated it has a strong mitigation plan to manage EWS alerts and resolve issues quickly. ***Recommendation:*** Determine if reporting mechanisms related to EWS findings and actions are time based on criticality of issue. • The ACH noted concern regarding continued funding and support for the HUB model. As a part of sustainability, the ACH will ensure that interim and intermediary outcome measures are collected to retain support as evidence builds. ***Recommendation:*** HCA may consider sharing successful approaches that maximize coordinated HUB incentives. • A risk for MTP success was noted by the ACH relative to access to state data. In response, Pierce County ACH is developing alternative methods to aggregate and use data sources. A regional data-driven population health strategy built on data sharing is being developed. This includes "smart targeting" of interventions and investments. ***Recommendation:*** HCA may consider sharing ACH approaches that successfully utilize quality improvement science methodologies to rapidly and systematically evaluate outcome and return-on-investment results to support on-going or new capital investment decisions.

Table 20. Achievement Values and Earned Incentives for Reporting Period July 1, 2018 – December 31, 2018

Pierce County ACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	4	4	$6,408,025
2B: Community-based Care Coordination	5	5	$4,405,517
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	4	4	$801,003
3D: Chronic Disease Prevention and Control	4	4	$1,602,006
Total	**17**	**17**	**$13,216,551**

SWACH

Table 21. SWACH Key Considerations

Findings for SWACH	
Examples of Progress and Strengths	**Examples of Adjustments and Opportunities**
• SWACH developed a Clinical Transformation Plan template and process that supports the administrative and clinical transition to IMC. This approach has allowed providers to work directly with SWACH to determine their needs, evaluate their priorities and begin to develop the goals, strategies, tactics and work steps to meet their organizational goals and the goals of the SWACH region. • SWACH has utilized three standing coalition meetings (Klickitat CORE, Healthy Skamania, and Clinical Integration Committee) to develop the framework for learning collaboratives. • SWACH created a training and TA matrix to inform future training and TA needs. The ACH has begun the process of creating a two-year training and TA calendar. • The ACH led a series of opioid learning sessions: "The Uses of Suboxone in a Practical Clinical Setting." Three counties were engaged for two events for providers in Clark and Skamania counties. Thirty-nine participants completed MAT prescriber training. • The ACH developed a process for community-serving organizations that often lack capacity to participate in transformation activities and identify needs/gaps. The main approach to support this process was release of an RFI . Approximately 30 new providers responded to the RFI and nine new providers will likely enter into contract negotiations with SWACH. • SWACH implemented a content strategy for its digital and social media that promotes and highlights the work of potential partners and SMEs around the region. This strategy will help build stronger linkages between SWACH and current and potential partners creating a stronger sense of community and connectedness around opioid crisis response, care coordination and VBP. • SWACH has established a Community Resiliency Fund to focus on primary prevention and/or social determinants of health. The fund will focus on strategies that could remove barriers to health and have a significant impact on one or more health sector partners.	• ACH has not yet established mechanisms to track partnering provider participation in transformation activities at the clinic/site level. As of the reporting period, SWACH was engaging in conversations with each partner to develop clinical transformation binding agreements. SWACH plans to then design partner reporting that will accommodate both organization and site level reporting but has not yet identified any barriers to tracking. ***Recommendation:*** Consider collecting additional specificity at the partner level, the intervention approaches and geographic spread of MTP projects. This information offers the state perspective on infrastructure changes that can be leveraged now and in the future. • Four positions appear to be added/modified including community engagement manager, finance/personnel administrator, communications manager, and opioid coordination. It appears that multiple staff have dual reporting relationships. ***Recommendation:*** Consider as a part of a routine monitoring process, a review of organization charts with ACH staff, including discussions of staff turn-over as well as training opportunities that could be made available.

Table 22. Achievement Values and Earned Incentives for Reporting Period July 1, 2018 – December 31, 2018

SWACH			
Project	**Total AVs Achieved**	**Maximum Possible AVs**	**Incentives Earned**
Domain 2: Care Delivery Redesigns			
2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation	4	4	$3,738,015
2B: Community-based Care Coordination	5	5	$2,569,885
Domain 3: Prevention and Health Promotion			
3A: Addressing the Opioid Use Crisis	4	4	$467,252
3D: Chronic Disease Prevention and Control	4	4	$934,504
Total	**17**	**17**	**$7,709,655**