Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Self Sufficiency of Accountable Communities of Health

Engrossed Substitute House Bill 1109; Section 211(2); Chapter 415; Laws of 2019

December 15, 2019

Self Sufficiency of Accountable Communities of Health

Washington State Health Care Authority

Policy Division
P.O. Box 45502
Olympia, Washington 98504-5502
Phone: (360) 725-1419
Fax: (360) 586-9551
www.hca.wa.gov

Table of contents

Legislative report requirements

Section 211(2) of ESHB 1109 (2019), states: "By December 15, 2019, the authority in collaboration with each accountable community of health shall demonstrate how it will be self-sustaining by the end of the demonstration waiver period, including sources of outside funding, and provide this reporting to the joint select committee on health care oversight. If by the third year of the demonstration waiver there are not measurable, improved patient outcomes and financial returns, the Washington state institute for public policy will conduct an audit of the accountable communities of health, in addition to the process set in place through the independent evaluation required by the agreement with Centers for Medicare and Medicaid services."

Executive summary

Developed in 2013, the five-year State Health Care Innovation Plan created a framework for health system transformation. The plan is far-reaching in its core strategies for achieving a healthier Washington through better health, better care, and lower costs.

The plan gained strong support in the 2014 legislative session with passage of E2SHB 2572 (2014). Following E2SHB 2572, Health Care Authority (HCA) received a $65 million federal award of a four-year State Innovation Model Round Two Model Test grant, which concluded in January 2019. Built upon the foundation of the federal SIM grant, the state pursued a section 1115 Medicaid Waiver, the Medicaid Transformation Project (MTP).

Accountable Communities of Health (ACHs) are a central component of Initiative 1, part of Washington's MTP and 1115 Waiver agreement and Delivery System Reform Incentive Payment (DSRIP) program with the Centers for Medicare & Medicaid Services (CMS). MTP is a five-year agreement that seeks to improve health outcomes for Medicaid beneficiaries in Washington State. Initiative 1 focuses on the implementation of regional health transformation projects through ACHs and Indian Health Care Providers (IHCPs). MTP spans from 2017 through 2021, with incentives paid out through June 2023.

As of fall 2019, ACHs are squarely in the first full implementation year for this work, opting to take a portfolio approach to regional project implementation. ACHs are engaging with health and social service partners to focus on care coordination, health information technology, enhancing connections to social determinants of health, and working on ways to address regional health disparities and care gaps. This work is building new connections, increasing capacity, and highlighting the value of ACHs as change agents and neutral conveners to promote better health outcomes statewide.

HCA designed MTP with several processes in place for monitoring and evaluation, as well as an incentive payment structure that rewards ACHs for achieving regional performance-based outcomes in later years. Full descriptions of these processes, including when evaluation reports are expected, are included in this report.

At this stage of development, HCA continues to work with ACHs and other community partners. HCA is also focusing on multiple ways to sustain transformational activities within Medicaid:

- The sustainability of promising interventions or programs implemented through MTP that are adding value to the state.
- The sustainability of MTP as an initiative.
- The sustainability of the ACH as an organization.

This report will cover:

- The background and history of MTP and the ACH role.
- DSRIP structure and timeline.
- Performance monitoring and evaluation.
- Initial sustainability considerations.
- A summary of regional activities, current statewide metric results, and a list of performance metrics.

Background

In 2012, HCA received a $1 million SIM Round 1 planning grant to create the State Health Care Innovation Plan. Using statewide stakeholder engagement, market research and analysis, and close partnership with the Governor's Office and partner agencies, the plan was developed in 2013. It created a framework for health system transformation that is far-reaching in its core strategies.

The goals of the plan are to achieve better health, better care, and lower costs for at least 80 percent of Washingtonians through a variety of strategies, including whole-person care, value-based payment, and stronger linkages between the health care delivery system through a collaborative, regional approach.

Through this original planning work, as well as the second round of SIM funding ($65 million from 2015-2019), HCA and partner agencies have led health system transformation activities to reach the goal of a healthier Washington. Keeping this collaborative and regional approach at the forefront, HCA worked to improve the health and wellness of Washington residents, improve health care quality, and reduce health care costs.

At the center of this work are nine ACHs, which are local organizations, tasked with:

- Building a structure for health and wellness collaboration.
- Creating local capacity to address the social determinants of health.
- Implementing projects to improve the health and wellness of community residents.
- Advising state agencies on effective approaches to addressing regional health needs across the state.

ACHs are a structural backbone to health system transformation in Washington State. They provide the infrastructure for our collaborative and regional approach, as well as a convening forum that goes beyond the traditional health care system. Beginning in 2012, the SIM grant investments and

foundational legislation in 2014 supported the development of ACHs. ACHs evolved from concept to strong legal entities that cover all regions of the state. One of the most important parts of this development process was building capacity through new and strengthened relationships with both traditional and non-traditional health and wellness system partners. Through their SIM evaluation, the Center for Community Health and Evaluation (CCHE) developed a detailed analysis on ACH development. This report is available on the HCA website.

In 2017, HCA and Department of Social and Health Services (DSHS) jointly secured additional funding to transform the Medicaid delivery system through MTP. MTP is the result of a Section 1115 Waiver, a contract between federal and state governments that waives certain Medicaid requirements, as long as the state can demonstrate the investment will be effective and budget neutral.

Under Medicaid Transformation, the state can use Medicaid funds for innovative projects, activities, and services that would not otherwise be allowed. A federal Medicaid waiver is not a grant. Funds are earned, and the state must show that it will not spend more federal dollars on its Medicaid program than it would have spent without the waiver. MTP goals include:

- Reduce avoidable use of intensive services and settings, such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long-term services and supports, and jails.
- Improve population health, including prevention and management of diabetes, cardiovascular disease, mental illness, substance use disorders, and oral health.
- Accelerate the transition to value-based payment using payment methods that take into account the quality of services and other measures of value.
- Ensure Medicaid cost growth is below national trends through services that improve health outcomes and reduce the growth rate of overall care costs.
- Implement population health strategies that improve health equity.

MTP includes Initiative 1, also referred to as the DRSIP program. DSRIP enables communities to improve the health system at the local level, and is implemented through ACHs. Each region, led by its ACH, is performing transformation projects specific to the needs of its region. These projects focus on:

- Health systems and community capacity building by adopting a value-based payment system, developing the health care workforce, and making improvements in population health management, including enhanced data collection and analytic capacity.
- Care delivery redesign by integrating physical and behavioral health care, improving care coordination, making better transitions between services and settings, and improving diversion interventions (helping people access the most appropriate service or facility for their needs).
- Prevention and health promotion by focusing on opioid use, maternal and child health, access to oral health services, and chronic disease prevention and management.

Other MTP initiatives

MTP also has other initiatives that are not the focus of this report. These include:

Indian Health Care Provider health systems and capacity

Also through Initiative 1, IHCPs are implementing projects that support improved outcomes for Tribal members and people served by IHCPs. These projects focus on:

- Statewide improvement of behavioral health for American Indian/Alaska Native (AI/AN) Medicaid clients.
- Building IHCP health systems, such as improving and expanding electronic health records and population health management tools.
- Expanding workforce capacity and service delivery innovation.

Initiative 2: Long-term Services and Supports

This initiative focuses on expanding options for people receiving long-term services and supports so they can stay at home and delay or avoid the need for more intensive services. Initiative 2 also supports families in caring for loved ones while increasing the well-being of caregivers. Learn more about Initiative 2.

Initiative 3: Foundational Community Supports

This initiative helps Washington's most vulnerable beneficiaries get and keep stable housing and employment, in support of their broader health needs. Learn more about Initiative 3.

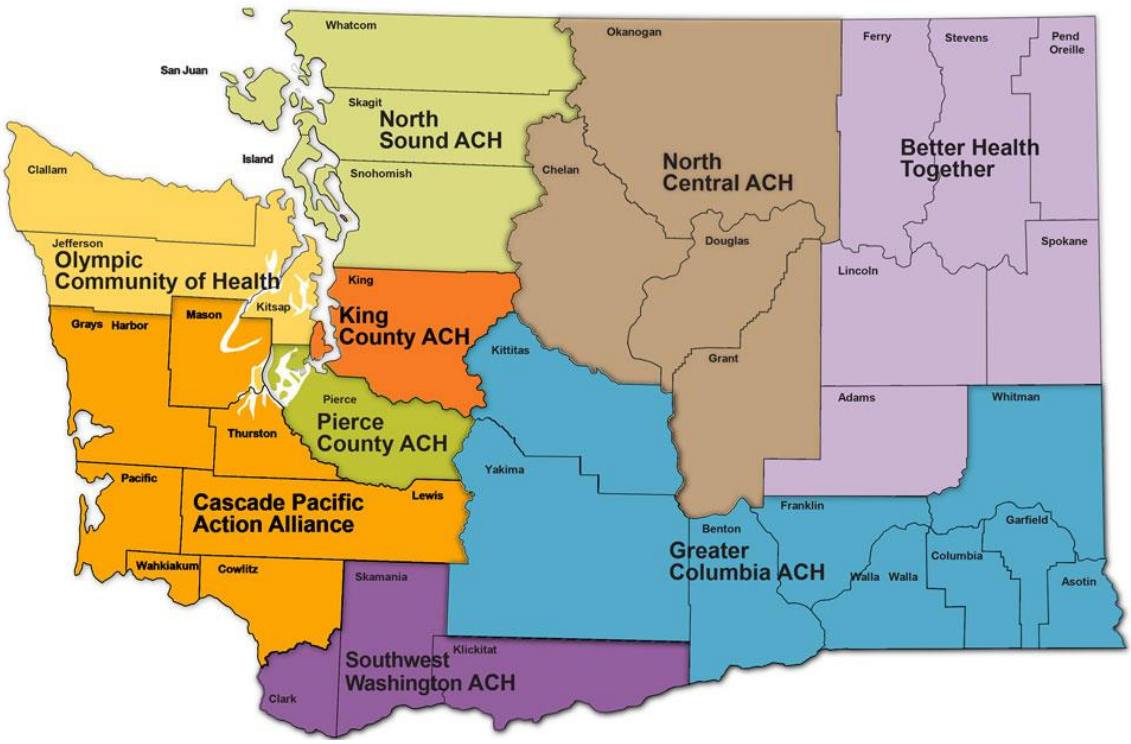
Initiative 4: substance use disorder (SUD) waiver amendment

In July 2018, Washington State received approval of its 1115 Waiver amendment to receive expanded federal financial participation for SUD treatment services, including short-term residential services provided in residential and inpatient treatment settings that qualify as an IMD. An IMD is a facility with more than 16 beds where at least 51 percent of the patients receive mental health or substance use treatment.

Accountable Communities of Health

ACHs cover all regions of Washington State, and are aligned with Washington's Medicaid purchasing regions.

Figure 1: ACH regions in Washington



Please note three ACHs have changed their names since the creation of this map. Pierce County ACH is now **Elevate Health**, King County ACH is **HealthierHere**, and Southwest Washington ACH is known by its acronym, **SWACH**. The below table lists the ACHs, what counties each ACH covers, and each ACH executive.

Table 1: detailed information about each ACH

ACH	ACH counties covered	ACH executive leader
Better Health Together (BHT)	Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens	Alison Poulsen
Cascade Pacific Action Alliance (CPAA)	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum Note: CPAA spans two purchasing regions	Jean Clark RN, BSN, MSN, MBA
Elevate Health (Pierce County ACH)	Pierce	Alisha Fehrenbacher, MHA

Greater Columbia ACH	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima	Carol Moser, MBA
HealthierHere (King County ACH)	King	Susan McLaughlin, PhD
North Central ACH	Chelan, Douglas, Grant, Okanogan	Senator Linda Parlette
North Sound ACH	Island, San Juan, Skagit, Snohomish, Whatcom	Elizabeth Baxter, MPH
Olympic Community of Health (OCH)	Clallam, Jefferson, Kitsap	Celeste Schoenthaler, MPH
SWACH (Southwest Washington ACH)	Clark, Klickitat, Skamania	Barbe West, MBA

MTP requires ACHs to implement projects to transform health and achieve better health outcomes in their region. Through DSRIP, ACHs receive incentive funds they distribute to local organizations and partnering providers who participate in transformation projects. The details of project requirements are available in the Medicaid Transformation Project Toolkit, and the details of funds flow for earned incentives are available in the DSRIP Measurement Guide. Specific regional implementation strategies are described in the ACH Project Plans.

An ACH implements transformational projects by tailoring a portfolio of activities to the local communities. Washington State and CMS agreed to house MTP projects in three "Domains." In Domain 1: Health and Community Systems Capacity Building, ACHs collaborate with HCA on statewide projects related to population health management, workforce development, and value-based payment. ACHs must implement a required project in Domain 2 and 3, and must implement at least four regional projects from both domains:

Domain 2: Care Delivery Redesign

- **Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation (required):** through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need.
- **Project 2B: Community Based Care Coordination:** promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
- **Project 2C: Transitional Care:** improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.

- **Project 2D: Diversion Interventions:** implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

Domain 3: Prevention and Health Promotion

- **Project 3A: Addressing the Opioid Use Public Health Crisis (required):** support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.
- **Project 3B: Reproductive and Maternal/Child Health:** ensure women have access to high-quality reproductive health care throughout their lives and promote the health safety of Washington's children.
- **Project 3C: Access to Oral Health Services:** increase access to oral health services to prevent or control the progression of oral disease, and ensure oral health is recognized as a fundamental component of whole-person care.
- **Project 3D: Chronic Disease Prevention and Control:** integrate health system and community approaches to improve chronic disease management and control.

Monitoring progress and measuring outcomes

Monitoring, accountability, and evaluation

HCA, in collaboration with DSHS, established mechanisms for monitoring and evaluating DSRIP processes and outcomes. Before describing these mechanisms, the DSRIP timeline highlights the implementation work that must occur to establish the program before beginning the evaluation process. Washington's DSRIP program did not have a "year zero" for planning purposes before the waiver period began. ACHs developed their organizations in year 1, becoming legal entities (e.g., a 501c(3) or LLC), establishing diverse boards and other governance structures, and evolving processes and protocols for administration and operations.

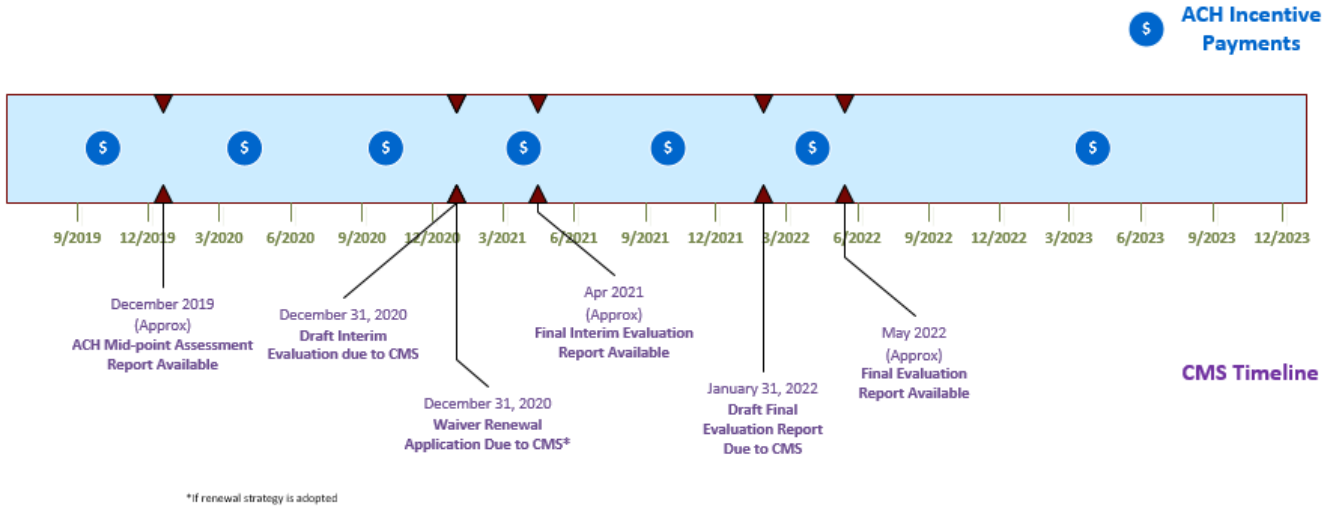
This evolution and development was essential for waiver participation, and was combined with active convening, engaging community partners, and identifying and establishing meaningful regional priorities. In year 2, ACHs focused on developing implementation plans and finalizing agreements with regional partnering providers who would participate in these projects in their local communities. Partnering providers continue to implement and perform services in 2019, year 3 of DSRIP, and HCA continues its support of implementation activities in all of the ACHs. This year puts ACHs squarely in phase 2: implementation.

Initiative 1 is a federal investment in Washington State communities. Because it is not a grant, ACHs and their partnering providers receive funds only after they achieve reporting and performance milestones. ACHs receive payment for achieving and reporting project milestones (pay-for-reporting (P4R)). ACHs and partnering providers also have a portion of their project incentive

payments at risk. They must demonstrate improvement and attainment of performance targets (pay-for-performance (P4P)) for key metrics approved by CMS. In addition, contracted partners independently assess and evaluate project activities at regular intervals. These entities provide objective observations and insights about how project activities are performed in the ACH communities.

HCA monitors transformation progress not only as it relates to the broad accountability metrics, but also across sub-populations and in conjunction with existing measurement efforts. HCA works in close partnership with the Research and Data Analysis Division at DSHS to calculate metrics, review measures, and communicate results. Additional information on the mechanisms by which the state and partners will have insight into DSRIP activities and progress over the course of Medicaid Transformation is detailed in the sections below.

Figure 2: milestones for monitoring and incentives



Regional and statewide performance measurement

MTP was designed to calculate performance metrics at regular intervals to track progress and measure outcomes. Each ACH is accountable for designing, implementing, and monitoring transformational activities and participating in the assessment of the activities. In demonstration year (DY) 3 through DY 5 (2019-2021), ACHs are also accountable for performance on quality and outcome metrics in their region that are tied to incentives.

Measures are calculated by both region and statewide, using pre-existing administrative data collection systems. Measures on adults and children span conditions, such as chronic illnesses and treatment for mental health conditions and substance use disorder. For the full list of P4P metrics ACHs are accountable for, see Appendix C.

To accurately calculate these results, a measurement period of 12 months is necessary. ACH progress toward improvement targets will be assessed based on reference baseline years that are

separated by two years (i.e., 2017 baseline for performance year 2019). This gap between baseline and performance measurement years is intended to allow time for project implementation to take effect. Processing time is needed for claims and encounter data, so the results for a performance year become available in the third quarter following the performance year.

For a more detailed analysis of MTP performance measurement, see the DSRIP Measurement Guide.

State tools for monitoring progress

To support ACH monitoring of project activities, state metric producers calculate P4P metric results quarterly. Results are shared directly with ACHs in addition to being publicly shared on the Healthier Washington Dashboard.

The dashboard provides data on the Washington Medicaid population and quality and outcome metrics. As of November 2019, the latest measurement period in the dashboard reflects the 12-month period, January 2018 to December 2018. There is a trends view within the dashboard that contains results from the last eight rolling 12-month measurement periods, which provides a look into how the state and ACHs are progressing over time.

Independent assessment of transformation project progress

In 2017, Washington State contracted with Myers and Stauffer, LC to serve as the independent assessor (IA) for the DSRIP program. During the planning phase, Myers and Stauffer reviewed, supported a question and answer period, and provided technical assistance to ACHs on their required planning documents to strengthen and support ACHs prior to implementation.

Over the MTP period, ACHs must submit semi-annual reports (SARs) on project implementation and milestones. The purpose of the reporting is to collect necessary information to evaluate ACH projects against milestones. Currently, the IA assesses ACH performance through review of SAR submissions, and calculates incentive payment adjustments accordingly. Through the SAR process, the IA provides at-risk project identification, guidance, and monitoring to ACHs and HCA.

In DY 3, the IA is also responsible for conducting a mid-point assessment of ACH project plan progress. The assessment is an impartial review of the ACHs and their projects to assess project plan implementation progress and confirm compliance with special terms and conditions and approved protocols. The IA also assists HCA in assessing progress as it relates to value-based payment targets and the attainment and improvement of quality measures. The mid-point assessment report will be available in December 2019.

Independent evaluation of impact

HCA selected the Oregon Health and Science University (OHSU) to perform an independent evaluation of MTP. OHSU is a recognized leader in developing health care policy and performing and providing technical assistance and evaluation on transformational initiatives and health care

policies. The assessment performed by OHSU will apply the best use of qualitative and quantitative research methods. Their analysis will assess the status of transformational activities and their effect upon Washington's Medicaid program, providing information on achieved outcomes and the potential to reshape the program for Medicaid beneficiaries through ongoing activities.

OHSU provides monitoring reports every quarter to assist HCA, ACHs, and other initiative partners in monitoring the development and implementation of MTP activities. OHSU will also conduct an interim and final evaluation of MTP. The interim evaluation report will be completed by December 2020, and the final evaluation report available by early 2022. Additional detail about the interim and final evaluation reports are available in the CMS approved evaluation design.

Sustainability options for ACHs

Introduction

MTP sustainability can apply to:

- Transformation achieved through DSRIP.
- ACH projects more broadly.
- Discrete functions or programs within MTP projects or ACH regions.
- ACHs as organizations.

In working toward sustainability, both ACHs and MTP have a foundational structure of relationship building and collaborative models, as well as blended funding and inclusive decision-making.

HCA is currently in phase 2: implementation. MTP is designed to evaluate and monitor statewide transformation and local activities to determine what interventions are leading to better outcomes for the Medicaid program. HCA is working with ACHs to continue the development and implementation of transformational activities through the support of waiver funding.

HCA has also begun working with partners to develop options for sustainable funding that offer opportunities to continue activities that have led to better outcomes or demonstrated the potential to do so. HCA and ACHs will continue to partner throughout the waiver period to identify the best options for sustaining the gains demonstrated by transformational activities through MTP.

ACH sustainability considerations and approaches

ACHs play an integral role within Medicaid Transformation and DSRIP, including coalition building, partner convening, providing local context, implementing projects, supporting providers, and being a critical partner in health transformation at the community level. Because of this, there are considerations regarding the sustainability of ACHs that extend beyond the current DSRIP activities and anticipated outcomes.

The need for regional collaboration across multiple health and social service sectors predates the ACH role in Medicaid Transformation. Recognizing the state's move to whole-person care and

value-based purchasing (VBP), the need for regional collaboration will only increase in the future. While DSRIP leverages the ACH role as a regional convener and lead entity for health system transformation, the value of the ACH extends beyond the outcomes to be realized under DSRIP investments. In the context of outcomes and sustainability, DSRIP activities and investments depend on collaboration between the ACHs, partnering providers, and HCA to meet the requirements of the program.

The sustainability of both ACHs as organizations, as well as the transformative projects ACHs are implementing in their regions, is a participatory process between ACHs, HCA, managed care organizations (MCOs), the Legislature, Tribes, communities, and many other partners.

Conversations to develop strategies are underway. The structures in place for monitoring, along with the individual implementation progress and strategic planning of ACHs, has established a venue for developing and discussing viable options for sustainability by 2023. This process promotes an informed dialogue, further development of partnerships, collective review of key evaluation results, and continued examination of the needs and perspectives of individual communities.

Regarding sustainability of DSRIP transformation activities, ACHs are in the midst of implementing their projects, including convening partners, building regional capacity, and participating in state monitoring and evaluation activities. While much of sustainability will depend on assessment and evaluation activities over the next several years leading up to 2023, the state is partnering with ACHs and other partners to proactively discuss ways to align investments and ensure DSRIP activities have a path forward after DSRIP funding ends. (E.g., through additional funding or policy levers, a one-time "startup" investment, or an innovation tested and adopted by partnering organizations.)

Regarding ACH organizational sustainability, ACHs and the state are concerned with the immediate work surrounding DSRIP implementation and ensuring an appropriate path to long-term transformation and sustainable investments. However, early discussions on how ACHs can continue to be supported are underway. These conversations are happening at the state level, and ACHs are having these conversations with their boards at the local level. Common themes are emerging, which include:

- Standing up community health funds (also called community resiliency or community wellness funds) to pool resources, or reinvest shared savings. All nine ACHs either have these funds or have plans to create them by 2021.
- Acquiring funding from other sources, including grants and public/private sources.
- Developing strategies for shared savings and community reinvestment, through Pathways HUB projects, partnerships with MCOs, or data and evaluation strategies.
- Exploring the ongoing role as neutral regional convener, and facilitating relationships between the clinical delivery system and social determinants of health.
- Building capacity and supporting providers through resources, training, and technical assistance.

- Enhancing the capacity for value-based payment arrangements through project implementation and collaboration across health care providers and community organizations.

HCA will work closely with ACHs as they develop their individual sustainability plans, while also working on statewide strategies for sustainability of ACHs and the value they deliver. At the state level, several options are available for continued funding of statewide Medicaid Transformation activities and programs. While discussions and decisions are still in development, these options could include[1]:

Federal incentives and grants

- Waiver renewal/new waiver application to fund specific effective pieces of ACH projects with Medicaid dollars.
- Innovation grants offered by federal agencies to continue to build capacity and test new approaches.

Leveraging new financing options

- Identifying VBP models that support clinical-community linkages and encourage clinical delivery system/social determinant partnership.

Identifying new public-private partnerships

- Sustaining/building Pay for Success models/social impact bonds to encourage private sector investments in the public sector by demonstrating the successful achievement of outcomes and associated shared savings.
- Using pooled data, such as data lakes, to demonstrate the impact of investing in social determinants of health on the well-being of targeted populations, and the associated savings for private sector health entities.

Broadening potential revenue sources

- Innovative state funding options, such as revenue from public health taxes.

Conclusion

The following analysis was pulled from the January 31, 2019, CCHE evaluation of ACHs, and provides context for the current state of ACH work:

> Although the MTP implementation is in the early stages, the ACHs have achieved significant accomplishments that set the stage for successful system transformation:

[1] These options are supported by research from the Funders Forum on Accountable Health, part of George Washington University: http://accountablehealth.gwu.edu/.

- Building trust and collaboration.
- Establishing infrastructure and capacity.
- Creating an integrated regional approach.
- Bringing in community voices and a focus on equity and social determinants of health.

The goals and structure of the MTP were prescribed in considerable detail to elevate common project categories and evidence-based approaches. However, regional needs and capacities vary widely and a key role of the ACHs was to bring their region-wide strategic perspective to designing projects that will promote greater long-term impact and sustainability.

Health system transformation requires a high degree of synergy between activities that is not possible without a collaborative foundation. Early indications are that ACHs have been effective in this role, although ultimate success can only be judged in several years when population-level impact can be measured, and sustainability assessed.

HCA is committed to Medicaid Transformation, and will continue to lead MTP to completion. ACHs are involving partner providers in setting priorities and the necessary steps of developing innovative regional projects that catalyze health system change. These are covered in detail in Appendix A. The current mechanisms in place are sufficient to monitor and evaluate ACH progress and impact, and we look forward to sharing those results and discussing them with the Legislature.

Appendix A: ACH project implementation overview and highlights

ACHs submitted Project Plans in late 2017 that responded to community specific needs and aligned with DSRIP objectives. Currently, ACHs are in stage 2: implementation. Key milestones for summer 2019 include:

- Partnering provider adoption of necessary policies, procedures, and guidelines to move ahead with implementing transformation strategies in their organizations.
- A comprehensive quality improvement plan the ACH will use to monitor and support selected transformation strategies.

Each region is implementing local strategies. The next sections summarize the unique ways each ACH is leveraging their resources and implementation strategies to add regional value.

Better Health Together

Project implementation highlights

Medicaid Transformation and the collaborative structure

BHT's creation of Community Based Health Collaboratives was the mechanism that made the partner communication and connections possible. More than 100 partners across the region hold a memorandum of understanding with BHT to participate in the collaboratives. By October 2019, 40 behavioral health and primary care partners from the collaboratives will be in contract with BHT for activities related to bi-directional integration, chronic disease management, and addressing the opioid epidemic. This group of contracted partners represents nearly 98 percent of the Medicaid delivery system.

BHT's Board-guided investment approach has allocated 55 percent of Medicaid funds to go to behavioral health and primary care providers; 30 percent to community infrastructure and social determinants of health; 10 percent to a community resiliency fund; and five percent to the ACH for management.

Technical assistance

To support partners in preparing for contracted activities, BHT offered a monthly Learning Cohort with opportunities for training, technical assistance, and shared learning. University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center and other independent health care consultants helped us to deliver the curriculum, which includes topics around change management, provider care compacts, social determinants of health, and health registries. There was a robust amount of discussion and support offered to partners for the implementation of policies, procedures, and clinical protocols. Additionally, the Learning Cohorts gave our partners another venue for peer-to-peer learning and collaboration.

Tribal relations

BHT's regional Tribal partners are integrated into the collaboratives. BHT convenes and provides project support for the monthly Tribal Partners Leadership Council meetings. Over the past six months, Tribal partners have discussed collaboration between their organizations to implement a community based care coordination project.

To support the unique responsibilities and contribution of Tribal partners, the BHT Board approved an alternative payment method that gives Tribes the flexibility to implement transformation efforts that are culturally appropriate for their health systems. Through this Tribal carve-out option, Tribal partners can earn $50,000 each year for the next three years by identifying a Medicaid Transformation project specific to their needs.

Integrated managed care transition

The BHT region was a mid-adopter for the integrated managed care (IMC) transition. To support behavioral health providers through the transition, BHT was asked by their behavioral health organization to lead the monthly (and sometimes weekly) IMC workgroup meetings to address

provider questions and issues. By working closely with the MCO, HCA, and providers, BHT was able to deliver answers to hundreds of provider questions and to connect providers to the right MCO contacts.

The workgroup gave providers a venue for shared questions and learning. The workgroup also continues to elevate longer-term issues to the state to make certain policy decisions and next steps are in line with local needs. (For example, working with Interpreter Services to request better options for rural providers, including reimbursement for telephonic interpreters.)

Equity

BHT is committed to ensuring there is an equity lens built into the work at all levels. Using the Community Health Needs Assessment, BHT worked in partnership with the Spokane Regional Health District to develop a framework for identifying health inequities. Each of the six county-based collaboratives are currently working on selecting one health inequity specific to a health issue in their community. Then all organizational members of the collaborative will work together to close the gap. This framework has created a way for communities to approach collective impact with an equity lens.

Project overview

Project 2A: bi-directional integration (required)

BHT designed this project to improve whole-person care and health outcomes by encouraging and facilitating evidence-based models of care for high-needs populations, while also building on existing physical and behavioral health integration activities. BHT is supporting clinics in the implementation of evidence-based models, such as the Bree Collaborative or the Collaborative Care Model (CoCM), and will leverage health information technology (HIT) and care coordination infrastructure to launch their integration efforts.

Project 2B: community based care coordination

BHT is implementing the Pathways Community HUB[2] model to better connect the community based social determinants of health system with the clinical delivery system. This also works as a portfolio approach to connecting other MTP projects, while also supporting at-risk individuals to address the range of clinical and social factors affecting their health.

Spokane County was awarded a nearly $1 million grant from the Department of Justice to utilize the Pathways Community HUB as the anchor strategy for a local initiative to reform the local criminal justice system. In partnership with BHT, the county will launch the Pathways Community HUB. This

[2] The Pathways Community HUB Model is an evidence-based model for improving care coordination by working with care coordinators to identify high-risk individuals, complete a comprehensive health assessment, identify risk factors, and determine what standardized "pathways" a care coordinator should employ with the individual to connect them with resources.

funding, in addition to a $1.75 million grant, came from the MacArthur Foundation in April 2016 to help reduce the jail population by 21 percent by 2019.

Project 3A: addressing the opioid use public health crisis

BHT is leading four interconnected opioid initiatives focused on providers and Medicaid consumers. These efforts align with the Washington State Opioid Response Plan and are as follows:

- Prevention, including improving provider prescribing practices through Transformation Collaboratives and promoting awareness of adverse effects.
- Treatment, including provider education on opioid use disorder (OUD) detection and available treatment options, increasing access to and use of community SUD treatment facilitates, and targeting patients most in need of specialized intervention.
- Overdose prevention, including increasing availability and use of Naloxone, educating consumers on overdose response, and increasing awareness and understanding of Washington's Good Samaritan Law.
- Recovery, including better access to recovery supports and long-term stabilization.

In addition, BHT is aligning community efforts related to opioid prevention, such as ARCORA Foundation's (the new name for Washington Dental Service Foundation) effort to support an oral health local impact network with a focus on reducing OUD. This strategy will assist in building a robust network of dental practices who are a key source of opioid prescribing, with involvement and leadership from the dental community. This strategy will be a key success factor for establishing a coordinated response to opioid addiction prevention and treatment activities.

Project 3D: chronic disease prevention and control

BHT selected this MTP project to accelerate efforts to improve health, with an initial focus on control and prevention of Type 2 Diabetes. The project strategies include:

- Increasing access to care.
- Educating consumers and their families.
- Identifying risk earlier.
- Increasing coordination of services that link clinical providers and services to social supports and other service needs.
- Working with the state to support healthy choices for Washington residents.

BHT is also exploring the possibility of focused efforts around prevention and management of asthma among youth and will make final decisions about project activities and target populations in consultation with its collaboratives and technical councils.

Cascade Pacific Action Alliance

Project implementation highlights

One Community CarePort

Community CarePort, CPAA's Pathways Community HUB, is a breakout success in the region, delivering care coordination services and shared regional infrastructure across the seven counties. Since November 2018, this project has aligned a workforce of more than 40 care coordinators across 12 agencies to connect with more than 400 clients.

One Community CarePort client was working with a care coordinator for over a year and was unable to get help with housing before this program was available. Now, with CarePort, that client has been successfully housed and is moving on to other personal goals. Another previously homeless client was pregnant and concerned about her substance use when she met a CarePort care coordinator. With the support she received, the client entered treatment and recently delivered a healthy weight, substance-free baby. Overall, Community CarePort has successfully housed 43 clients and completed 841 Pathways (verified outcomes that reduce identified risks).

Success in addressing the opioid epidemic

A key goal of the MTP is addressing the opioid epidemic. CPAA and a network of diverse partners have prioritized "meeting people where they're at" along the continuum of recovery. While regional projects include prevention and education, treatment and recovery supports, and overdose prevention, increased access to medication-assisted treatment (MAT) is a notable success in the region.

Support from CPAA helped the Olympia Bupe Clinic (OBC) secure start-up funds to open a low-barrier, high-volume, and cost-effective MAT clinic. Since opening its doors in January 2019, OBC has seen 433 cumulative patients with 2,006 visits. Between January and May, 75 percent of patients visited more than once, and 49 percent visited four or more times.

One patient first came to the OBC while 34 weeks pregnant. She met with a peer recovery counselor on-site and started with low-dose buprenorphine to manage early heroin withdrawal. This patient was recently featured in a video about OBC produced by KING 5 News. In her interview, she stated: "At first, I didn't have a whole lot of faith that it was going to work. Actually, it's done everything that I didn't think it was going to do." MAT does more than support individuals toward recovery; it helps them get their lives back.

Project overview

Project 2A: bi-directional integration (required)

CPAA is addressing the physical and behavioral health needs of children and adults through an integrated system of care that focuses on whole-person health. This changes the dynamics of health care teams, such that providers will use shared care plans, track treatments in new patient registries, use evidence-based screening tools and treatment, and receive reimbursement for quality of care and clinical outcomes through value-based payment.

Within primary care and behavioral health settings, CPAA partners are using elements CoCM, Bree Collaborative behavioral health integration recommendations, and Milbank Report as the evidence-based approaches for bi-directional care integration.

Project 2B: community based care coordination

CPAA is improving the care coordination occurring between systems of care through the implementation of Community CarePort. Using the Pathways HUB model, Community CarePort partners with 12 care coordinating agencies (CCAs), which are a mix of clinical and community based organizations from across the region. Community CarePort provides training, access to a common software platform, and supports ongoing quality assurance and improvement. Outcome-based payments are provided to CCAs for verified client outcomes.

Project 2C: transitional care

Transitional care has been a focus for aligned action among health care providers in the CPAA region for a number of years. Led by CHOICE Regional Health Network, the organization providing administrative support to CPAA, the region is working to improve connections between different care systems that are currently highly fragmented. These include acute care, behavioral health, primary care, home health, housing, and transportation. The goal is to create and maintain standardized practices and procedures that support successful transitions, with a focus on five major action areas:

1. Target interventions
2. Identify key care providers
3. Notify key care providers
4. Coordinate transitions
5. Activate patients

Project 3A: addressing the opioid use public health crisis (required)

CPAA is working to decrease the number of opioid overdose deaths by increasing access to naloxone and improving the systems of care for people experiencing OUD. CPAA's strategy is focused on increasing access to evidence-based therapies delivered in a cohesive system by providers that understand the role of trauma in SUD. Training reduces stigma and judgement with the goal of "meeting patients where they're at" along the continuum of behavior change. This project is working with Community CarePort to create supports for people with OUD to help them maintain their recovery and improve their lives.

Project 3B: reproductive and maternal and child health

CPAA is implementing a three-pronged strategy that includes:

- Coordinating and expanding home visiting programs to reduce adverse childhood experiences and intergenerational trauma.

- Expanding primary care and reproductive care through One Key Question[3], pregnancy intention screening, and training on trauma-informed practices and highly effective contraceptive methods, including long-acting reversible contraception.
- Expanding implementation of Bright Futures guidelines or enriched medical home intervention into clinical models and working with MCOs, pediatricians, family practitioners, and children's stakeholder groups to increase and improve well-child visits.

Project 3D: chronic disease prevention and control

CPAA is implementing the Chronic Care Model (CCM), The Community Guide, Community Paramedicine, Chronic Disease Self-Management, and Million Hearts interventions to improve chronic disease prevention and management. An integrated health system, along with community approaches, is crucial to improving chronic disease prevention, management, and control.

Through health system improvements and taking a whole-person approach to care, providers have the opportunity to reduce chronic diseases and conditions that create an overwhelming burden on the health system in terms of costly, preventable health problems.

[3] One Key Question® is a transformative tool that starts the conversation about if, when, and under what circumstances women want to get pregnant and have a child.

Elevate Health (Pierce County ACH)

Project implementation highlights

Elevate Health utilized a structured set of criteria for contracting with providers on transformation projects. The level at which their action plans demonstrated depth in the various categories was key to defining the specific project statements of work and the incentive levels. In addition to committing to operate under Elevate Health's rules of engagement, a set of strategies and approaches designed in collaboration with Elevate Health's community members, providers, community based organizations, MCOs, and governance structure then embedded within the Action Plans, Elevate Health agreed to:

- Demonstrate high and increasing levels of partnership with collaborators outside of our organization.
- Integrate an equity lens in hiring practices and within care settings.
- Embrace a culture of learning by committing to participate in learning collaboratives convened by Elevate Health.

For all partners under contract with Elevate Health, a clinical improvement advisor is assigned to assist with project planning and project management and to monitor results. Their statements of work require regular quarterly reporting on progress and project plan status updates, as well as P4R requirements. Project charters are documented, and levels of partnership is tracked across the spectrum. This tracking includes common goals and coordinated activities, as well as formal collaboration agreements for shared governance and legal partnerships or affiliation where there is shared governance and resources are pooled.

Elevate Health offered several opportunities to convene partners to:

- Share best practices.
- Work as teams to develop standard policies and procedures.
- Report on issues or challenges experienced as various models were implemented.
- Experience shared learnings through the Whole-Person Care Collaborative, learning labs, Provider Integration Panel, and several workgroups.

Elevate Health brings in subject matter experts to provide technical assistance, provides a forum for sharing resources, and builds capacity in the region for sustainable rapid cycle improvements.

Example of transformative partnership: Bridge of Hope

HopeSparks and Pediatrics Northwest began a partnership termed "Bridge of Hope" to increase early access to behavioral health care services for pediatric patients with mild to moderate mental health needs and connect with pediatric primary care. The two groups entered into a formal partnership on November 1, 2018, and committed to utilizing the CoCM from the AIMS Center to ensure patients have wrap-around, whole-person care.

Elevate Health contracted with the Bridge of Hope partners under a shared statement of work in which outcomes are measured for the partnership and earned incentives are shared. Primary care

services and screening for behavioral health needs will occur at the primary care site, Pediatrics Northwest. HopeSparks will provide a behavioral health therapist and pay for psychiatric consultative services.

Beginning in August, the partnership will begin billing Medicaid for the collaborative care codes for initial patients screening into the program. The ability to bill Medicaid for these codes indicates a successful adoption of CoCM and cross-organization partnership.

HopeSparks and Pediatrics Northwest's clinical and executive leadership teams meet monthly to review policies, procedures, workflows, and internal and external communication plans for this partnership. They have also shared and co-developed policies, procedures, and job descriptions to ensure the successful launch of the Collaborative Care Program. HopeSparks and Pediatrics Northwest have also developed a:

- Shared method for deploying screening to identify patients for behavioral health services (GAD-7, PHQ9).
- Risk stratification methodology for services to be rendered based on patient's needs and diagnoses.
- Job description for a behavioral health integration program manager.

These partners even have meetings between their respective Boards of Governance to share policies and strategic direction.

Initial challenges were faced in tracking data, establishing a shared cohort, and defining measures for tracking patient access to services. To address these challenges, Elevate Health provided a clinical improvement advisor to assist the two teams in chartering their work, establishing data and workflows that will be tracked and updated as the project progressed, and provided oversight and project management to joint meetings.

Additionally, Elevate Health, through its Binding Letter of Agreement, awarded the Bridge of Hope Partnership funds, which allowed them to hire a long-term project manager to oversee the scope and cross-functional partnership. Quarterly, the Bridge of Hope Partnership shares a work plan, and the measures they are tracking for their scope of work with Elevate Health as required in their Binding Letter of Agreement.

Project overview:

Project 2A: bi-directional integration (required)

Elevate Health is implementing a clinically integrated system of care using the CoCM, with elements of the Bree recommendations. The CoCM has demonstrated success in delivering integrated health care to patients in the care settings that are most familiar and comfortable to them, whether that is the primary care clinic, the behavioral health center, or other clinical settings. CoCM allows leveraging of limited financial and human resources, and will also increase the capacity for improvement and innovation across agencies and care settings. Elevate Health is utilizing HIT and a care continuum network to support the integration of behavioral health and primary care.

Project 2B: community based care coordination

Elevate Health has established a regional Pathways Community HUB that is an element of the Care Continuum Network to provide community based, culturally competent and person-centered care coordination for identified vulnerable populations in Pierce County.

Elevate Health provides an integrated model of the Pathways Community HUB providing standard training, development of workflows, and critical tools, such as the HUB information technology platform to track and share information. They are supporting partnering organizations by:

- Centrally tracking the progress of individual clients.
- Monitoring the performance of individual workers.
- Assessing the outcomes of priority populations.
- Evaluating overall organizational performance.

The HUB is working closely with CCAs and referring organizations to ensure an individual's health risk factors are addressed through all 20 standardized Pathways that attend to an individual's needs by connecting them to a range of community based health and social services. To date, more than 540 clients have participated in the HUB program.

In addition, Elevate Health is working with five local fire districts to support and sustain community paramedicine work, which will be another element of the Care Continuum Network. The Community Paramedicine Collaborative is an identified best practice in the Pierce County to address overuse of emergency medical services calls.

This collaborative, initiated in 2014, has demonstrated outcomes improvement and better knowledge of care coordination services providers for emergency management system (EMS) partners. The model utilizes a central referral hub to connect clients to a care coordinator. Some EMS partners have a nurse care coordinator or community paramedic hired to initiate and facilitate initial care coordination. Success measures to date include a 44 percent decrease in EMS calls in the 12 months after receiving services, as well as a 47 percent decrease in EMS transports. The collaborative is exploring scaling up the population and developing sustainable payment models for this partnership. They will propose a plan to sustain the paramedicine collaborative by end of 2019.

Project 3A: addressing the opioid use public health crisis (required)

Community level leadership role

Elevate Health serves as a regional leader and convener for OUD strategies at a regional level. Local stakeholders in the county, including the county council, county Human Services, the Tacoma/Pierce County Health Departments, MCOs, providers across physical/behavioral/substance-abuse settings, and provider administrators came together to form the Pierce County Opioid Task Force. This team is co-led by Elevate Health. We are working closely with Tacoma Pierce County Health Department to support the work of this task force and its sub-committees. Below is a summary of the work in motion within each sub-committee:

- **Access to Treatment Committee**
  Priority: increase appropriate use of suboxone prescribing among providers.

- **Right Services, Right Time Committee**
  Priority: develop a clear intake tool for first responders and law enforcement to assess readiness for OUD treatment and access areas in the community.
- **Prevention and Education Committee**
  Priority: address the opioid epidemic upstream with children and youth and identify drivers for addiction.

National level initiative

Elevate Health was an inaugural member organization of the national consortium of service providers and researchers convened and hosted by the Massachusetts Institute of Technology (MIT). The CEO of Elevate Health serves on the National Opioid Consortium Steering Committee, bringing opportunity to learnings and resources from across the nation to Washington.

The goal of this national consortium is to:

- Share best practices, policies, and programs that have effectively impacted and reduced addiction and opioid crisis.
- Design and assess capacity and technology needed to replicate and scale best practices.
- Access research support from MIT to measure best practices and outcomes.

Project 3D: chronic disease prevention and control

Elevate Health has identified chronic disease prevention and control as a priority for the region and focuses on sustaining implementation of the evidence-based CCM across diverse care settings. CCM serves as a key strategy to ensure integration of health system and community based approaches to improve health outcomes, with special focus on Pierce County's Medicaid beneficiaries experiencing the greatest level of disease burden.

Elevate Health supports a sustainable health system transformation for the target populations by:

- Expanding the necessary infrastructure to assess efficacy of current approaches, as well as identifying additional needed capacity/resources across the Pierce County community.
- Aligning chronic disease and prevention efforts across health system and community partners that allow for greater efficiency and deepened impact.
- Extending intentional focus on specific subpopulations experiencing the greatest health disparities.
- Building experience with the use of data, health information exchange (HIE)/HIT resources and strategic quality improvement tools across regional providers and organizations.
- Deepening experience with VBP contracting among providers and community based organizations related to chronic disease prevention.

Greater Columbia ACH

Project implementation highlights

CHAS Lewis and Clark Dental Clinic

GCACH has been working on practice transformation with CHAS Lewis and Clark Dental Clinic in Clarkston, Washington. Since this is a dental clinic and not a primary care site, GCACH had to be creative and innovative so the work would be meaningful and have a positive impact on patients. Over the past six months, there has been tremendous work done by the staff at CHAS to meet the milestones that primary care sites and hospitals have to meet.

To meet the bi-directional integration of behavioral health (BH), CHAS decided to implement the Patient Health Questionnaire-2 (PHQ-2). To be successful with the implementation of the PHQ-2, staff received training on how to use the screening, when to use it, and why the PHQ-2 was being implemented.

Because of the implementation of the PHQ-2, during quarter two of the practice transformation period, they screened 385 patients who are 16 and older. Out of the 385 screened patients, 58 were identified as needing BH services. For the patients identified as needing BH services, they were referred back to their primary care provider (PCP) or BH provider, if they had a BH provider.

One of the patients who received assistance finding BH services came back and wrote CHAS a thank you card because he was able to receive the services he needed and was feeling better. After a Plan Do Study Act was completed on the implementation of the PHQ-2, it was identified that some patients were hesitant to verbally ask for assistance in finding a PCP or BH services. After this was identified, leadership at CHAS dental clinic decided to add third question to the PHQ-2 that asks patients if they want to receive a call from their community health worker (CHW) so that they can help them find the services they need. Once this question was added, 17 patients requested a follow-up by the CHW.

Local health improvement networks and community health fund

GCACH covers the largest geographic area in the state, covering nine counties and the Yakama Nation, from the Idaho border to the Cascade Mountains. The size presents a logistical challenge in efforts to stay in tune with each community's localized healthcare challenges. As a result, GCACH created six Local Health Improvement Networks (LHINs) to ensure local input and voices into our programming.

GCACH is currently in conversations with the Yakama Nation to create its own network. LHINs are an extension of GCACH in their communities. They convene with local partners, delivery system providers, and local governments, among others, to communicate GCACH activities. They review the resources in the community that strengthen the local health care delivery system by facilitating collaboration between physical/behavioral health providers and community based organizations. LHINs also align and collaborate local health improvement activities as necessary to complement initiatives and programs of the GCACH.

GCACH created a community health fund to address the most pressing social determinants of health in each region. We allocated $1.4 million total, and each LHIN was allotted an amount based on their total Medicaid population and the number of health risk indicators in the Robert Wood Johnson Foundation County Health Rankings. This method allowed us to treat the less populous counties with equity by allocating to them a larger amount per Medicaid consumer, as their risk factors tend to be more numerous.

LHINs surveyed their Medicaid population to find, from their perspective, what barriers people face to reach good health. Housing, food insecurity, mental health, and transportation were the most common. Once we determined the social determinants of health priorities for each region, GCACH contracted with third-party administrators (TPAs) to administer the funds and select the organizations that will address them. This ensures transparency and avoids self-dealing by members of the LHINs.

Currently, the entire $1.4M has been disbursed to the TPAs, and they in turn, have selected (with one exception) the organizations that will address the social determinants of health in their region. A notable example of how these organizations are helping improve the health of our region is Columbia County Public Hospital. They applied for funds to purchase two patient transport vans, and were awarded both. One van has already been purchased.

Partnership with the Yakama Nation

Greater Columbia ACH has been collaborating with the Yakama Nation to form a Health Commons information technology project tied to their Circles of Care Program (SklÍ Nak Nú ii). The Yakama Nation face many ongoing challenges in their delivery of health care and social services within the Reservation.

On May 29, 2019, the Yakama Nation's Circles of Care Database Work Group identified a project associated with family reunification that would be beneficial to Tribal members and meet the goals of the Medicaid Transformation Project. The Tribal Behavioral Health, Child Welfare, Youth Treatment, and Alcohol and Drug programs and Tribal Justice Services would support this project.

The Circles of Care Database Work Group identified internet connectivity as needing significant upgrades, and the need for an information exchange between the various program areas as their highest priority. Recognizing the importance of this need, GCACH agreed to fund the Yakama Nation Behavioral Health Services and their Circles of Care Program to upgrade their internet connectivity. GCACH will also fund work with Quad Aim Partners, a social purpose corporation, to establish a Health Commons that will act as a communications and information exchange between the Yakama Nation programs to implement the Family Reunification Workflow project.

The Health Commons is a technology platform that has an underlying system for delivery of whole-person care, also known as a Natural Communities of Care. This fully integrated system of care is where health and social service providers work together to ensure there is "no wrong door" for people to access the care and services they need.

The Health Commons Network is a communication network that digitally connects health and social service agencies in a community. Along with the software system architecture build-up, GCACH will

also cover the costs of system hardware needed to operate the Health Commons (e.g., system routers). In addition, Quad Aim Partners will facilitate Health Insurance Portability and Accountability Act training and certification for all participating Tribal programs and personnel linked to the Health Commons.

Project overview

Project 2A: bi-directional integration (required)

Greater Columbia ACH is using the patient-centered medical home (PCMH) model of care to implement bi-directional integration, with processes guided by the Safety Net Medical Home toolkit. GCACH is allowing practices to self-determine which evidence-based model (Bree Collaborative, Collaborative Care (AIMS), Co-location of Primary Care and Behavioral Health) to implement. The GCACH Practice Transformation Implementation & Reporting Toolkit is a guide to implement the following:

1. A practice is able to identify and meet the BH care needs of each patient and situation, either directly or through co-management or coordinated referral.
    - The practice has an available range of skills in BH in the practice for primary care management of BH issues.
    - There is a training strategy (formal or on-the-job) to develop capacity for primary care management.
    - The practice has identified and collaborates with appropriate specialty referral resources in the health system (as applicable) and medical neighborhood.
2. The practice has a systematic clinical approach that:
    - Identifies patients who need or may benefit from BH services.
    - Engages patients and families in identifying their need for care and in the decisions about care (shared decision making).
    - Uses standardized instruments and tools to assess patients and measure treatment to target or goal.
    - Uses evidence-based treatment counseling and treatment.
    - Addresses the psychological, cultural, and social aspects of the patient's health, along with his or her physical health, in the overall plan of care.
    - Provides systematic assessment, follow up, and adjustment of treatment as needed reflected in the care plan.
3. The practice measures the impact of integrated behavioral health services on patients, families, and caregivers receiving these services and on-target conditions or diseases, and adapts and improves these services to improve care outcomes.

Project 2C: transitional care

This project builds upon and expands several existing programs within the region that have demonstrated success to support care transitions. In addition, the project implements proven tools to support management of acute changes in condition without transport to the hospital. The project encompasses care transitions from hospital to home, home health agency, skilled nursing facility or

other setting, as well as transitions from these settings to less intensive care levels. Key components of this project include:

- Adoption of Interventions to Reduce Acute Care Transfers evidence-based model.
- Expansion of collaborative community paramedicine efforts.
- Leverage and expand existing family and patient-centered interagency interdisciplinary collaborative care models.
- Expands use of field-based nurse care coordinators, CHWs, and community paramedics.
- Enhanced access, e.g., 24/7 access for patients.

Project 3A: addressing the opioid use public health crisis (required)

GCACH has proposed to develop community based Opioid Resource Networks to advance strategies in four core areas: dependence prevention, treatment, overdose prevention, and recovery. Each Opioid Resource Network will serve as a resource for local communities throughout the region. Networks will provide trauma-informed case management for individuals with opioid dependence in community throughout the GCACH. The network will be a locus for cross-sector partnerships between health care providers, MAT providers, law enforcement, justice systems, drug prevention specialists, and other key community partners to advance system-level prevention, access to treatment, overdose prevention, and recovery.

Project 3D: chronic disease prevention and control

The GCACH has targeted chronic disease prevention and management through the implementation of the PCMH, which incorporates the internationally recognized CCM and has become a popular framework for transforming health care organizations. The PCMH principles are adopted by the GCACH's practice transformation organizations through the technical assistance provided by the Greater Columbia's Practice Transformation staff and Learning Collaboratives. Guidance is provided through the GCACH Practice Transformation & Implementation Toolkit, which includes the following milestone deliverables:

- **Empanelment:** assigning responsibility for a patient's care to an individual provider.
- **Risk stratification:** grouping patients with similar severity of condition or risk.
- **Care management:** providing personalized care planning services to high-risk patients.
- **Self-management supports:** providing patients with disease or condition-specific skills for managing their conditions.
- **Evidence-based approaches:** employing standardized care processes to manage chronic care conditions and using proven instruments or tools to systematically assess patients and monitor care.
- **Medication management:** applying processes to improve medication effectiveness and safety.
- **Shared decision making:** clinicians and patients work together to make decisions and select tests, treatments, and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values.

- **Care coordination across the medical neighborhood:** the practice enacts care agreements with community partners in different specialties to improve the coordination and transitions of care.

HealthierHere

Project implementation highlights

HealthierHere has a vision of a transformed health system that includes effective mechanisms for meaningful community and consumer involvement and voice in system improvement work. To reach this vision, we have a Community and Consumer Voice (CCV) committee as a formal committee of the Board. The CCV is made up of community members and representatives from local community based and consumer advocacy organizations. Its goal is to ensure that community voice, knowledge, experience, and expertise is included in planning and decision-making.

To date, the CCV developed an Equity Tool as well as an Equity Definition and Guidelines document that was adopted by the HealthierHere Governing Board. Both are used to address impact and authentic consumer inclusion in design and implementation.

The CCV also championed a Community Grants program, in partnership with the Center for Multicultural Health. In 2018, the Community Grants program funded 22 community based social service organizations and grassroots community groups to engage community members, and capture insights and feedback about their experiences with Medicaid and accessing care. More than 900 community members completed a survey and/or participated in focus groups with materials translated into 13 different languages. Responses are informing HealthierHere's transformation work.

HealthierHere has also configured their Governing Board so that one-third is made up of consumers, Tribal leaders, and community based organizations to ensure community voice is part of all decision making. In addition, HealthierHere is opening monthly Board meetings to the public and holding open public comment periods throughout the meetings. HealthierHere also created an Equity and Community Partnerships staff team that includes a Director of Equity and Community Partnerships, as well as two Community and Tribal Engagement Managers. These positions support the work with community and Tribal partners, to ensure that HealthierHere continues to lead with equity.

There are multiple partners and initiatives interested in implementing community information exchange (CIE) technology to strengthen community and clinical partnerships and better address social determinant needs in the region. HealthierHere has prioritized the initial exploration and design of a CIE as part of our 2019 investment strategy, as it also aligns with the goal to enable whole-person care under MTP.

A CIE is a cross-sector network of social service, community, Tribal, government, and medical and behavioral health providers who are connected through a cloud-based integrated technology platform. It enables providers to use and contribute to a single, shared longitudinal record for each client and to collaborate across sectors to achieve the best outcomes. The CIE will allow partners to efficiently match individuals to appropriate care, make and accept/decline bi-directional closed loop referrals, communicate with each other, and contribute to case planning. The CIE will also allow HealthierHere to track data on social service utilization and capacity in an intentional way to

provide currently unavailable data on care gaps and make data driven investment decisions for the region.

HealthierHere successfully helped convene two kick off meetings to develop a shared vision and obtain agreement to work collectively toward a connected system for greater impact and success. Continued design and planning will occur through 2019 with a goal to begin launch in early 2020.

Project overview

While HealthierHere selected four projects from the MTP Project Toolkit (minimum required), the region opted to take a portfolio approach to transformation instead of implementing discrete projects. Investments in 2018 and 2019 have focused primarily on building foundational infrastructure and capacity within partner organizations as it relates to having a population health approach to care. (I.e. ensuring ability to stratify risk, having disease specific client registries in place, and establishing quality improvement processes.). These foundational capacities are critical to all of the project areas and are necessary to achieve success and improve health. Additionally, there are project-specific goals related to MTP that have been set for the region detailed below.

Project 2A: bi-directional integration (required)

HealthierHere is moving forward with expanding bi-directional integration of physical and behavioral health care, including the integration of oral health and pregnancy intention screening, to offer more comprehensive, whole-person care. This project reflects HealthierHere's vision of a system that provides whole-person, patient-centered care, with a primary strategy of building a bridge between medical, behavioral health, and community providers.

Though this project, HealthierHere seeks to achieve four key goals:

1. Improve access to behavioral health through enhanced screening, identification, and treatment of behavioral health disorders in primary care settings.
2. Improve access to physical health services for individuals with chronic behavioral health conditions through increased screening, identification, and treatment of physical health disorders in behavioral health care settings.
3. Improve active coordination of care among medical and behavioral health providers, as well as addressing barriers to care.
4. Align new bi-directional integration with successful existing community efforts, including addressing the social determinants of health.

Project 2C: transitional care

HealthierHere focuses on three populations with evidence-based strategies to improve transitional care services, reduce avoidable hospital utilization, and ensure beneficiaries are getting the right care in the right place:

1. Medicaid beneficiaries returning to the community from jail.
2. Medicaid beneficiaries with serious mental illness or SUD who have been discharged from inpatient care.

3. High-risk Medicaid beneficiaries transitioning from hospitals, including older adults and people with disabilities.

Project 3A: addressing the opioid use public health crisis (required)

In 2016, King County, in partnership with the cities of Seattle and Burien, formed the Heroin and Prescription Opiate Task Force. Through a six-month, multisector collaborative process, the task force engaged stakeholders to evaluate regional needs and evidence-based practices to address the opioid crisis. This work resulted in recommendations to pursue strategies to prevent OUD and overdose, improve access to treatment, and provide other supportive services.

Project 3D: chronic disease prevention and control

The Chronic Disease Prevention and Control Project integrates health system and community approaches to improve chronic disease management and control. Focusing on populations experiencing the greatest burden of chronic disease in King County, the target populations are child and adult Medicaid beneficiaries. These populations may have or are at risk for two high-prevalence and high-cost complexes:

1. Chronic respiratory disease (including asthma).
2. Cardiovascular disease (including diabetes).

This project aims to reduce the impact or prevent the onset of complications connected to chronic conditions among high-risk individuals. HealthierHere set plans to develop a chronic disease management incentive payment program, initially focusing on disease bundles. (E.g., a respiratory bundle and a cardiovascular bundle, including diabetes.) Bundles include a range of services, including self-management programs, CHW services, and activities outside the clinic walls that support prevention and effective management of the selected chronic disease conditions.

North Central ACH

Project implementation highlights

NCACH has developed a Whole Person Care Collaborative (WPCC), a primary example of their success in developing relationships with clinical partners across the region. This effort has supported a behavioral health provider (Catholic Charities) redesign space to allow for a primary care provider (Columbia Valley Community Health) to collocate in their building. Moses Lake Community Health Center, another primary care provider, gave electronic health record (EHR) access to their local behavioral health staff (Grant Integrated Services) to address bi-directional integration.

NCACH is working with partners to help break down silos often formed because organizations only have the capacity to focus on internal priorities and have not had the opportunity or time to focus on reaching out to partners. A more recent connection includes initiating conversations between a rural health clinic (Coulee Medical Center) and a local behavioral healthcare provider (Grant Integrated Services). NCACH is also introducing medical directors in order to tour each other's facilities and discuss staffing and workflows. NCACH is also working with a Federally Qualified Health Center (Family Health Centers) and other partners with successfully securing funding to establish an Opioid Treatment Network that covers all of Okanogan County.

This relationship building is also evident in workforce and community initiatives started by nonclinical partners in the North Central Region. One key example of this is the formation of the North Central Community Partnerships for Transition Solutions. This group was formed in response to a presentation at the 2018 NCACH regional annual summit and continues to gain traction across the community, supported by NCACH staff.

As part of this collaboration, Okanogan County established its first ever Oxford House (clean and sober recovery housing). In addition, NCACH identified workforce needs for chemical dependency professionals. Through partnerships with the workforce development, education, healthcare, and statewide associations, the Okanogan Healthcare Workforce Collaborative was established in 2018. Based on work from this Collaborative, NCACH is in the process of developing a Chemical Dependency Provider Apprenticeship program. These examples show how partnerships across the clinical community lead to innovative approaches to improving the health of community residents.

Project overview

Project 2A: bi-directional integration (required)

NCACH selected a comprehensive approach to practice transformation to serve as the foundation for all clinical process improvement efforts in both behavioral and physical health organizations. In September 2017, NCACH established WPCC, which involves 17 organizations that provide behavioral and physical health care (several of whom provide both). WPCC also involves other entities who share and support the vision of whole-person care, including MCO representatives, as well as representatives from emergency services and hospitals.

For primary care providers, NCACH has chosen to follow the Bree Collaborative evidence-based approach, Patient-Centered Medical Home, and incorporate additional principles of CoCM into the work in their region. For behavioral health providers, NCACH has chosen to follow the integration practices outlined in the Milbank Memorial Fund report.

Project 2B: community based care coordination

The NCACH region has a fragmented and often duplicated system of care coordination. Where care coordination is provided, it delivers a significant benefit to the client. The Community Based Care Coordination project is developing a regional platform through the Pathways Community HUB model, to maximize and align the services of current care coordination agencies in the region. This approach helps to prevent duplication of services to clients and place clients with the most appropriate level of care coordinator (i.e. community health worker, nurse, social worker).

The Community Based Care Coordination project promotes care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.

Project 2C: transitional care

The Transitional Care Project is focused on more effective transitions from acute care back to the community. This has been accomplished by working with acute care providers (inpatient and emergency department (ED)) to improve internal processes. This includes how they discharge and connect patients with follow-up care, such as developing a regional standard for inpatient transitional care. This has also been accomplished through developing workflows out of EDs for scheduling follow up appointments, and improving the utilization of EDie (Emergency Department Information Exchange system). This work is also done in collaboration with both the Pathways Community HUB and NCACH's WPCC. The region knows that transitions involves all partners and is focusing on enhancing the collaboration between all these partners to facilitate efficient communication and care coordination.

Project 2D: diversions interventions

NCACH's Diversions Intervention Project focuses on diverting and transitioning people from emergency care for non-emergent conditions. Coordinated processes for ED diversion, in collaboration with outpatient primary care and behavioral health, Pathways Community HUB, and a Community Paramedicine program[4] assist in reducing the likelihood of continued ED utilization for patients within the NCACH region. This work helps indirectly address Domain I workforce development strategies and access to care issues. This is done by training an already existing workforce in the regions (paramedics) to provide patient care in traditionally underserved regions

[4] Community paramedicine is a health care model that allows paramedics and emergency medical technicians to operate in expanded roles by assisting with public health and primary health care and preventive services to underserved populations in the community. The goal is to improve access to care and avoid duplicating existing services.

where primary care workforce shortages exist. This is also done by better connecting the existing workforce (acute care and primary care) to ensure patients receive follow up care out of the ED.

Project 3A: addressing the opioid use public health crisis (required)

Through efforts of the opioid project, NCACH expects to reduce the number of opioid-related deaths, opioid overdoses, people abusing opioids, and inappropriate use of opioids (people with higher than recommended prescriptions). To accomplish these expected outcomes, NCACH has aligned with the 2016 Washington State Interagency Opioid Working Plan, which uses a multipronged approach that includes strategies targeting prevention, treatment, and overdose.

Project 3D: chronic disease prevention and control

NCACH has selected a comprehensive approach to practice transformation to be the foundation for all clinical process improvement efforts. This includes targeting chronic disease prevention and control in both behavioral and physical health organizations. Using the principles of team-oriented, evidence-based practices embodied in the CCM, the WPCC Learning Community is designed to take each organization at its own starting point and move it further along the continuum of whole-person care.

The founding notion is that all clinical practices must transform from an acute, episodic, and reactive model built around a fee-for-service payment system to a population-based, proactive model of care that manages both acute and chronic disease in a value-based payment scheme. In this model, providers will build registries to allow them to identify patients with chronic diseases and ensure patients receive the evidence-based care necessary for effective disease management and control.

North Sound ACH

Project implementation highlights

North Sound ACH determined that when looking from the perspective of an individual, family, or provider, it was not possible to select from the list of eight project areas. Therefore, we made a decision to move forward with strategies in all eight.

Families are experiencing challenges due to behavioral health issues or SUD, may have children in crisis, be pregnant, have oral health access limitations, and be living with chronic disease. The people who interact with those individuals and families are in clinical and non-clinical settings, including police, fire, EMS, courts, and others. The population the North Sound region opted to address fell across all of the strategies.

In addition, North Sound ACH chose to prioritize addressing equity as a grounding, crosscutting strategy, looking at issues of race, ethnicity, Tribes, geography, and poverty. The region is embarking on a multi-year Tribal and equity learning journey that will transform the region and its partners.

Lastly, North Sound is the only region where a county is separated from the mainland by a body of water, making access a unique challenge. This region is dependent on a ferry system to transport an individual in a behavioral health crisis.

Medicaid Transformation and the collaborative structure

North Sound ACH, working with clinical and community partner leaders, transformed the eight project areas into four initiatives: care coordination, care integration, care transformation, and capacity building. Capacity building includes crosscutting strategies, such as quality improvement, training, equity strategies, and launch of the Tribal and equity learning series. This approach allowed the region to foster partners working on common strategies to work together and form relationships to expand opportunities for additional work.

Technical assistance

To support partners, North Sound ACH has built a network of:

- Online tools, such as fact sheets, briefs, source documents for evidence-based models, webinars, and a partner resource portal.
- In-person convening, some broadly focused on all partners while others are smaller, bringing together partners working on oral health, or community paramedicine.

Tribes of the Salish Sea

North Sound ACH is building relationships with each of the eight tribes upon whose land we currently live. The North Sound ACH Board passed a resolution in 2016 establishing eight seats on the Board, one for each Tribe. Currently, seven seats have a representative appointed by their Tribal government. The North Sound ACH Board has had a preliminary training on Tribal sovereignty and made a commitment to host a Board meeting at each of the eight Tribes, to learn

about the work and priorities of each in the North Sound region. The Board meets six times each year, and has so far held a board meeting at four of the eight Tribal locations.

Equity

The North Sound ACH leadership, including the Board of Directors, made a commitment in 2017 to equity resulting in an explicit requirement of contracting partners to embark on a Tribal and equity learning journey with us. The region has engaged national experts to help inform and provide technical assistance to this journey. The ACH also turned to regional partners, including Children of the Setting Sun, to launch the Tribal learning journey. Participation in this learning journey is a condition of receiving any payment from the North Sound ACH. The region also included specific elements in the crosscutting section of partner change plans to address equity. Examples include partners providing:

- Toll-free phone access to their organization.
- Interpreter services.

On written and web materials, a link to how information can be obtained in a language other than English.

Project overview

Project 2A: bi-directional integration (required)

Through a whole-person approach, bi-directional integration of care has the potential to affect all Medicaid enrollees in the North Sound ACH region by targeting the expansion of health services to two key demographics:

1. Enrollees with behavioral health needs using the primary care system.
2. People with serious mental illness.

Key North Sound ACH partners in this project area are health systems, regional hospitals, federally qualified health centers, behavioral health providers, and primary care clinics. Both directions of integration will work to transform clinical practice to team-based medicine that serves the whole-person in either practice setting.

Project 2B: community based care coordination

Guided by john a. powell's work on targeted universalism[5], North Sound ACH is implementing the Care Coordination Project using core elements of the Pathways Community HUB model. Establishing a care coordination HUB in the North Sound region ensures patients and clients

[5] Targeted universalism is a way to address health equity by setting universal goals pursued by targeted processes to achieve those goals. Within a targeted universalism framework, universal goals are established for all groups concerned. The strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal.

receive robust care coordination through community based care coordinators, including CHWs who can help them navigate resources.

The region's care coordination HUB will connect more Medicaid enrollees with community based services, improving outcomes, and reducing costs. The Pathways model also provides North Sound ACH and their partners with a formal structure for reducing duplication of care coordination providers, achieving better health outcomes, and addressing social determinants of health.

In the planning process, North Sound ACH collaborated with MCOs and other partners to ensure a design for the HUB and a system that has potential for payer buy-in, and can last beyond the MTP period. Additionally, North Sound ACH sees opportunities to pursue other sources of HUB funding (e.g., private insurance payers, foundations) as they scale the model.

Project 2C: transitional care

This project is focused on transitions from inpatient hospitalization, from inpatient mental health and SUD treatment facilities and incarceration. The strategies used to improve transitions in each of these areas build upon and add to existing work to improve transitions of care in the North Sound region. Some of North Sound ACH's crosscutting strategies to improve transitions from all care settings include:

- Supporting widespread adoption and expansion of HIE tools, such as PreManage for care management at physical health, behavioral, social service providers, including jail-based health providers.
- Building capacity to serve targeted populations.
- Establishment of sustainable funding sources for transitional care planning, through VBP systems for health care providers or dedicated county funding for jail transition services.
- Integration of behavioral health screening in non-behavioral health provider settings through the CoCM, whether in inpatient physical health facilities or at booking in jails to identify which patients need behavioral health services.
- North Sound ACH expects implementation of the North Sound Community HUB will positively affect most of the care coordination measures for transitional care. This is because of the importance of effective community based care coordination for follow-ups after discharge, hospitalization, ED utilization, and readmission.

Project 2D: diversion interventions

Recognizing the current burden to North Sound's health and community systems due to the lack of high intensity/cross-sector care plans that address high utilizers' needs, North Sound ACH supports coordinated and wrap-around care through community paramedicine and complex case care coordination. Both strategies were put in place to improve health outcomes for high-risk, high utilizer individuals in the North Sound region. Both strategies use a patient-centered, evidence-based approach to meet the complex needs of these community members, including regional priorities, such as homelessness. Both strategies engage first responders as key partners, including fire, EMS, and police.

Project 3A: addressing the opioid use public health crisis (required)

Physical and behavioral health providers, local health jurisdictions, county human services, SUD treatment providers, experts from the University of Washington, and others developed a comprehensive regional Opioid Reduction Plan (ORP). This served as the foundation of the North Sound ACH approach to this project.

North Sound ACH partnered with the behavioral health administrative services organization (formerly the behavioral health organization) and other regional partners in the exploration of the ORP to implement collaborative strategies. North Sound ACH will leverage external resources while coordinating with regional stakeholders to avoid duplication of efforts and create synergy.

Project 3B: reproductive and maternal and child health

North Sound ACH is working to reduce unintended pregnancy, increase healthy planned pregnancies, strengthen and support young families, and promote early childhood health and well-being. This work sets the foundation for good health across the life course. To achieve these goals, North Sound ACH has put several strategies in place, including:

- Establishing the systems and supports needed to integrate and evaluate One Key Question pregnancy intention screening.
- Establishing counseling and support into physical health care practices and behavioral health settings, with a focus on settings serving women between the ages of 15 and 30 who are low-income (at or below 185 percent of the Federal Poverty Level).
- Linking pregnancy intention screening and counseling with access to effective contraception, particularly Long-Acting Reversible Contraception, as well as preconception care, counseling, and risk reduction for those planning for pregnancy.

Project 3C: access to oral health services

North Sound ACH oral health capacity building strategies aim to expand access to and utilization of dental care by addressing barriers to care due to lack of capacity and location of care. These strategies include:

- Expansion of existing clinic capacity.
- Implementation of new provider models.
- Integration of dental screening and referral into primary care practices.
- Mobile dental services in community settings.

The North Sound region, with support from the ARCORA Foundation, is facilitating a Local Impact Network of regional partners to collaborate on agenda setting, prioritizing investment strategies, and looking for ways for local and regional partners to work together to address oral health strategies. A second set of regional strategies were designed to introduce population management approaches and coach practices on how to use them. North Sound ACH and partner organizations are working to include more diverse partners in this work, and conduct outreach to private dentists to increase participation and collaboration in serving Medicaid patients.

Project 3D: chronic disease prevention and control

North Sound ACH's objective for this project is to integrate health system and evidence-based community approaches to improve chronic disease management and control. There are several chronic disease prevention and management best practices being implemented across the region, focused on reducing chronic disease burden through clinician-patient teams and community based resource referral links.

Additionally, the North Sound ACH is working to expand regional capacity for community based chronic disease prevention and management, and referral to community based resources, which requires strong, available community programs where patients can receive support in self-management and lifestyle modification.

Olympic Community of Health

Project implementation highlights

OCH proudly serves Kitsap, Clallam, and Jefferson counties and the sovereign nations of the Hoh, Jamestown S'Klallam, Lower Elwha Klallam, Makah, Port Gamble S'Klallam, Quileute, and Suquamish Tribes. By population, the Olympic region is the smallest ACH. Our region is home to Olympic National Park and many other bucolic landscapes and terrains. Key challenges in the Olympic region include access and engagement in rural and frontier areas and attracting and retaining a talented health care workforce. That said, our region has seen early success in many areas of Medicaid Transformation work.

The first effort in the Olympic region was to tackle the growing opioid epidemic. The Three-County Coordinated Opioid Response Project (3CCORP) works tirelessly to engage multiple sectors and organizations including providers, drug courts, first responders, law enforcement, youth, public health, community-based organizations and others to:

- Increase the number of medication assisted treatment (MAT) providers and programs.
- Reduce overdose deaths.
- Provide the Six Building Blocks program in multiple provider organizations.

We have also collaborated with partners to add new dental chairs in remote areas of our region, launch a community paramedicine program in Clallam County, and initiate a police navigator program in Jefferson County. Providers in the region are also implementing low-tech solutions to coordinate care given the limited HIE capabilities throughout the region. As one example of this, Forks Hospital saw a 50 percent reduction in emergency room visits because of internal care coordination strategies.

Project overview

Project 2A: bi-directional integration (required)

OCH's strategies include supporting primary care and behavioral health partners adopting the Bree Collaborative approach by improving population health management capacity, sharing strategies for sufficient and trained workforce, furthering payment methodologies for sustainability to develop, and maintaining:

- Integrated care teams.
- Patient access to behavioral health as routine part of care.
- Accessibility and sharing of patient information.
- Practice access to psychiatric services.
- Operational systems and workflows to support population-based care.
- Evidence-based treatments.
- Patient involvement in care.
- Data for quality improvement.

Project 2D: diversions interventions

OCH's selected diversion strategies are expected to not only decrease unnecessary emergency room visits, but also reduce arrests and deaths due to opioid overdose and homelessness, while increasing the benefits associated with having a patient-centered medical home, such as chronic disease education management and MAT for OUD.

Reducing high utilization requires improvements in systems of care coordination, patient engagement and activation, and access to primary care. This project addresses all three of these areas through two evidence-based approaches: ER is for emergencies and community paramedicine.

For diversion strategies, there are a few existing programs and providers whose expertise can inform implementation of transformational strategies within change plans. One example is Kitsap Connect, a care coordination program serving persons who are high utilizers of the ED stemming from complications of severe mental illness, chemical dependency, and homelessness.

Peninsula Community Health Services, CHI/Harrison Medical Center, Kitsap Public Health, Kitsap Mental Health Services, and the county jail system work together to ensure the highest utilizers of costly health and social services are connected to a medical home, housing, and behavioral health. Lessons learned from existing efforts are also shared across NCCs to help providers identify optimal transformation strategies, including a focus on community-clinical linkages and collective impact.

Project 3A: addressing the opioid use public health crisis (required)

OCH leveraged SIM funding to implement Phase One of 3CCORP with a group of community partners and engaged Tribes to create a regional opioid response plan. The three goals in the response plan are:

1. Prevention of opioid misuse and abuse, including among youth, primarily through improving prescribing practices and community education.
2. Improve access to the full spectrum of best practices for the treatment of OUD, including among pregnant and parenting women. This is done primarily through increasing the number of waivered primary care providers, increasing support for waivered providers to increase the number of patients they can serve, aligning outpatient SUD providers and MAT prescribers to coordinate care, promoting regional efforts, and promoting community education.
3. Prevent opioid overdose primarily through increasing the number of people trained to recognize and respond to an overdose, increasing the number of access points for naloxone, promoting safe storage and disposal of medicines, and promoting community education.

The structure of 3CCORP consists of a multi-sector steering committee that reports to the OCH Board of Directors and three workgroups. 3CCORP hosts an annual opioid response summit and collaborates with the University of Washington Six Building Blocks program to support clinical practice changes.

Project 3B: reproductive and maternal and child health

The primary goal of this project is to improve the reproductive health of women, men, and couples, with a focus on the period before and between conception. The secondary goal is to increase awareness of the need for well-child checks, improve the referral processes into providers for these visits, and create provider learning collaboratives to enhance trauma-informed care and patient outreach and engagement. This project will employ two evidence-based strategies:

1. Centers for Disease Control and Prevention recommendations for preconception health and health care, which include individual responsibility across the life span; consumer awareness; preventive visits; interventions for identified risks; inter-conception care; pre-pregnancy check-ups; health insurance coverage for women with low incomes; public health programs and strategies; research; and monitoring improvements.
2. Coordinated, targeted outreach, and engagement to increase well-child visits, which include hand-off from Coordinated Care, an MCO, to Peninsula Community Health Services; system wide, targeted outreach and engagement; population health management system; and CHWs.

Project 3C: access to oral health services

OCH's expected outcomes for Project 3C include increased utilization of dental services by Medicaid beneficiaries, increased periodontal evaluation and ongoing care in adults with chronic periodontitis, increased dental sealants for children, and decreased ED visits attributed to dental issues. Integrating oral health prevention interventions like oral exams, oral health education, and fluoride varnish into primary care visits, including well-child visits, and into school-based clinics is a key strategy of this project.

Additionally, OCH partners with the Arcora Foundation to advance MTP oral health efforts. The Arcora foundation is providing additional dollars to the Olympic region to create, implement, and evaluate a Local Impact Network.

Project 3D: chronic disease prevention and control

OCH strategies for Project 3D are focused on organization of the health care delivery system through community linkages, self-management support, decision support, delivery system redesign, and clinic information systems.

Partners have selected the CCM and National Heart, Lung, and Blood Institute Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (EPR-3) to guide practice transformation around the management of diabetes, cardiovascular disease, hypertension, and asthma. Existing efforts include regional offerings of chronic disease self-management (including Wisdom Warriors) and Diabetes Prevention Programs, primarily through community-based organizations and Tribal clinics.

The three public health departments in the region have collaborated around policy, systems, and environmental changes to improve access to healthy eating and active living through local coalitions.

SWACH (Southwest ACH)

Project implementation highlights

SWACH is supporting a hepatitis C Cures Project**.** The partnership between SeaMar, Community Voices are Born, and SWACH, formed in March 2018, seeks to see 20 percent increase in hepatitis C treatment as compared to baseline data for six months previous to peer provider services. This will be achieved through a community/clinical collaboration, bringing peer providers alongside the clinical team to improve treatment adherence through care coordination and patient self-management support.

Initial data looks promising. The period in which a patient can be supported through the hepatitis C Cures peer program is 22-30 weeks. This varies depending on the condition of their liver and when they receive their first round of medication. Many engaged patients are waiting to start medication.

Success story: peer support overcomes stigma and trust barriers while supporting patient-centered whole-person health care

Mr. Smith sought hepatitis C treatment at a local clinic, met with a physician, then met with a peer who presented the hepatitis C program and an opportunity for peer support. The peer shared her personal story of addiction and recovery and successful hepatitis C treatment. She reassured Mr. Smith that she would support him in hepatitis C treatment as well as connect him to treatment services for SUD. Mr. Smith is now in recovery, on MAT, engaged in hepatitis C treatment, and supported by a trusted peer in addressing his physical, behavioral, and social barriers to improving his health.

As of October 2018, the peer program started, and 101 patients have presented at a hepatitis C Clinic to initiate hepatitis C treatment between October 2018 and June 2019. More than 75 percent of patients have elected peer support, and 24.75 percent elected not to receive peer support.

Table 2: hepatitis C Cures Project outcomes

	Peer Supported Pts	Unsupported Pts	All Patients
Started Medication	39 (51.3% of supported pts) *34 (44.7%) yet to start but engaged in regular peer contact*	5 (20% of unsupported pts)	44 (43.56% of all pts)
Finished Medication	35 (46.1% of supported pts)	3 (12% of unsupported pts)	38 (37.62% of all pts)
Test of Cure/Cured	10 (13.2% of supported pts)	0 (0% of unsupported pts)	10 (9.9% of all pts)
Patients actively engaged in care / supported by peer	73 (97% of supported pts)	5 (20% of unsupported pts)	78 (77.2% of all pts)

Expected outcomes include a reduction of acute hepatitis C infections resulting in lower healthcare utilization costs.

SWACH is also leading innovative clinical-community linkage work in their region. PeaceHealth Family Medicine of Southwest Washington is the patient-centered medical home for about 3,400 patients on Medicaid in the Southwest region. This facility provides both medical and behavioral health care for its patients. SWACH is working in partnership with PeaceHealth to improve the system of care for these clients through Access to Health, a partnership formed to address enrollment in benefits, improve access to care, and support better health for clients.

The majority of PeaceHealth patients live in Rose Village, which is a public-supported housing community located near the clinic. SWACH CHWs live and work in Rose Village. They are residents of the community who build trusting relationships with community members to advocate for the community as a whole. They bring the community's voice to systems that affect the community, such as government and health care delivery organizations' policies and processes. The PeaceHealth and CHWs are working together to improve clinical-community linkages—how the clinic can better serve the community and what the community can do to support individual health management outside the walls of the clinic.

The first project is Transitioning to Medicare Benefits. Rose Village residents who are eligible for Medicare benefits may not be signing up for Medicare A, B, and D, and therefore cannot access or pay for their healthcare services. Signing up for these benefits is complicated. Barriers to enrolling may include language and cultural differences, level of education, additional of out of pocket costs for care and prescriptions, and loss of dental, vision, and transportation benefits. Through outreach and support by SWACH CHWs, 75 percent of eligible PeaceHealth who live in Rose Village will have enrolled in Parts A and B of the Medicare plan by August 31, 2020.

The current payment system does not reimburse the clinic for population-based and individual support in enrolling in healthcare benefits. Without the benefits, patients cannot afford the healthcare they need. In the future, Rose Village CHWs and PeaceHealth will work together to identify, test, and implement activities that meet the cultural needs of Rose Village residents who are eligible to enroll in Medicare benefits.

Expected outcomes:

- Residents of Rose Village who are eligible to enroll in Medicare are enrolled without a lapse in health plan benefits.
- The processes tested and implemented for supporting Rose Village members in enrolling in Medicare are sustained over time.
- SWACH Rose Village CHWs and PeaceHealth establish a partnering relationship to leverage continuity between the clinic's role and the community's role in supporting community member well-being.

Project overview

Project 2A: bi-directional integration (required)

In SWACH, Project 2A is built upon five core concepts of integration that have been identified by the Care Integration Committee and that are fundamental in the evidence-based practices and

strategies of the CoCM and the Bree Collaborative. The core concepts go beyond a single project and provide a foundational path for sustainable integration beyond the project timeline.

The core concepts include:

1. Offering enhanced development of integrated care teams.
2. Ensuring behavioral health and primary care become routine services, including health screenings, regardless of setting.
3. Sharing of clinical information across settings.
4. Implementing strategies and systems to increase capacity to support population health management.
5. Utilizing data to provide accountable care.

SWACH does not require providers to choose between the CoCM and a specific model of clinical integration. The core concepts of integration that have been identified allow providers to develop practical models of integration that align with their strategic goals and the variety of clinical settings they operate.

Project 2B: community based care coordination

The SWACH HealthConnect HUB project seeks to reduce health disparities by providing community-based, culturally competent, and person-centered care coordination for targeted, vulnerable populations in their region. The HUB infrastructure provides tools and strategies necessary to ensure at-risk individuals in a community are served in a timely, coordinated manner, and utilizes a trained and expanding CHW workforce to do so. The HUB ensures persons and populations within the region it serves are connected to meaningful health and social services that contribute to positive health outcomes. Community care coordination is a key SWACH strategy that drives improved health outcomes, health equity, and system savings.

Project 3A: addressing the opioid use public health crisis (required)

Klickitat Valley Health (KVH) is one of two hospital providers in the county with a primary care clinic and has expressed interested in taking a lead in regional implementation of SWACH opioid strategies. Klickitat is a two-hour drive from Clark County, so the KVH Opioid Taskforce was convened in addition to the Opioid Workgroup to identify and act on SWACH opioid strategies specific to the rural Klickitat context.

The SWACH collective impact manager attends taskforce meetings to consider opportunities and plan SWACH project implementation details specific to the KVH context. The SWACH collective impact manager and the KVH physician champion report back to the larger opioid workgroup to ensure coordination and avoid duplication.

Taskforce meetings have explored opportunities for implementation of SWACH strategies in the KVH settings, including:

- Improving opioid prescribing through registration in the state prescription monitoring program (PMP) and participation in the PMP quality improvement program.
- Increasing drug-take back capacity.

- Increasing number of MAT providers.
- Collaborating with Comprehensive Health Services on treatment services, like MAT and counseling.
- Creating protocols for naloxone prescription.
- Supporting expansion of peer services in community.

Regional Medicaid providers have partnered with SWACH to guide opioid project planning through workgroup and committee participation. Opioid workgroup participants represent primary care, hospitals, behavioral health, SUD, public health, schools, community coalitions, MCOs, corrections, and community based organizations.

Project 3D: chronic disease prevention and control

SWACH's strategy for Project 3D recommends for providers to use the CCM elements, including:

- **Systems of care:** promote effective improvement of strategies aimed at comprehensive system change, encourage open and systematic handling of errors, provide incentives based on quality of care, and develop agreements that facilitate coordination of care across organizations.
- **Self-management support:** train providers and staff on helping patients with self-management goals, using evidence-based self-management tools, using group visits to support self-management, set and document self-management goals collaboratively with patients, follow-up, and monitor self-management goals. SWACH also seeks to break down barriers to utilization of CHWs as part of a treatment team; and actively promote evidence-based self-management education for patients as part of whole-person care.
- **Delivery system design:** use planned interactions to support evidence-based care, ensure regular follow-up by care team, define roles and tasks of team members, and provide clinical case management services for complex patients with coordination.
- **Decision support:** embed evidence-based guidelines into daily clinical practice, integrate specialty expertise in primary care, and share evidence-based guidelines and information with patients.
- **Clinical information systems:** provide timely reminders for providers and patients for recommended care, identify relevant subpopulations for proactive care, facilitate individual patient care planning, share information with patients and providers to coordinate care, and monitor performance of practice team.
- **Community based resources:** encourage patients to participate in effective community programs for partnerships with community organizations to support and develop interventions that fill gaps in needed services.

Appendix B: early insights into progress and improvement

Background

This appendix provides a window into progress that occurred during the initial planning years of DSRIP. Data reflects project implementation progress, as well as a point-in-time view of quality and outcome metrics common to all ACH Project Plans. A full description of the state metric production process is available in the DSRIP Measurement Guide. Below are a few concepts to aid interpretation:

Data source: information related to partnering provider participation and ACH incentives earned and distributed are derived from the financial executor portal. Quality and outcome metrics are generated through the state's metric production process that occurs on a quarterly basis. These results, as well for additional population health metrics, are publicly available on the Healthier Washington Dashboard.

Measurement period: data related to partnering provider participation and incentive funds were pulled from the financial executor portal as of September 30, 2019. It is cumulative of all portal activity from the beginning of DSRIP through the end of 2019's third quarter. Quality and outcome metrics represent 12-month measurement periods. The results at the time of this report reflect January 1–December 31, 2018.

Selection of quality and outcome metrics highlighted: there are more than 50 quality and outcome metrics associated with DSRIP performance (including metrics with specific sub-rates, such as age group). Since the timing of this report corresponds with the end of the first performance measurement period, there is an emphasis on the DSRIP performance metrics that ACHs have in common across their approved Project Plans, and that ACHs are accountable for performance beginning in DY 3 (2019). These metrics align with the Statewide Common Measure Set and metrics in the MCO VBP withhold program.

ACH acronyms

Below are the acronyms for each ACH, which is how the name will appear in the tables within this appendix.

- Better Health Together (BHT)
- Cascade Pacific Action Alliance (CPAA)
- Elevate Health (EH)
- Greater Columbia (GCACH)
- HealthierHere (HH)
- North Central (NCACH)
- North Sound (NSACH)
- Olympic Community of Health (OCH)
- Southwest ACH (SWACH)

Evidence of project progress: partnerships and incentives

Since CMS approved MTP and the DSRIP program just two and half years ago, all nine ACHs are fully functioning organizations, staffed to do the work of DSRIP. ACHs established partnerships across their communities and mobilized efforts to define and implement health transformation strategies that best fit the context of the region.

Partnering provider organizations are committed to participate. ACHs have established elaborate networks of partners to implement community driven health transformation approaches. Partners span a variety of settings and types, including but not limited to primary care, behavioral health, oral health, Tribes, hospitals, and community based organizations. According to the financial executor portal, more than 500 organizations are participating in DSRIP activities in one or more ACH. Non-Tribal providers are categorized according to traditional Medicaid providers and non-traditional Medicaid providers.

- **Traditional Medicaid provider**: these providers bill for services, either to an MCO or to the state directly (e.g., hospitals, primary care providers).
- **Non-traditional Medicaid provider**: this category of partners may receive some Medicaid funding through programs that provide grant dollars, but they do not provide billable healthcare services to Medicaid members (e.g., behavioral health organizations, community based organizations, fire districts).

While it may be the case that the list of partners registered in the financial executor portal is not exhaustive of all entities supporting project activities, it is a reliable indicator of the breadth of partner engagement at the regional level.[6] If a provider organization is partnered with more than one ACH, the organization will be counted under each ACH it partnered with for DSRIP.

Table 3: number of partnering providers registered in financial executor portal, by ACH (as of September 30, 2019)

Type	BHT	CPAA	EH	GCACH	HH	NCACH	NSACH	OCH	SWACH
Non-traditional provider	34	26	22	38	67	23	46	11	17
Traditional Medicaid provider	43	59	67	78	95	50	70	55	59
Tribal provider (IHS)	-	1	-	-	-	-	-	-	-
Tribal provider (Tribe)	4	6	-	1	2	-	5	3	1
Tribal provider (UIHP)	2	-	-	-	1	-	-	-	-
Total	83	92	89	117	165	73	121	69	77

[6] MCOs are expected to participate in delivery system reform efforts as a matter of business interest and contractual obligation to the state. For this reason, they do not receive incentive payments for participation in ACH-led transformation projects. However, MCOs are eligible to earn MCO VBP incentives (through the challenge pool) for achieving annual MCO VBP targets.

Through semi-annual reporting, ACHs report on their DSRIP activities, project implementation, and progress on required milestones as outlined in the Project Toolkit. ACHs submit semi-annual reports every six months. The IA reviews submissions to verify project milestone completion and related eligibility for incentives. After rigorous independent assessment, all nine ACHs demonstrated completion of milestones as of the first half of 2019. To date, all ACH regions have earned the full amount of incentive funds to continue health transformation efforts.

Under DSRIP, regions that implement IMC prior to 2020 were eligible to earn additional incentive payments above the ACH's maximum valuation for project plans. Incentive payments earned for IMC milestones are to assist providers and the region with the process of transitioning to IMC. As of the latest reporting period, ACHs demonstrated the use of integration incentive funding for billing and information technology technical assistance, EHR incentive payments, managed care contract training, and for milestones for IMC planning and/or readiness assessments in the region.

Table 4: type of incentive funds earned, January 2017–September 2019

ACH	Project incentives	Project plan bonus	VBP incentives	Integration incentives	Total
BHT	$40,069,350.95	-	$300,000.00	$8,301,872.00	$48,671,222.95
CPAA	$36,426,682.94	$1,455,842.00	$300,000.00	-	$38,182,524.94
EH	$43,712,018.53	-	$300,000.00	$9,321,788.00	$53,333,806.53
GCACH	$50,997,357.21	-	$300,000.00	$10,183,916.00	$61,481,273.21
HH	$80,138,702.40	-	$300,000.00	$14,888,792.00	$95,327,494.40
NCACH	$18,213,341.01	$1,455,842.00	$300,000.00	$5,781,980.00	$25,751,163.01
NSACH	$54,640,023.06	$1,941,123.00	$300,000.00	$10,831,088.00	$67,712,234.06
OCH	$14,570,674.42	$1,455,842.00	$300,000.00	-	$16,326,516.42
SWACH	$25,498,678.50	-	$300,000.00	$8,802,056.00	$34,600,734.50
TOTAL	$364,266,829.02	$6,308,649.00	$2,700,000.00	$68,111,492.00	$441,386,970.02

The success and sustainability of the state's DSRIP program is dependent on moving along the VBP continuum, at both the state and regional level. ACHs earn incentives for demonstrated improvement and achievement of VBP adoption targets in their regions.

During DSRIP, ACHs are accountable for investing resources to support partnering providers. Similar to project incentives, VBP incentives shift from P4R to P4P in the latter years of DSRIP. ACHs used a number of strategies to support regional providers in the transition to VBP. These efforts included notifying providers of VBP readiness tools, convening partners for workgroups and webinars, and supporting organizational assessments of strengths and opportunities for moving to VBP contracting. The first assessment of regional VBP adoption target attainment will be complete in the fourth quarter of 2019.

At-a-glance: indicators of regional improvement

As DSRIP implementation progresses, ACHs are increasingly accountable for demonstrating improvement for a set of quality and outcome metrics associated with the ACH project portfolios. The first two years of DSRIP focused on planning and initial project implementation. As such, the first two years of metric results reflect baseline performance, from which to measure performance in the later years of DSRIP. As of October 2019, the state completed calculation of metric results for calendar year 2018. The state now has P4P metric results for the first two baseline years of DSRIP, providing a look at opportunities for regional improvement.

- The metrics highlighted below are a subset of metrics common to all ACH project portfolios, and for which ACHs are accountable for performance beginning in DY 3 (with official results available fall 2020).
- Metric results were calculated according to standard criteria that are consistently applied over the course of DSRIP. Metric specific criteria constricts the total Medicaid population to the specific subpopulation of focus for the metric. Eligible population criteria further narrows the population to the beneficiaries who meet DSRIP project P4P Medicaid eligibility criteria. Finally, regional attribution identifies how to attribute a beneficiary to a single ACH for a given measurement period. For more information, see Measurement Guide (Chapter 7) and metric-specific technical specifications.
- The table below reflects a comparison of 2018 and 2017 results. As 2017 and 2018 results serve as baselines for 2019 and 2020 (respectively). Full metric details and results are available on the Healthier Washington Dashboard.

Overall, early results from the initial DSRIP baseline periods indicate improvements by the state and ACHs, with opportunities for continued effort and progress. The state and ACH regions demonstrated some improvement on more than 60 percent of metric results reviewed from this set of P4P metrics. Different factors influence metric results, beyond the DSRIP work underway in each ACH region. The state will continue to implement metric production processes that are consistent with best practices and yield timely, actionable insights into state, regional, and local progress.

This table displays a subset of P4P metrics that ACHs are accountable for in 2019. Shaded cells indicate improvement during calendar year 2018, compared to calendar year 2017.

Table 1: comparison of results, calendar year 2018 compared to calendar year 2017

DSRIP P4P metric	STATE	BHT	CPAA	EH	HH	GCACH	NCACH	NSACH	OCH	SWACH
All cause ED visits, 0-17 years										
All cause ED visits, 18-64 years										
All cause ED visits, 65+ years										
Plan all-cause readmissions (30-days)										
Mental health treatment penetration, 0-17 years										
Mental health treatment penetration, 18-64 years										
Substance use disorder treatment penetration, 12-17 years										
Substance use disorder treatment penetration, 18-64 years										
Patients prescribed chronic concurrent opioids and sedatives										
Patients prescribed high-dose chronic opioid therapy (>50 mg MED)										
Patients prescribed high-dose chronic opioid therapy (>90 mg MED)										
Antidepressant medication management, acute										
Antidepressant medication management, continuation										
Comprehensive diabetes care: HBA1c testing										
Comprehensive diabetes care: medical attention for nephropathy										
Child and adolescent access to primary care, 12-24 months										
Child and adolescent access to primary care, 25 months - 6 years										

Child and adolescent access to primary care, 7-11 years										
Child and adolescent access to primary care, 12-19 years										

Table displays subset of P4P metrics that ACHs are accountable for in 2019 ("active" P4P metrics). Shaded cells (BLUE) indicate improvement during calendar year 2018, compared to calendar year 2019.

What's ahead

DSRIP provides the opportunity for time-limited, up-front investments to advance health systems transformation. With the support of ACHs, partnering providers can invest in the things they need to ensure individuals and families receive the care and services they need to be healthy, and ultimately improve health outcomes.

The state continues to make important progress in health system transformation, but there is opportunity for DSRIP resources to create change. Early successes, such as the establishment of robust partnerships, successful approval of community driven transformation approaches and on-track, assessed implementation activities, lay the foundation for successful regional performance on outcome metrics, and promote sustainability of transformation post-DSRIP.

State resources to monitor progress

- Healthier Washington Dashboard
- Analytics, Research, and Measurement Data Dashboard
- Washington Tracking Network

Appendix C: Project Toolkit P4P metrics

The following table provides a high-level description for the Project Toolkit P4P metrics. Full measure specifications and measure production information is available in the DSRIP Measurement Guide.

Table 6: Project Toolkit P4P metrics

How to read the table	
Name of measure	Term used to reference the measure.
NQF#	Measures endorsed by National Quality Forum (NQF) will have an identification number. A full list of NQF-endorsed measures is available through the Quality Positioning System.
Measure steward	An individual or organization that owns a measure is responsible for maintaining the measure. Measure stewards are often the same as measure developers, but not always. Measure stewards are also an ongoing point of contact for people interested in a given measure.[7]
Measure description	Summary information to provide high-level understanding of measure intent.
ACH P4P metrics for project incentives, by year	Outlines the DYs when the measure is "activated", or associated with project P4P incentives. P4P begins DY3; however, not all measures are "activated" at the same time.
Associated Toolkit projects	Indicates the projects for which the metric is associated with project P4P incentives.
ACH high-performance metric	Indicates whether the metric is associated with earning incentives from the ACH high-performance pool.

[7] More information is available at https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=73681.

Table 7: ACH project P4P metrics

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Acute Hospital Utilization	N/A	NCQA (HEDIS)	The rate of acute inpatient discharges among Medicaid beneficiaries, 18 years of age and older, during the measurement year. Measure is expressed as a rate per 1,000 denominator member months.	Inactive	P4P	P4P	2.a, 2.b, 2.c, 3.a, 3.d	N
All Cause ED Visits per 1,000 Member Months	N/A	WA DSHS (RDA)	The rate of Medicaid beneficiary visits to an emergency department during the measurement year, including visits related to mental health and SUD. Measure is expressed as a rate per 1,000 denominator member months.	P4P	P4P	P4P	2.a, 2.b, 2.c, 2.d, 3.a, 3.b 3.c, 3.d	Y
Antidepressant Medication Management	0105	NCQA (HEDIS)	The percentage of Medicaid beneficiaries, 18 years of age and older, who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment during the measurement year.	P4P	P4P	P4P	2.a	Y

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Asthma Medication Ratio	1800	NCQA (HEDIS)	The percentage of Medicaid beneficiaries, 5-64 years of age, who were identified as having persistent asthma and had a ratio of controller medication to total asthma medications of 0.50 or greater during the measurement year.	Inactive	P4P	P4P	2.a, 3.d	Y (DY 4, DY 5)
Children's and Adolescents' Access to Primary Care Practitioners	N/A	NCQA (HEDIS - Modified)	The percentage of Medicaid beneficiaries, 12 months-19 years of age, who had an ambulatory or preventive care visit during the measurement year.	P4P	P4P	P4P	2.a, 3.d	N
Childhood Immunization Status (Combo 10)	0038	NCQA (HEDIS)	The percentage of Medicaid beneficiaries who turned 2 years of age during the measurement year who, by their second birthday, received all vaccinations in the Combo 10 vaccination set.	Inactive	P4P	P4P	3.b	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Chlamydia Screening in Women	0033	NCQA (HEDIS)	The percentage of female Medicaid beneficiaries, 16-24 years of age, identified as sexually active and who had at least one test for chlamydia during the measurement year.	P4P	P4P	P4P	3.b	N
Comprehensive Diabetes Care: Eye Exam (retinal) Performed	0055	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (Type 1 and Type 2) who had a retinal or dilated eye exam by an eye care professional during the measurement year, OR a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement year.	Inactive	P4P	P4P	2.a, 3.d	N
Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (Type 1 and Type 2) who received a Hemoglobin A1c (HbA1c) test during the measurement year.	P4P	P4P	P4P	2.a, 3.d	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 18-75 years of age, with diabetes (Type 1 and Type 2) who had a nephropathy screening test or evidence of nephropathy during the measurement year.	P4P	P4P	P4P	2.a, 3.d	N
Contraceptive Care – Most & Moderately Effective Methods	2903	US Office of Population Affairs	The percent of female Medicaid beneficiaries, 15-44 years of age, at risk of unintended pregnancy who are provided a most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception during the measurement year.	Inactive	P4P	P4P	3.b	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Contraceptive Care – Postpartum	2902	U.S. Office of Population Affairs	The percent of female Medicaid beneficiaries, 15-44 years of age, who had a live birth who are provided a most effective (i.e., sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved method of contraception within 3 and 60 days of delivery during the measurement year.	Inactive	P4P	P4P	3.b	N
Dental Sealants for Children at Elevated Caries Risk	2508, 2509	Dental Quality Alliance (DQA)	The percent of Medicaid beneficiaries, 6-14 years of age, at elevated risk of dental caries who received a sealant on a permanent first molar tooth (age 6-9 years) or a sealant on a permanent second molar tooth (age 10-14 years) during the measurement year.	Inactive	Inactive	P4P	3.c	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence	2605	NCQA (HEDIS)	The percent of ED visits for Medicaid beneficiaries, 13 years of age and older, with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. ED visit and follow-up must occur during the measurement year.	Inactive	P4P	P4P	2.a, 2.b, 2.c	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Follow-up After ED Visit for Mental Illness	2605	NCQA (HEDIS)	The percent of ED visits for Medicaid beneficiaries, 6 years of age and older, with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit. 2. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. ED visit and follow-up must occur during the measurement year.	Inactive	P4P	P4P	2.a, 2.b, 2.c	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Follow-up After Hospitalization for Mental Illness	0576	NCQA (HEDIS)	The percent of discharges for Medicaid beneficiaries, 6 years of age and older, who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 7 days after discharge. 2. The percentage of discharges for which the member received follow-up within 30 days after discharge. Hospitalization discharge and follow-up must occur during the measurement year.	Inactive	P4P	P4P	2.a, 2.b, 2.c	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Medication Management for People with Asthma: Medication Compliance 75%	1799	NCQA (HEDIS)	The percent of Medicaid beneficiaries, 5-64 years of age, who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for the treatment period during the measurement year. Rate are reported for the percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	P4P	Inactive	Inactive	2.a, 3.d	Y (DY 3 only)
Mental Health Treatment Penetration (Broad Version)	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries, 6 years of age and older, with a mental health service need identified within the past two years, who received at least one qualifying service during the measurement year.	P4P	P4P	P4P	2.a, 2.b, 3.b	Y
Patients Prescribed Chronic Concurrent Opioids and Sedatives Prescriptions	N/A	Bree Collaborative	The percent of Medicaid beneficiaries prescribed opioids and a concurrent sedative prescription, among beneficiaries prescribed chronic opioids.	P4P	P4P	P4P	3.a	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Patients Prescribed High-dose Chronic Opioid Therapy	N/A	Bree Collaborative	The percent of Medicaid beneficiaries prescribed chronic opioid therapy. Two rates reported according to dosage threshold: (1) Greater than or equal to 50mg morphine equivalent dosage in a quarter. (2) Greater than or equal to 90mg morphine equivalent dosage in a quarter.	P4P	P4P	P4P	3.a	N
Percent Arrested	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries, ages 18 and older, who were arrested at least once during the measurement year.	Inactive	P4P	P4P	2.d	Y
Percent Homeless (Narrow Definition)	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries who were homeless in at least one month during the measurement year. Narrow definition excludes "homeless with housing" living arrangement code from the Automated Client Eligibility System.	P4P	P4P	P4P	2.b, 2.c, 2.d	Y

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Periodontal Evaluation in Adults with Chronic Periodontitis	N/A	Dental Quality Alliance (DQA)	The percent of Medicaid beneficiaries, ages 30 years and older, with history of periodontitis who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the measurement year.	Inactive	P4P	P4P	3.c	N
Plan All-Cause Readmission Rate (30 Days)	1768	NCQA (HEDIS)	The percent of acute inpatient stays among Medicaid beneficiaries, 18 years of age and older, during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	P4P	P4P	P4P	2.a, 2.b, 2.c	Y
Primary Caries Prevention Intervention as Offered by Medical Provider: Topical Fluoride Application Delivered by Non-Dental Health Professional	N/A	WA Health Care Authority (HCA)	The percent of Medicaid beneficiaries, 0-5 years of age, who received a topical fluoride application from a profession provider (non-dental medical provider) during any medical visit during the measurement year.	P4P	P4P	P4P	3.c	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Statin Therapy for Patients with Cardiovascular Disease (Prescribed)	N/A	NCQA (HEDIS)	The percent of Medicaid beneficiaries, male 21-75 years of age and females 40-75 years of age, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one high- or moderate-intensity statin medication during the measurement year.	Inactive	P4P	P4P	3.d	N
SUD Treatment Penetration	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries 12 years of age and older with a SUD treatment need identified within the past two years, and who received at least one qualifying SUD treatment during the measurement year.	P4P	P4P	P4P	2.a, 2.b, 3.b	Y
SUD Treatment Penetration (Opioid)	N/A	WA DSHS (RDA)	The percent of Medicaid beneficiaries, 18 years of age and older, with an OUD treatment need identified within the past two years, who received MAT or medication-only treatment for OUD during the measurement year.	Inactive	P4P	P4P	3.a	N

Name of metric	NQF#	Measure steward	Measure description	ACH P4P metrics for project incentives, by year			Associated Toolkit projects	ACH high-performance metric
				DY 3 (2019)	DY 4 (2020)	DY 5 (2021)		
Timeliness of Prenatal Care	N/A	NCQA (HEDIS)	The percent of live birth deliveries that received a prenatal care visit in the first trimester, on the enrollment start date or within 42 days of enrollment during the measurement year.	Inactive	P4P	P4P	3.b	N
Utilization of Dental Services	N/A	DQA	The percent of Medicaid beneficiaries who received preventative or restorative dental services in the measurement year.	P4P	P4P	P4P	3.c	N
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	1516	NCQA (HEDIS - Modified)	The percent of Medicaid beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year.	P4P	P4P	P4P	3.b	Y
Well-Child Visits in the First 15 Months of Life	1392	NCQA (HEDIS - Modified)	The percent of Medicaid beneficiaries who turned 15 months old during the measurement year and who had six or more well-child visits during their first 15 months of life.	Inactive	P4P	P4P	3.b	N